MoeMents, PLLC – New Client Intake Packet

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Welcome to MoeMents, PLLC! We're honored to support you on your path toward healing, growth, and self-awareness. Our goal is to create a collaborative and empowering space to help you navigate life's challenges and transitions.

MoeMents, PLLC provides professional mental health counseling services for individuals ages 16 and up. We are licensed to practice in Maryland, Virginia, and Georgia.

Please review and complete the following forms before your intake appointment. These documents help ensure that your care meets professional, ethical, and legal standards.

1. Patient Demographic Information

Full Name: _____

Date of Birth: _____

Age: _____

Gender: _____

Address: _____

Phone (Cell): _____

Phone (Home): _____

Email (for appointment reminders/billing): _____

Preferred Contact Method (circle): Phone / Email / Text / Mail _____

Emergency Contact: _____

Relationship: _____

Emergency Contact Phone: _____

Insurance Provider (if applicable): _____

Policy Number: _____

Group Number: _____

Subscriber Name & DOB: _____

2. Consent to Treatment

I understand that I am voluntarily seeking mental health services. I acknowledge that counseling/therapy involves discussing sensitive topics and that while treatment can lead to growth and improved well-being, there may also be discomfort. I consent to participate in psychotherapy with the provider listed above. I understand that I may withdraw consent and stop treatment at any time.

Signature: _____ Date: _____

3. Fee for Services & Financial Policy

Session Fees:

Initial Intake: $180/ 60 minutes

Individual Therapy: $150 / 50 minutes; $50 every additional ½ hour. (must be previously scheduled and cannot impact other patients care); exceptions for crisis.

Couples: $180/ 60 minutes

Other Services (reports, letters, extended sessions): $50/ hour

Payment: Payment is due at the time of service unless other arrangements are made. Accepted forms of payment: cash, check, credit/debit card, HSA/FSA.

Insurance: If you are using insurance, you are responsible for knowing your benefits. Any portion not covered (deductibles, co-pays, co-insurance, or denied claims) is your responsibility.

4. Practice Policies

Appointments & Scheduling:
- Sessions are typically 45–55 minutes.
- Appointments must be scheduled in advance.

Cancellations & No-Shows:
- Late Cancellations: Appointments canceled with less than 24 hours' notice will be charged a fee of $75.
- No-Shows: Failure to attend a session without notice will result in a full session fee ($150).
- Exceptions may be made in emergencies at provider's discretion.

Communication:
- Phone, secure messaging, or email may be used for scheduling/admin purposes.
- Therapeutic communication should occur in session only.
- Provider may not be immediately available outside of sessions; in crisis, call 911, 988, or go to the nearest ER.

5. Privacy & HIPAA Acknowledgment

Your privacy is protected by federal and state laws. Information shared in session is confidential except in the following cases:
- If you present a risk of harm to yourself or others
- Suspected child, elder, or dependent adult abuse
- Court orders requiring release of records
- As otherwise required by law

You have the right to access your records, request amendments, and know how your information is used. A full Notice of Privacy Practices will be provided separately.

6. Acknowledgment & Agreement

I have read and understand the policies above regarding treatment, confidentiality, cancellations, and financial responsibility. I agree to abide by these policies as a client of this practice.

Patient/Guardian Signature: _____ Date: _____

Provider/Witness Signature: _____ Date: _____

Telehealth Consent Form

Telehealth services allow therapy sessions via secure video or phone. By consenting, you acknowledge:

• You understand the potential benefits and risks of telehealth.
• You agree to ensure a private, distraction-free environment.
• You know how to reach your clinician and emergency contacts. **You must provide your location at the beginning of each visit.**
• You may withdraw consent for telehealth at any time.

Provider cannot see you virtually in a state that is not covered through licensure. If you are on vacation, you will have to see your provider following your return unless they are a part of the Compact Act. You can discuss this further with your provider.

Client Signature: _____ Date: _____

Authorization for Release of Information (ROI)

Patient Name: _____ Date of Birth: _____

From/To:
Name/Organization: _____
Address: _____
Phone: _____ Fax: _____

And:
[Practice Name & Provider Information]

Information to be Released: ☐ Assessment ☐ Progress Notes ☐ Treatment Plan ☐ Discharge Summary ☐ Entire Record ☐ Other: _____

Purpose of Release: ☐ Continuity of Care ☐ Insurance ☐ Legal ☐ Personal ☐ Other: _____

Expiration: This authorization expires on _____ (default: 1 year).

Patient Rights: I may revoke this at any time in writing. Re-disclosure may occur. Signing is voluntary.

Patient/Guardian Signature: _____ Date: _____

Provider/Witness Signature: _____ Date: _____

Emergency Contact & Crisis Plan

Primary Emergency Contact: _____ Phone: _____
Relationship: _____

If you are in crisis or feel unsafe, please contact:
- National Suicide and Crisis Lifeline: 988
- Local Emergency Services: 911
- Go to your nearest emergency room.

Your therapist may provide additional crisis resources specific to your state or region.

Psychosocial History Questionnaire

Presenting Concerns: _____

How long have these concerns been present? _____

Prior Mental Health Treatment: ☐ Yes ☐ No If yes, describe: _____

Medical Conditions / Medications: _____

Substance Use: ☐ Yes ☐ No Details: _____

Family / Social Support: _____

Goals for Therapy: _____

Credit Card Authorization Form

Name on Card: _____
Card Number: _____
Expiration Date: _____ CVV: _____
Billing Address: _____

I authorize MoeMents, PLLC to charge this card for services rendered and/or missed appointments per the practice's cancellation policy.
Client Signature: _____ Date: _____