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ADULT INTAKE QUESTIONNAIRE

Referred by: _____Today's Date: _____

Name:_____

Date of Birth_____ Place of Birth_____ Gender: _____

Home Address_____ City_____ Zip_____

Home Phone_____ Cell Phone _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Level of Education _____ Occupation _____

Spouse Name _____ Spouse Phone_____

Current Family Structure: (residing in the home)

Name	Age	Relationship	Job/School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other Children: (not in home)

Name	Age	Relationship	Job/School
_____	_____	_____	_____
_____	_____	_____	_____

Family of Origin Structure: Include parent/caregivers, step-parents, medical/mental history (substance abuse, cancer, depression).

Parents Name	Age	Relationship	Marital Status	Job/Occupation	Mental/Substance History

Siblings

Parents Name	Age	Relationship	Marital Status	Job/Occupation	Medical/Mental History

Client Name:_____

Current Symptoms: Please check if you currently experience any of these symptoms:

___ Irritability
___ Aggression
___ High activity level
___ Staring spells
___ Trouble expressing self (please explain)_____
___ Frequent fatigue
___ Low energy level
___ Trouble falling asleep
___ Trouble getting up in the morning
___ Coping with pain (please explain) _____
___ Recent weight gain/loss
___ Appetite changes
___ Excessive fears/worries
___ Social isolation
___ Depressed mood
___ Mood swings
___ Hopelessness
___ Anxiety
___ Anger/rage
___ Guilt
___ Easily frustrated
___ Sexual abuse history
___ Physical abuse history
___ Suicide thoughts/actions
___ Desire to hurt someone
___ Drug/alcohol use
___ Tobacco use
___ Self-harm
___ Problems in thinking
___ Problems with memory
___ Grief/morning
___ Frequent awakenings during the night

Aches and pains (please explain)_____
History of traumatic event(s) (please explain)_____
Recent legal charges/police involvement (please explain)_____
Other (please explain)_____

Relevant Health and Mental Health History:

Physician Name _____Physician Phone _____
Medical or mental health conditions _____
History of substance abuse problems _____
Frequency of use of the following: Alcohol _____ Caffeine _____ Nicotine _____
Other Substances (e.g., marijuana, cocaine, sleeping pills)_____
Previous hospitalizations and date(s) _____

Client Name:_____

Current Medications:	Medication	Dose	Treating Physician
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

History of Psychotherapy:	Previous Therapist	Dates	Issues Addressed
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

What in your life are you grateful for?_____

_____

My goals for therapy are _____

_____

I will know I've reached them when

_____

_____

Client Signature _____ Date _____

Informed Consent for Treatment

Welcome to my practice. This document contains important information about my 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 us. We can discuss any questions you have when you sign them or at any time in the future.

Psychological Services

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, 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. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy 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.

The first session will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

Our Financial Policy

Welcome to the office of Anelas Holistic Counseling, PLLC. In order to ensure the efficiency of our practice, we wish to explain our policy with regard to financial responsibility for sessions with the psychotherapists from this office.

The standard fee for the initial intake is $250.00 and each subsequent individual therapy session is $150.00 or group therapy session $85.00. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by debit or credit card; Any transactions returned to my office are subject to an additional fee of up to $25.00 to cover the bank fee that I incur.

All payments are due prior to each session. If we are in network with your insurance carrier, a copay/coinsurance is expected. Our office will then file to your insurance carrier for the remaining amount owed. Benefits quoted by your insurer are not a guarantee of payment. Ultimately, you are responsible for all charges incurred. If we are out of network with your insurance carrier, payment in full is expected. As a courtesy we will file to your insurance. If you have out of network benefits, they will reimburse to you directly. During office hour's payment may be given to your psychotherapist or the office staff. After hours, payment is due to your therapist at the time of service. With so many insurance carriers, policies, and various benefit packages available, we will help you with your insurance filing, but we cannot guarantee payment or accept responsibility for negotiating your claim(s). It is important that you understand the provisions of your insurance policy.

Our Late Cancellation/No-Show Policy

If you are unable to keep a scheduled appointment, you are required to give us at least a 24- hour notice. Late cancellations (with less than 24-hour notice) and No Shows (missing a scheduled appointment) are charged $75.00 each time, regardless of the reason. For all group sessions, you will be charged $30.00.

This fee cannot be billed to insurance. _____(Initials)

Statement Fee

All payments are due at the time of service. If a balance is owed and a statement sent to you via e-mail from Simplepractice.

Collections Services

If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

Outstanding Balance Policy

Payment is due at the time of session. Account balances that exceed $250 must make payment before further appointments can be scheduled.

Returned Checks

The return of a check (electronic or paper) issued to Psychological and Life Skills will result in a $25.00 returned check fee being placed on the account of the patient, or individual, on whose behalf the check was presented for each returned check, no matter the reason.

Consent for Release and Use of Confidential Information

I, _____hereby give my consent to Anelas Holistic Counseling PLLC. to use for the purpose of payment, all information contained in the patient record

of:_____.

The undersigned has read, understands, and agrees to the above terms and conditions.

_____ _____

Signature of Person Financially Responsible Date

_____ _____

Address (if other than patient's) Signature of Therapist/Witness

_____

Date of birth of financially responsible party

Insurance

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, my billing service and I 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 me know if/when your coverage changes.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans such as HMOs and PPOs often require advance authorization, without which they may refuse to provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM-V. There is a copy in my office and I will be glad to let you see it to learn more about your diagnosis, if applicable.). Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I 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 therapy 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 (which is called co-insurance) or a flat dollar amount (referred to as a co-payment) 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. This will typically mean that you will be responsible to pay for initial sessions with me until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year. Once we have all of the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits that are available and what will happen if coverage ends before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above, unless prohibited by my provider contract.

If I am not a participating provider for your insurance plan, I 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, I will refer you to a colleague or another community provider.

Our Financial Policy for Insurance

Information Ins. Co.

Co. (Name/Address):_____

Policy Holders Name:_____ DOB:_____ SSN and Insurance ID:_____

If Military (Active/Retired):_____

Any secondary insurance? (if so, name of company)_____

Policy Holders Name (if different from above):_____ DOB:_____

SSN and Insurance ID:_____

All Payments are Due at the Time of Your Appointment Using Your Credit/Debit Card on File. Our company policy is to require a credit/debit card on file to be charged.

_____

Initial here

I agree that Anelas Holistic Counseling PLLC may charge my credit/debit card for my therapy or assessment sessions, ancillary services, copayment, missed appointments, or late cancellation/late reschedule fees for scheduled session(s). (Please complete below).

NAME OF CLIENT_____

Card # _____

Exp. Date_____

Sec code_____

Billing zip_____

Name of Cardholder_____

Signature_____

Address (if different than above)_____

Private Pay Agreement (PPA)

**Please provide your initials on the line if in agreement with the following:

_____ I have decided to participate in therapeutic services as a private pay client.

_____I understand that I am fully responsible to pay the Therapists full rate as well as any fees charged for late cancellations and no shows for appointments.

_____ I have made my therapist aware that I do not have any insurance coverage

_____ I have agreed to let my therapist know if anything changes with my status. I will notify my therapist if I obtain alternative insurance at a later date and decide that I would like my sessions billed to my insurance.

_____ I understand that if I obtain insurance, I cannot use the payment of sessions towards my deductible without first communicating this to Therapist.

_____ I understand that if I choose to acquire insurance my therapist is not liable and is not obligated to reimburse previous sessions where I have chosen to opt out of billing my insurance.

My opt in to use insurance will start from the day I notify my therapist of the change and cannot be backdated to previous sessions.

I HEREBY AFFIRM THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS.

_____

Client Printed Name

_____ _____

Client Signature Date

_____

Provider Printed Name

_____ _____

Provider Signature Date

Charges for Ancillary Services

Please be aware that it is our policy to charge for non-clinical services. Such services include, but are not limited to, telephone consultations with other providers or schools, writing letter on behalf of clients, completing paperwork at the request of clients (eg. filling out disability paperwork), and fielding emergency calls. 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 the professional time required even if another party compels me to testify. Charges will reflect the time needed to complete the service and is billed in 15 minute increments at a rate of $215/hour.

*Please note that advance notification will be sent before additional charges are applied.

For example:
15 minutes = $53.75
30 minutes = $107.50
45 minutes = $161.25
60 minutes = $215.00

Charges for Medical Records

Searching and Handling Fee - $10
Pages 1 - 50: $0.50 per page
Pages 51+: $0.25 per page

I have read, understand, and agree to the above office policy.

_____

_____

Signature of Patient Date

Professional Records

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional , which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

Confidentiality

My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

Telehealth Informed Consent

I, _____ hereby consent to engage in Telehealth with Anelas Holistic Counseling PLLC.

I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.

By signing this form, I understand and agree to the following:

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in the Informed Consent Form I received from my therapist also apply to my Telehealth services.

2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.

3. I understand that miscommunication between myself and my therapist may occur via Telehealth.

4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.

5. I understand that at the beginning of each Telehealth session my therapist is required to verify my full name and current location.

6. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist believes I would be better served by in-person therapy, my

therapist will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.

7. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

8. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party's written permission.

9. I have discussed the fees charged for Telehealth with my therapist and agree to them [or for insurance patients: I have discussed with my therapist and agree that my therapist will bill my insurance plan for Telehealth and that I will be billed for any portion that is the patient's responsibility (e.g. co-payments)], and I have been provided with this information in the Informed Consent Form.

10. I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

I have read and understand the information provided above, have discussed it with my therapist, and understand that I have the right to have all my questions regarding this information answered to my satisfaction.

_____

Patient's Signature

_____

Patient's Printed Name

_____

Date

Acknowledgement of Notice of PrivacyPolicy

I acknowledge that I may review the Privacy Policy found on Simplepractice and the practive website's services page for Anelas Holistic Counseling PLLC. The Notice of Privacy Policy provides detailed information about how the practice may use and disclose my confidential information.

I understand that my therapist has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be available to me upon a written request to the Privacy Officer.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to my therapist. I also understand that I will not be able to revoke this consent in cases where the therapist has already relied on it to use or disclose my mental health information. Written revocation of consent must be sent to our office.

I understand that I have the right to request that the practice restricts how my individually identifiable mental health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that the practice does not have to agree to such restrictions, but that once such restrictions are agreed to, the practice and their agents must adhere to such restrictions.

Signed:_____ Date:_____

If you are not the patient, please specify your relationship to the patient_____.

Contacting Me

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a brief voicemail and your call will be returned within 2 business days if it a non-urgent matter. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe,

1) contact your local Community Service Board Emergency Services Line,

2) If safely able to do so, go or get someone you trust to take you to your Local Hospital Emergency Room, or

3) Call 911. I will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering my practice.

Other Rights

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender identity, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

Termination of Services

If the clinician and/or clinical supervisor/owner determine appropriate services can no longer be provided to you or your child, for any reason treatment will be terminated and referrals to other services will be provided.

Electronic Record and Signature Disclosure

From time to time, Anelas Holistic Counseling PLLC, may be required by law to provide to you certain written notices or disclosures. Described below are the terms and conditions for providing to you such notices and disclosures electronically via email. The words “the Company,” “we,” “us,” and “our” refer to Anelas Holistic Counseling PLLC. The words “you and “your” mean you, the individual(s) identified on this intake form. “Communication” means any client agreement, amendments, disclosures, notices, responses, transaction history, privacy policies and all other

information related to the service, including but not limited to information that we are required by law to provide to you in writing. Please read the information below carefully and thoroughly, and if you can access this information electronically to your satisfaction and agree to these terms and conditions, please confirm your agreement by clicking the "I agree" button at the bottom of this document.

Communications in Writing

All Communications, either electronic or paper format, from us to you will be considered "in writing." You should print or download for your records a copy of this intake form and disclosure that you deem important.

Federal E-Sign

Consent You acknowledge and agree that your consent to electronic Communications is being provided in connection with a intake form and with a transaction that is subject to federal Electronic Signatures in National Commerce Act, and that you and we both intend that the Act apply to the fullest extent possible to validate our ability to conduct services as a business with you electronically.

Acknowledging your access and consent to receive materials electronically.

To confirm to us that you can access this information electronically, which will be similar to other electronic Communications that we will provide to you, please verify that you were able to read this electronic disclosure and that you are also were able to print on paper or electronically save this page for your future reference and access or that you were able to e-mail this disclosure and consent to an address where you will be able to print on paper or save it for your future reference and access. Further, if you consent to receiving Communications exclusively in electronic format on the terms and conditions described above, please let us know by clicking/checking the "I agree" button below.

By clicking the 'I agree' box, I confirm that:

- I can access and read this Electronic CONSENT TO ELECTRONIC RECEIPT OF ELECTRONIC RECORD AND SIGNATURE DISCLOSURES document; and

- I can print on paper the disclosure or save or send the disclosure to a place where I can print it, for future reference and access; and

- Until or unless I notify Anelas Holistic Counseling PLLC, as described above, I consent to receive electronic means all notices, disclosures, authorizations, acknowledges, and other documents that are required to be provided or made available to me by Anelas Holistic Counseling, PLLC during the course of my relationship with you.

I AGREE ☐ _____ _____

PRINT NAME OF PATIENT DATE

ACKNOWLEDGEMENT OF OFFICE POLICIES AND PROCEDURES AND CONSENT FOR TREATMENT

I, the undersigned, acknowledge that I have received and reviewed the following policies of Anelas Holistic Counseling PLLC in its entirety and agree to abide by the terms set forth in them for the duration of my professional relationship with my or my child's clinician and/or Anelas Holistic Counseling PLLC:

(Initial next to policy)

_____ Psychological Services

_____ Termination of Services

_____ Telehealth Informed Consent

_____ Financial Policy for Insurance

_____ Confidentiality

_____ Contacting Me

_____ Private Pay Agreement (PPA)

_____ Acknowledgement of Notice of Privacy

_____ Professional Records

_____ Charges for Ancillary Services

_____ Electronic Record and

_____ Other Rights

_____ Consent for Psychotherapy

Signature Disclosure

If you or your child are using insurance benefits, please review the statements below and initial here _____.

- I authorize Anelas Holistic Counseling PLLC to submit claims to my insurance company.
- I authorize the use of this form for all my insurance submissions.
- I authorize release of information to all of my insurance companies.
- I authorize the provider to act as my agent in helping me obtain payment from my insurance company.
- I authorize payment directly to Anelas Holistic Counseling PLLC.
- I understand that I am ultimately responsible for my bill.

If you are not using insurance benefits (Private Pay Agreement), please review the statement below and initial here _____.

- I am not using insurance benefits and I understand I am therefore responsible for 100% of the applicable fee at the time services are rendered.

Consent to Psychotherapy

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their term

_____

Signature of Patient or Personal Representative

_____

Printed Name of Patient or Personal Representative

_____

Date

Description of Personal Representative's Authority:_____

_____

Signature of Clinician

_____

Printed Name of Clinician

Date _____