Counseling Associates of MA & NH, LLC

Child, Adolescent, Adult, Couple, and Family Psychotherapy

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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 ______________________________ Okay to use? Yes ___ No___

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. #) _____________________________________

INFORMED CONSENT REGARDING LIMITATIONS ON CONFIDENTIAL COMMUNICATIONS

I understand that information about my treatment and communications with my therapist may not be released without my written authorization. However, these communications or this information may have to be revealed without my permission, as explained below:

1. **If necessary to protect my safety or the safety of others.**
   (A) If I am clearly dangerous to myself, my therapist may take steps to seek involuntary hospitalization and may contact members of my family or others.
   (B) If I threaten to kill or seriously hurt someone and the therapist believes I may carry out my threat, or if the therapist believes I will attempt to kill or seriously hurt someone, my therapist may:
      - Tell any reasonably identified victim;
      - Notify the police; or
      - Arrange for me to be hospitalized.
2. **If necessary for me to be hospitalized for psychiatric care.**
3. **If a judge thinks the therapist has evidence about my ability to provide care or custody in a child custody or adoption case.**
4. **In court proceedings involving the care and protection of children or to dispense with the need for parental consent to adoption.**
5. **If the therapist believes a child, a disabled person, or an elderly person in my care is suffering from abuse or neglect.**
6. **To provide information regarding my diagnosis, prognosis and course of treatment, or for the purposes of utilization review or quality assurance, to a third party payer.**
7. **In legal proceeding where I introduce my mental or emotional condition.**
8. **If I bring an action against the therapist and disclosure is necessary or relevant to the defense.**
9. **If necessary to use a collection agency or other process to collect amounts I owe for services.**
10. **If a court orders access to my records in a sexual assault or other criminal case.**

I additionally authorize my therapist to consult professional colleagues if needed to enhance the clinical service I receive.

(Continued on back page)

OTHER IMPORTANT INFORMATION FOR YOU TO UNDERSTAND: Office Policies

Telephone: Clients can call and leave a confidential message on the voice mail system, on their therapist's extension.

Emergencies: In the event of an emergency when the office is closed, call the voice mail and follow directions about how to contact a therapist on call. The person on call can be reached by calling x0.

Length of Sessions: The standard length of each session is forty five minutes. In some cases, it is beneficial to have a sixty minute session.

Fees: Sessions are $160.00 for the initial 50 minute intake session. Subsequent sessions are $120 per 45 minute session and $140 for a 60 minute session. Services are reimbursable to some extent by most insurance companies. Clients are held accountable for all costs not covered by insurance. Balances, co-payments, and deductibles are required to be paid each session. In child-related cases, the person who brings the child to treatment is responsible for paying required costs. In some cases, discount rates are negotiable.

CANCELLATIONS AND "NO-SHOWS": Clients are responsible for payment of each session unless cancellations are made at least 24 hours in advance. INSURANCES CANNOT BE BILLED UNLESS THE CLIENT ATTENDS. You can be billed $50- $65 if you do not give 24 - 48 hour notice. PLEASE NOTE.

I hearby acknowledge that I received and have been given an opportunity to read a copy of the practice's Informed Consent Regarding Limitations of Confidential Communications and Office Policies.

I have also been given an opportunity to read and have a copy if I wish of the practice's HIPPA Notice.

I understand that if I have any questions regarding these notices, I may contact Leigh Bryant.

I have had the opportunity to discuss this informed consent statement (both pages) with my therapist. I understand its meaning and consent to receiving services based on this understanding.

Name: ______________________________ ______________________________

CLIENT (Print) signature

DOB:____________________ Date:__________________

Signature of Parent, Guardian or Personal Representative* ______________________

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, health surrogate, etc).

_____ Client refuses to Acknowledge Receipt

____

Signature of Staff Date

Counseling Associates of MA and NH

Initial Information

Name:		**DOB:**		**1st Date of Service:**	
Gender:	**Marital Status:**		**E-mail:**		

CONTACT INFORMATION

Address:

Cell Phone:	**Work Phone:**	**Home Phone:**
OK to leave message: ❑ No ❑ Yes	**OK to leave message:** ❑ No ❑ Yes	**OK to leave message:** ❑ No ❑ Yes

Preferred Phone: Home ❑ Work ❑ Cell ❑

Call in Case of Emergency

Name:

Phone: **Email:**

Relationship to client:

CURRENT LIFE SITUATION

Who Referred You?

Name: **May I contact the referral to thank them?** ❑ Yes ❑ No

Phone #: **Email:**

Living situation

❑ alone ❑ w/ family ❑ rooming house ❑ group residence ❑ foster care ❑ other:

Household members and ages:

Culture

Race:

Language spoken at home:

Religion/Faith/Spirituality raised in if any:

Religion/Faith/Spirituality currently practice if any:

Social club/organization

❑ No ❑ Yes *(description)*:

Other agencies or providers involved

❑ None ❑ Yes *(description)*:

Education

Highest grade completed (K-12) or college/university (U1-U8):

❑ None ❑ The following was reported:

Learning Disabilities ❑ No ❑ Yes *(explain)*:

Additional Education ❑ No ❑ Yes *(explain)*:

Further comments on above ❑ No ❑ Yes *(explain)*:

Legal Issues

❑ None ❑ Yes *(description)*:

Vocational *(Job/Career training and/or work experience)*

❑ None ❑ Yes *(description)*:

Military Service

❑ None ❑ Yes *(description)*:

RELEVENT MEDICAL HISTORY

PCP Name:
Address:

Zip:
Phone: Fax:

illnesses and Allergies

❑ None reported ❑ the following was reported

Type of Illness or Allergy	Date or Age of Onset	Medications	Relevant Information	Severity

Mental Health History

Psychiatrist Name:
Address:

Zip:
Phone: Fax:

Current Psychiatric Medication/s

❑ None reported ❑ the following was reported

Medication	Dosage	Prescriber	Date Started	Side Effects

Previous Psychiatric Hospitalizations, Individual and/or Group Treatment

❑ None ❑ See the following:

Dates or Age	Therapist or Hospital	Type of TX	Reason/Symptoms/Medications	Outcome

Mental Health History Biological Family	Mother	Father	Sister/s	Brother/s	Grdmother	Grdfather	Aunt/Uncle
Depression	❑	❑	❑	❑	❑	❑	❑
Anxiety	❑	❑	❑	❑	❑	❑	❑
Panic	❑	❑	❑	❑	❑	❑	❑
Alcohol/drug abuse (specify):	❑	❑	❑	❑	❑	❑	❑
Eating D.O. (specify):	❑	❑	❑	❑	❑	❑	❑
Bipolar D.O.	❑	❑	❑	❑	❑	❑	❑
Mania	❑	❑	❑	❑	❑	❑	❑
Schizophrenia	❑	❑	❑	❑	❑	❑	❑
Paranoia	❑	❑	❑	❑	❑	❑	❑
Learning Disability (specify):	❑	❑	❑	❑	❑	❑	❑
ADHD	❑	❑	❑	❑	❑	❑	❑
Other:	❑	❑	❑	❑	❑	❑	❑