Client Intake Questionnaire

Please complete the information below and bring with you to your first session.
Please note: Information provided on this form is protected as confidential information.

Personal Information

Name: _____ Today's Date: ____/____/____

Parent/Legal Guardian (if under 18): _____

Street Address: _____

City, State, and Zip Code: _____

Patient Date of Birth: ____/____/____ Age: _____ Gender: Male Female

Martial Status (circle one): SINGLE MARRIED DOMESTIC PARTNER
DIVORCED WIDOWED SEPARATED

How did you hear about our office? _____

Cell Phone Number: _____

- this number belongs to (circle one): Patient Other: _____

May we leave a voice message (circle one)? YES NO

May we send a text message (circle one)? YES NO

Home Phone Number: _____

May we leave a voice message (circle one)? YES NO

Work Phone Number: _____

May we leave a voice message (circle one)? YES NO

E-mail: _____
(please note; e-mail correspondence is not considered to be a confidential medium of communication)

May we contact you via e-mail (circle one)? YES NO

HISTORY

(1) How would you describe the issue that led you to seeking psychotherapy?

_____

_____

_____

(2) Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? NO YES

Previous therapist/practitioner: _____

(3) Are you currently taking any prescription medication? NO YES

please list: _____

_____

(4) Have you ever been prescribed psychiatric medication? NO YES

please list and provide dates: _____

_____

GENERAL AND MENTAL HEALTH INFORMATION

(1) How would you rate your current physical health? (circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing: _____

_____

(2) How would you rate your current sleeping habits? (circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing: _____

_____

(3) How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

_____

(4) Please list any difficulties you experience with your appetite or eating problems: _____

_____

(5) Are you currently experiencing overwhelming sadness, grief, or depression? YES NO

If yes, for approximately how long? _____

(6) Are you currently experiencing anxiety, panic attacks, or have phobias: YES NO

Is yes, when did you begin experiencing this? _____

_____

(7) Are you currently experiencing any chronic pain? YES NO

If yes, please describe: _____

_____

(8) Do you drink alcohol more than once a week? YES NO

(9) How often do you engage in recreational drug use? (circle one)

Daily Weekly Monthly Infrequently Never

(10) Are you currently in romantic relationship?: YES NO

If yes, for how long? _____

On a scale from 1 - 10 (with 1 being poor and 10 being exceptional); 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 the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. 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	_____

Educational/Vocational History

(1) Are you currently employed? YES NO

If yes, what is your current employment situation? _____

_____

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

_____

_____

(2) Are you enrolled in school? YES NO

If yes, which school? _____ Grade/Year _____

(3) Do you have an IEP or 504 plan? YES NO

If yes, what is the diagnosis addressed? _____

Strengths

(1) Do you consider yourself to be spiritual or religious? YES NO

If yes, describe your faith or belief: _____

_____

(2) What do you consider to be some of your strengths? _____

_____

_____

_____

(3) What do you consider to be some of your weaknesses? _____

_____

_____

_____

(4) What would you like to accomplish out of your time in therapy? _____

_____

_____

_____

INSURANCE INFORMATION

Insurance Company Name: _____

Member Identification Number: _____

Group Number: _____

Insurance Company Claims Mailing Address: (if a copy has been made of your insurance card, there is no need to complete this part): _____

_____

Is the insurance plan under your name? YES NO

If no, who is the main policy holder? _____

What is your relationship to the policy holder? Spouse Dependent Other: please explain: _____

Name of Policy Holder? _____

Address, if different than the patient: _____

_____

Birthdate of Policy Holder? _____/_____/_____

Phone Number for Policy Holder? _____

Do you have a secondary insurance? YES NO

If yes, what is the name of your secondary insurance company? _____

** Please be sure the front desk has a copy of your insurance card **

_____ _____

Patient (Parent/Legal Guardian) Signature Date

Ten Ten Counseling, LLC
Client-Counselor Service Agreement

Welcome to Ten Ten Counseling. This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between you and your therapist. Your therapist can discuss any questions you have when you sign them or at any time in the future.

Counseling is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in counseling, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. Your counselor has corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Goals of Counseling

There can be many goals for the counseling relationship. Some of these will be long term goals such as improving the quality of your life, learning to live with mindfulness and self-actualization. Others may be more immediate goals such as decreasing anxiety and depression symptoms, developing healthy relationships, changing behavior or decreasing/ending drug use. Whatever the goals for counseling, they will be set by the clients according to what they want to work on in counseling. The counselor may make suggestions on how to reach that goal but you decide where you want to go.

Risks/Benefits of Counseling

Counseling is an intensely personal process which can bring unpleasant

memories or emotions to the surface. There are no guarantees that counseling will work for you. Clients can sometimes make improvements only to go backwards after a time. Progress may happen slowly. Counseling requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

However, there are many benefits to counseling. Counseling can help you develop coping skills, make behavioral changes, reduce symptoms of mental health disorders, improve the quality of your life, learn to manage anger, learn to live in the present and many other advantages.

Appointments

Appointments will ordinarily be 50-60 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours' notice. If you miss a session without canceling, or cancel with less than 24 hour notice, you may be required to pay for the session [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible the cancellation fee. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

Confidentiality

Your counselor will make every effort to keep your personal information private. If you wish to have information released, you will be required to sign a consent form before such information will be released. There are some limitations to confidentiality to which you need to be aware. Your counselor may consult with a supervisor or other professional counselor in order to give you the best service. In the event that your counselor consults with another counselor, no identifying information such as your name would be released. Counselors are required by law to release information when the client poses a risk to themselves or others and in cases of abuse to children or the elderly. If your counselor receives a court order or subpoena, she may be required to

release some information. In such a case, your counselor will consult with other professionals and limit the release to only what is necessary by law.

Record Keeping

Your counselor may keep records of your counseling sessions and a treatment plan which includes goals for your counseling. These records are kept to ensure a direction to your sessions and continuity in service. They will not be shared except with respect to the limits to confidentiality discussed in the Confidentiality section. Should the client wish to have their records released, they are required to sign a release of information which specifies what information is to be released and to whom. Records will be kept for at least 7 years but may be kept for longer. Records will be kept either electronically on a USB flash drive or in a paper file and stored in a locked cabinet in the counselor's office.

Professional Fees

You are responsible for paying for any fees upon arrival for your session unless prior arrangements have been made. Payment must be made by check, cash or credit card. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for our consultation rate for any time preparing for court and $1,000 per day to appear in court.

Clinician	Intake Session	Individual Session/hour	Couples Session/hour	Family Session/hour	Consultation Fee/hour
Lenny Smith	$185	$145	$220	$220	$145
Cyrus Davani	$170	$135	$185	$185	$135
Leah Chiaverini	$170	$135	$185	$185	$135
Sarah Giacalone	$150	$125	$185	$185	$125
Katie Streett	$150	$125	$185	$185	$125
Tori Fayard	$150	$125	$185	$185	$125
Katie Smith	$125	$100	$150	$150	$100

Insurance

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, we will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting us know if/when your coverage changes.

You should also be aware that most insurance companies require you to authorize us to provide them with a clinical diagnosis. Sometimes we have to provide additional clinical information which will become part of the insurance company files. By signing this Agreement, you agree that we can provide requested information to your carrier if you plan to pay with insurance.

In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover counseling fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee. Many policies leave a percentage of the fee to be covered by the patient. Either amount is to be paid at the time of the visit by check or cash. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount that must be paid by the patient before the insurance companies are willing to begin paying any amount for services.

If we are not a participating provider for your insurance plan, we will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, we will refer you to a colleague.

Communication between Client and Therapist

We are often not immediately available by telephone. We do not answer phones when we are with clients or otherwise unavailable. At these times, you may leave a message on our confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If you feel you cannot wait

for a return call or it is an emergency situation, go to your local hospital or call 911.

Email

Counselor may request client's email address. Client has the right to refuse to divulge email address. Counselor may use email addresses to periodically check in with clients who have ended therapy suddenly. Counselor may also use email addresses to send newsletters with valuable therapeutic information such as tips for depression or relaxation techniques. Counselor also has a blog and if this is appropriate for the client, counselor may send information through email about subscribing to the blog or information related to mental health and wellness. If you would like to receive any correspondence through email, please write your email address here _____.

If you would like to opt out of email correspondence, please check here _____ .

Consent to Counseling

Your signature below indicates that you have read this Agreement and agree to its terms.

Client Signature _____ Date_____

Guardian Signature (client under 18) _____

Date: _____

2nd Guardian Signature (client under 18) _____

Date: _____

CREDIT CARD ON FILE POLICY

At Ten Ten Counseling, LLC, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account. I authorize Ten Ten Counseling, LLC to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

□Visa □Mastercard □Discover

Credit Card Number _____

Expiration Date _____ / _____ CVV Code _____

Cardholder Name _____

Signature _____

Billing Address _____

City _____ State_____ Zip _____

I (we), the undersigned, authorize and request Ten Ten Counseling, LLC to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Ten Ten Counseling, LLC. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Ten Ten Counseling, LLC in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Date: _____ / _____ / _____

CLIENT AND STAFF INTAKE CHECKLIST

Have client and therapist initial next to each section to verify that all information in the consent agreement has been reviewed and understood prior to therapy beginning.

_____ _____ Goals of Counseling

_____ _____ Risks/Benefits of Counseling

_____ _____ Appointments

_____ _____ Confidentiality

_____ _____ Record Keeping

_____ _____ Professional Fees

_____ _____ Insurance

_____ _____ Communication between Client and Therapist

_____ _____ Consent to Counseling

_____ _____ Credit Card on File Policy

Date Completed _____