INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. PLEASE BRING TO YOUR FIRST SESSION.

Name: _____

(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____

(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status:

□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Please list any children/age: _____

Address: _____

(Street and Number)

_____

(City, State, and Zip)

Home Phone: (_____)_____ May we leave a message? □Yes □No

Cell/Other Phone: (_____)_____ May we leave a message? □Yes □No

E-mail: _____ May we email you? □Yes □No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Who should we contact in case of emergency: _____

Emergency Contact Phone Number: (_____)_____ May we leave a message? □Yes □No

INSURED INFORMATION

Self Pay ( ) Private Insurance ( )

If insurance is to be billed, please complete the following information:

Name of insured:_____DOB:_____

Social Security #:_____Relationship to patient:_____

Address if different from above:_____

Phone numbers if different from above:_____

Insurance Company:_____

Policy ID#_____Group#_____

Add. Ins. _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No

□ Yes, previous therapist/practitioner: _____

3. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

4. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

5. How many times per week do you generally exercise? _____

What types of exercise to you participate in: _____

6. Are you currently experiencing overwhelming sadness, grief or depression?

□ No

□ Yes

If yes, for approximately how long? _____

7. Are you currently experiencing anxiety, panic attacks or have any phobias?

□ No

□ Yes

If yes, when did you begin experiencing this? _____

8. Do you drink alcohol more than once a week?

□ No

□ Yes

9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly

□ Infrequently □ Never

10. Are you currently in a romantic relationship?

□ No

□ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation:

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

_____

4. What do you consider to be some of your weakness?

_____

_____

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

_____

_____

I do hereby seek and consent to take part in treatment. I authorize payment of mental health benefits to ANEW COUNSELING, LLC for the services rendered. I know that I am financially responsible for services received. I understand that my insurance will be billed as a courtesy; however I am responsible for any unpaid balance, including but not limited to co-pays and deductible.

_____ _____

Signature Date

Your signature below indicates that you have received the patient services agreement and agree to its terms and also serves as an acknowledgement that you have received the HIPAA notice for described above.

_____ _____

Signature Date

50 Leanni Way, Suite B-3
Palm Coast, FL – 32137
Phone: (386) 334-3777

Consent to Treatment

This letter serves to inform you about the therapeutic process, give you some information and answer questions about the professional relationship between therapist and clients.

Psychotherapy cannot ensure the successful resolution of the issues you bring to it. Human beings are far too complex and life is too uncertain. However, it is our experience as therapists that most people can gain some value from the therapeutic process. Know that as we journey together, new, often unforeseen destinations may appear. The therapeutic process may not only affect you, but also relationships, work, and other areas of life. There are alternatives and many adjuncts to psychotherapy. These include, but are not limited to, medications, support groups and complimentary modalities. I will be happy to discuss any alternatives you want to consider at any time. We have a number of client expectations about the professional relationship we embark on with each client. We expect you to keep your appointments. Please remember that someone else may want this time. **Please give our other clients, their obligations, relations and your therapist the courtesy of a 24 hour notice if you must cancel an appointment; otherwise, you will be charged <u>THE FULL SESSION FEE</u> for this time (Please see Fee agreement for more information). We always consider broken appointments individually and understand that emergencies do arise. Insurance will not pay for broken appointments. Our current Self-pay fee is $100 per session and $200 for the Initial Assessment Session.** We do have a sliding scale depending on your household income. Payment for your session is due at the time of service. We accept cash, personal checks, and credit cards. We work with a number of insurance companies via managed care contracts and we are responsible for filing claims for our services; you must pay your copay at the time services are rendered, before your session. There are no exceptions. Other insurance plans (out of network) are accepted, but you may be required to pay the difference.

Payment arrangements are discussed during your initial session. **We also charge for our time when you require written correspondence, for example letters to the court, probation officer, School, or your employer, letters to other practitioners, disability applications, etc. This is billed according to the amount of time utilized with a minimum fee of $25.** Insurance will not pay for correspondence. We do not charge for customary insurance filing. Telephone consults are also billed at regular rates. **The first 10 minutes, we consider a professional courtesy to our relationship; thereafter, the time is billed at regular rates to** the nearest quarter hour. Sessions are 45 to 50 minutes in length. We take a few minutes of an hour between clients to relax, let go of the last session and prepare for the next one.

Our appointment times are generally on the hour from 11AM to 8 PM. We do make earlier and later appointments but these are reserved for long standing clients. You may reach us via telephone/voice-mail during regular office hours. If your call is non-urgent, we will respond as soon as possible. Calls left after 8 PM will be returned the following business day at the earliest.

If you are in a life and death emergency situation dial 911 for assistance or go immediately to your local emergency department.

Although the client-therapist sessions will be intimate psychologically, it is important for you to understand that the client-therapist relationship is professional and not social. All contact will be limited to sessions you arrange with your therapist. Sessions are usually held in one of our offices.

If you should encounter your therapist outside of the office, the therapist will speak with you only if you initiate the contact; this allows you to maintain the privacy of your psycho-therapeutic relationship.

Please do not invite your therapist to social gatherings (including, but not limited to, parties, weddings, business meetings, etc.), offer gifts, or ask them to relate to you in any way other than the professional context of our therapy sessions. Although this may seem artificial and/or awkward, it is the best way to promote a good psycho-therapeutic relationship.

Your sessions should focus on your concerns exclusively. You will learn a great deal about your therapist the longer you work together; your therapist may occasionally share experiences and struggles with some regularity as models for clients. Nonetheless, you will still be experiencing the therapist in a professional role solely.

As your therapist, I will keep confidential anything you say with the following exceptions:
1. You direct the therapist to speak about you with someone,
2. The therapist determines that you are a danger to yourself or others, or
3. There is evidence of child or elder abuse. In the event of the latter two exceptions, the therapist will contact family, friends, DCFS and/or law enforcement authorities to attempt to prevent harm from coming to anyone.

We use an eclectic approach to therapy, meaning that we utilize a variety of therapeutic models. We work diligently to use what is most helpful for each individual rather than take any one approach exclusively. We hope this information is helpful to you. If you have any questions at any time during your relationship with your therapist, please feel free to ask.

I do hereby seek and consent to take part in the treatment provided by this agency. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I (or my child) may stop treatment with this therapist at any time. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court ordered, I will have to answer to the court.)
I am aware that an agent of my insurance company or other third-party may be given information about the type (s), cost (s), and providers of any services I receive. I understand that if payment for the services I receive here is not made, the therapist may stop treatment. My signature below shows that I understand and agree with all of these statements. I have been given the opportunity to ask questions regarding this information.

_____ _____
Signature of Client (or person acting for client) **Date**

Client Name _____

Relationship to Client
_____

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Signature of Therapist **Date**

FEE AGREEMENT

- I understand that I will be responsible for full payment of the session fee, as well as for any outstanding balance, prior to my scheduled session. Face-to-face appointments, as well as telephone or SKYPE calls, lasting longer than 5 minutes, will be billed at the same hourly rate. The initial hourly rate shall be $_____.

- Anew Counseling, LLC., will be happy to provide you with an estimate of the cost for specific services prior to your appointment. We accept cash, checks, MasterCard and Visa credit and debit cards.

- It is your responsibility to bring your most current insurance card with you to every office visit. You will be asked to present the card upon arrival along with any applicable co-payment. Please check with your Insurance provider to verify that we are a participating provider. Some charges may not be covered and are your responsibility to pay.

- If you have changed insurance since the previous visit, please obtain the expiration date of the old policy and the effective date for the new coverage prior to your appointment. If this information is not provided, you will be expected to pay the allowed billable amount at the time of service.

- If two or more parties will be responsible for services, Anew Counseling, LLC. May charge either party the full fee, or at our discretion, the fee may be charged proportionately.

- All time involved in the preparation of written reports, telephone calls, communication with other professionals, and any travel expenses will be billed at the same hourly rate.

- I understand that I will be responsible for any postage (first class postage rate) or copying fees ($.50/page) incurred on my behalf by Anew Counseling.

- Any time set aside in preparation for a subpoenaed court appearance, including actual appearances, preparation of testimony or reports to your attorney or the court, travel depositions, or any schedule adjustments necessary to accommodate such a court appearance will be billed at an hourly rate of $200.00/hour. Anew Counseling, LLC., will charge a retainer in advance of an agreed or subpoenaed court proceeding in a minimum amount of $1,000 (or such time estimated to be expended). This retainer shall be a deposit towards fees for professional time expended. If time expended is less than the retainer, the balance will be refunded within 30 days of termination of services. If time extended is more than the retainer, the balance will be charged to the account/s on file.

- I agree to pay Anew Counseling, LLC. the cost of collections, including any reasonable attorney fees.

- ***I agree to notify Anew Counseling, LLC. At least 24 hours in advance should I need to cancel an appointment. I understand that I will be charged the full regular session fee for any appointments that I miss or fail to cancel at least 24 hours in advance. Insurance does not cover a missed session, therefore, the allowed billable amount will be considered a full regular session fee should your sessions usually be covered by insurance (this amount varies depending on your insurance).***

- I understand that I will need to provide a valid credit card that will remain on file with Anew Counseling, LLC, and I authorize Anew Counseling, LLC. To keep my signature on file for charges incurred on my account.

Name on card: _____ Credit Card type:_____

Credit Card Number:_____ Expiration: _____

3 (or 4) digit security code: _____ Billing Zip Code: _____

Cardholder Signature:
_____

Should the responsible party decline to place a credit card on-file with Anew Counseling, the responsible party must pay the amount of one full session as a credit to be placed on the client account prior to the first session. This credit must remain on the account in order to continue to receive services from Anew Counseling. This credit will be utilized only to ensure payment in case of a missed appointment, late cancellation, or lapse in insurance. Should the credit be used, a new credit must be pre-paid prior to the next appointment.

Release of Information and Payment Authorization

- **All Insurance Companies and Third Party Payers:** I hereby authorize ANEW COUNSELING, LLC and/or any of its representatives to submit a claim to my Insurance Carrier or its intermediaries for all services rendered by the provider(s) and authorize my insurance carrier or its intermediaries to issue payment directly to Anew Counseling, LLC and/or provider(s) rendering service. I authorize the release of any and all medical information to my insurance carrier or its intermediaries regarding services rendered.

- **Guarantee of Payment:** I understand that filing claims with my insurance company or other third party payer, under any circumstances, does not relieve me from my responsibility for the payment of all charges. I further acknowledge that I am responsible for the payment of all charges for services rendered by Anew Counseling, LLC to me or the patient indicated. By signing this document, I personally guarantee the payment of these charges for medical/behavioral services rendered. This includes, but is not limited to claims filed for Workman's Compensation and/or claims due to personal injury accidents/illnesses. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

I have read the information on this form and agree to the terms set forth and outlined above.

_____ _____

Signature of Client Date

_____ _____

Signature of Client Date

HEALTH HISTORY QUESTIONNAIRE

Client Name:_____Date:_____

DOB:	M/F	Date of last Physical:
Physician Name/Address:		

Mark with an X if you have or have had any of the following conditions:

Family	Client		Family	Client	
		alcohol/drug problem	☐	☐	gout
☐	☐	anemia	☐	☐	gynecological problems
☐	☐	anxiety	☐	☐	hearing problems
☐	☐	arthritis	☐	☐	heart condition
☐	☐	asthma	☐	☐	hepatitis
☐	☐	bedwetting	☐	☐	hyperactivity
☐	☐	breathing conditions	☐	☐	high blood pressure
☐	☐	cancer/tumors	☐	☐	kidney disease
☐	☐	chronic constipation	☐	☐	liver problems
☐	☐	chronic cough	☐	☐	lung problems
☐	☐	chronic headaches	☐	☐	seizures
☐	☐	depression	☐	☐	skin rashes
☐	☐	diabetes	☐	☐	sores that do not heal
☐	☐	fainting	☐	☐	stomach problems
☐	☐	fibromyalgia	☐	☐	stroke
☐	☐	frequent backaches	☐	☐	thyroid problems
☐	☐	frequent dizziness	☐	☐	vision problems
☐	☐	frequent urination	☐	☐	weight problems
☐	☐	tuberculosis	☐	☐	lupus

OTHER CONDITIONS:

Comments

Do you now or ever smoke? Yes No If yes, how long:

Do you have or have you ever had sexually transmitted disease? Yes No If yes, type, treatment and current status:

Have you ever been hospitalized for a physical illness or accident? Yes No If yes, when, why and how long?

Are Immunizations complete (for children and adolescents only)? Yes No

Comments:

List of Medications individual is taking (Psychiatric, prescriptions and over the counter):

Medication and Strength	Frequency taken	MD/ARNP	Dates
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Do you take your medications the way your doctor prescribed them i.e. according to the time schedule and dosage on the label? Yes No If no, explain:

Are you experiencing any side effects from your medication? Yes No If yes, explain:

Are you allergic to any medications? Yes No If yes, explain:

Do you have any other allergies e.g. food allergies? Yes No If yes, explain

Pain Screening:

Are you currently experiencing any pain or have you experienced pain in the recent past? Yes No

If yes, Please continue:

Location of pain:
Intensity of pain most of the time. Rate intensity of pain on a scale from 1-10 (with 1 being the least and 10 being the worst pain):
Are you currently receiving treatment for your pain? Yes No
If yes, Please continue:
Who is treating you?
What pain medications are you taking?
Is the treatment helping your pain?
Nutrition Screening:
Is your appetite: Good Fair Poor
Check if you are experiencing or have experienced (in the recent past) any of the following: ___Nausea/Vomiting ___Weight loss or gain (more than 10lbs in a month) ___Overeating ___Chewing or swallowing problems ___ Indigestion problems or distress after eating ___Restricting Food ___Problems with obtaining food ___Other health problems related to nutrition: Specify:
Do you have any other health related problem(s) that you think we should know about? Yes No
If yes, explain:

Client Signature: _____ Date: _____

Informant if Other than Client: _____ Date: _____

Relationship to Person Served: _____

Staff Signature: _____ Credentials: LMFT/MCAP Date: _____