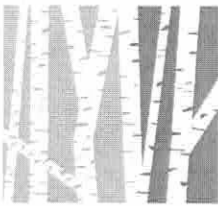


Counseling Associates of MA & NH, LLC

Child, Adolescent, Adult, Couple, and Family Psychotherapy

184 Pleasant Valley St., Unit 1-206
Methuen, MA 01844
Phone: (978) 683-0133
Fax: (978) 441-0800

173 So. River Road, Ste. 3
Bedford, NH 03110
Phone: (603) 472-5279
Fax: (603) 488-1682

Date of first Session________

INTAKE FORM

Name of Client____ Sex M__ F__

(If the client is under 18, the names of all parents/legal guardians) ____________________

____

Emergency Contact _________________________ Their telephone _________________

Your Address: Street____

City ___________________________ State _________ Zip Code __________

Home Phone ( )__________ cell ( ) ___________ work ( ) _______________

Client's Date of Birth _____ Marital Status _______ Preferred Spoken Language________

Email Address ______________________________

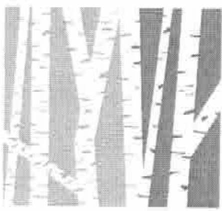
INSURANCE INFORMATION (Your card will also be copied)

Name of Insurance ____

Name of the Insured (if not self) ____

I.D. # (this is very important) ________________________ Employer _____________

Name of any *other* insurance (and I.D. #) ____________________________________



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RELEASE OF INFORMATION

I, (client name) ______________________________, DOB__________, give permission for ______________________________ (name of psychotherapist), to speak with the following person or persons in order to share information regarding my psychotherapy treatment about myself (or my child)_________________________ DOB____________________.

This permission is good for:

- ❑ Assessment
- ❑ Diagnosis
- ❑ Psychosocial Evaluation
- ❑ Psychological Evaluation
- ❑ Psychiatric Evaluation
- ❑ Treatment Plan or Summary
- ❑ Current Treatment Update
- ❑ Medication Management Information
- ❑ Presence/Participation in Treatment
- ❑ HIV status
- ❑ Drug and Alcohol Use
- ❑ Medical Information
- ❑ Educational Information
- ❑ Discharge/Transfer Summary
- ❑ Continuing Care Plan
- ❑ Progress in Treatment
- ❑ Demographic Information
- ❑ Psychotherapy Notes
- ❑ Any information relevant to psychotherapy
- ❑ Other: ______________________________

NAME of PROVIDER: ____
ADDRESS: ____
____
PHONE: ______________________________ FAX ______________________________

❑ I understand that I have the right to rescind this release at any time by writing the above-named psychotherapist that I choose to rescind this permission. I further understand that a revocation of the authorization is not effective to the extent that action has been taken prior to the release being revoked.

❑ I understand that protected health information disclosed under this release may be re-disclosed by the recipients(s) to other individuals or organizations that are not subject to privacy protection laws. I hereby release the above-named psychotherapist, from all legal responsibilities and liabilities that may arise from the release of such protect health information.

❑ I understand that this release is valid until ____________ or one year from date of this document.

______________________________ ______________
Client signature Date:

Or

______________________________ ______________
Signature of personal representative of client: Date

If signed by a personal representative, state your relationship to patient and/or reason and legal authority for signing below.

Client is: ❑ minor ❑ incompetent ❑ disabled ❑ deceased
Legal authority is: ❑ parent ❑ legal guardian ❑ next of kin of deceased