Intake Form

Type of Counseling: __Individual___Couples___Pre-Marital___Family__Groups___Evaluation

Name: _____
(Last) (First) (Middle Initial)

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

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Social Security Number: _____

Age: _____ ***Gender:*** □ Male □ ***Female***

Address: _____
(Street and Number) (City) (State) (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

How did you hear about us? _____

Insurance: _____Policy Holder_____

Policy Number: _____Group Number_____

EAP Name:_____ Authorization: _____Phone Number: _____

Primary Physician: _____Phone Number: _____

Emergency Contact: _____Phone Number: _____

Relationship: _____

Marital Status:
□ ***Never Married*** □ ***Domestic Partnership*** □ ***Married*** □ ***Separated*** □ ***Divorced*** □ ***Widowed***

Please list any children/age: _____

GENERAL HEALTH INFORMATION:

1. Are you currently taking any prescription medication (excluding psychiatric meds)?

□ ***Yes***
□ ***No***

Please list: _____

_____

2. 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:

_____

3. 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:

_____

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

What types of exercise to you participate in _____?

5. Please list any difficulties you experience with your appetite or eating patterns

_____

MENTAL HEALTH INFORMATION

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

□ ***No***
□ ***Yes, previous therapist/practitioner: _____***

7. Have you ever been prescribed psychiatric medication?

□ ***Yes***
□ ***No***

Please list and provide dates: _____

_____

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

□ *No*
□ *Yes*

If yes, for approximately how long? _____

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

□ *No*
□ *Yes*

If yes, when did you begin experiencing this? _____

10. Are you currently experiencing any chronic pain?

□ *No*
□ *Yes*

If yes, please describe _____

11. Do you drink alcohol more than once a week? □ *No* □ *Yes*

12. How often do you engage recreational drug use (marijuana, etc…)*?*

□ *Daily* □ *Weekly* □ *Monthly* □ *Infrequently* □ *Never*

13. 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? _____

14. 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.

	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 field do you work in? Your position?

_____

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?

_____

_____

_____

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

_____

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to types of services, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____
Client Signature (Client's Parent/Guardian if under 18)

_____
Today's Date

Consent for Treatment

It is our goal to make your experience here an informed and positive one. Please review and complete the following information. If you have any questions, please feel free to discuss them with us.

It is the responsibility of all clients of SMR Counseling Services to be aware of all fees due for services rendered under private pay or through health insurance. Payments are due at the **beginning** of each session. We cannot continue to schedule sessions if payments have not been made on prior sessions. There will be a $30.00 service charge on returned checks (NSF). **_____Client Initials**

Counseling Rates for Private Pay (per 50-minute session):

Individual Counseling	$125.00
Couples Counseling	$150.00
Family Counseling	$150.00
Psychological Evaluation	$150.00
Court Appearances	$200.00
Group Counseling	Varies
Returned Check Fee	$30.00
Missed Appointment Fee	$50.00

Health Insurance Coverage

Please bring a copy of you medical insurance card to each appointment. As a courtesy, **SMR Counseling Services will verify your benefits with your insurance company. However, this is not a guarantee of payment**. **If prior authorization or approval is needed for mental health services, it is the clients' responsibility to contact the insurance agency.** It is also your responsibility to understand your coverage, including co-pays, co-insurance, and deductibles. This includes understanding which services are covered and what are not covered. It is also your responsibility to let us know if there is a change in your insurance coverage or changes in employment. We will be glad to file your insurance for you. You are responsible for your deductibles and co-payments. **_____Client Initials**

Financial Responsibilities

You ae responsible for payments of fees (co-pays, co-insurance, deductibles, non-covered services) for SMR Counseling Services. If we provide services that are not covered by your medical insurance or EAP, you are responsible for the payment of these services. Payment of fees are due prior to the start of an appointment**. _____Client Initials**

The person who signs below is agreeing to be the "financial guarantor," which means this person agrees to pay any of these fees. If we determine there is a balance on your account (ex. Session fees, Missed Appointment, Returned Check, etc.), we will send you a statement. We ask that you complete payment in 30 days. If the fees are not paid in 30 days, we will send you account to a collection agency where you will be responsible for all collection fees, court costs, and legal fees. **_____Client Initials**

Training and Clinical Supervision

- SMR Counseling Services is a training center for Master's and Doctoral level Counseling, Social Work, and Psychology interns. All counselors at SMR Counseling Services are under the supervision of licensed mental health professionals.
- In order to ensure that counselors receive the best possible training, and that clients are well served, some sessions will be video or audio taped. Tapes are viewed by SMR Counseling Services clinical supervisors only, and are erased in a timely manner. You must agree to be taped to receive counseling services at SMR Counseling Services.
- Counselors are generally on a time limited contract with SMR Counseling Services, Therefore, it is possible that your counselor may leave SMR Counseling Services prior to the end of your therapy. If this occurs we will take reasonable steps to ensure a smooth transition. **_____Client Initials**

Child Care Release

SMR Counseling Services does not provide childcare and is not responsible for children or adolescents left unsupervised in the waiting room. Minors must be picked up following their appointments on time. If you must leave your child in the waiting room during a session, it is your responsibility to provide appropriate supervision for that child. Children under the age of 10 may not be left without supervision in the waiting room.
_____Client Initials

Cancellations and Missed Appointments

SMR Counseling Services is a very busy counseling office, so we require 24-hour notice for cancellations and reschedules so that your appointment time could be available for another client in need. If you do not cancel or reschedule 24 hours before an appointment, a fee of $50.00 will be assessed to your account. Clients are responsible for all cancellation/no-show fees. Insurance companies will not reimburse for missed appointments. Fees **MUST** be paid before your next session is scheduled.
_____Client Initials

***Psychological Evaluations**:*

The psychological evaluation can be used to identify psychiatric disorders, provide treatment referrals, and flag any contraindications. It also provides an opportunity to educate patients, resolve ambivalence, and build motivation. Psychological evaluations can take up to 2.5 hours with completing assessments and clinical interview. Evaluations ae completed within 10 business days. We do not offer express evaluations. _____Client Initials.

End of Treatment

In addition to your right to confidentiality, you have the right to end your counseling at any time, for whatever reason and without any obligation, with the exception of payment of fees for services already provided. You have the right to question any aspect of your treatment with your counselor. You also have the right to expect that your counselor will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with you. **_____Client Initials.**

SMR Counseling Services reserves the right to discontinue counseling at any time including, if we do not believe you will make progress on your mental health condition because of no-shows or late cancellations. We may consider you an inactive client with us if: (1) Sixty (60) days have passed, (2) You do not have any scheduled appointments with us, and (3) We have not heard from you. You will receive a letter stating that your file has become in-active. You may contact us to set up an appointment to become active again. Although we make an effort to remind you about upcoming appointments by text message and email, you are responsible for remembering and attending your appointments. **_____Client Initials.**

Your signature below indicates that you have read and understand this information and have received a copy of this consent form and give permission to SMR Counseling Services to provide counseling services and that this contract is binding for all future sessions you may have with this entity.

I, _____agree to all the terms and conditions of this contract.
Printed name of client or representative

Client Signature (Client's Parent/Guardian if under 18) **Today's Date**