Intake Packet

Daniels Counseling, LLC

Fort Collins, Colorado

**FEE SCHEDULE**

One Time Consultation: 30 minutes $60

I hour $110

Individual Counseling: 50 minutes $90

Family and Couples Counseling: 50 minutes $90

Group Counseling: Per Hour $25

Phone Consultation (up to 10 minutes) Per Call $25

No Show/Late Cancellation Fee: $50

The client is responsible for all fees at the time of service. A $50 no show/late cancellation fee applies to missed and cancelled appointments less than before 24 hours before the appointment time. As a courtesy, a one-time waiver will be provided to a cancelled or missed appointment. However, after missed appointments and/or cancellations, Daniels Counseling has a right to reevaluate the scheduling of services. After three such appointments, services may be terminated and the client referred.

My signature below shows that I understand and will adhere to this agreement.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of client (or person acting for client) Date

**FINANCIAL AGREEMENT**

Payment for Services: Payment is due at the time of service. Self-pay clients are responsible for paying the self-pay rates in full at the start of every session.

Missed Appointments: Clients must give 24 hours notice when canceling an appointment. A $50 no-show/late cancellation fee applies to all appointments. The client will be provided a one-time fee waiver of $50.

Past Due Balances: Payments are due at the time of service. Any outstanding balances over 30 days past due are subject to be sent to an outside collection agency.

I have read, understand and agree to the above financial policy for payment of professional fees.

The client is ultimately responsible for payment of all professional fees.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT FOR TREATMENT & LIMITS OF LIABILITY**

**Limits of Services and Assumption of Risks**:

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any “cures” cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

**Limits of Confidentiality**:

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

**Duty to Warn and Protect**

If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

**Abuse of Children and Vulnerable Adults**

If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

**Prenatal Exposure to Controlled Substances**

Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

**Minors/Guardianship**

Parents or legal guardians of non-emancipated minor clients have the right to access the clients’ records.

**Insurance Providers**

Insurance companies and other third-party payers are given information that they request regarding services to the clients.

The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

*By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature (Client’s Parent/Guardian if under 18) Date

**CLIENT INTAKE FORM**

***Please provide the following information for our records. Leave blank any question you would rather not answer, or would prefer to discuss with your therapist. Information you provide here is held to the same standards of confidentiality as our therapy.***

**TREATMENT HISTORY**

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ( ) yes ( ) no

Have you had previous psychotherapy?

( ) no

( ) yes, with (previous therapist’s name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking prescribed psychiatric medication (antidepressants or others)? ( ) yes ( ) no

If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescribed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH AND SOCIAL INFORMATION**

Do you currently have a primary physician? ( ) yes ( ) no

If yes, who is it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently seeing more than one medical health specialist? ( ) yes ( ) no

If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last physical? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you currently on medication to manage a physical health concern? If yes, please list:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Are you having any problems with your sleep habits? ( ) yes ( ) no

 If yes, check where applicable:

( ) Sleeping too little ( ) Sleeping too much ( ) Poor quality sleep

 ( ) Disturbing dreams ( ) other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many times per week do you exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approximately how long each time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you having any difficulty with appetite or eating habits? ( ) no ( ) yes

If yes, check where applicable: ( ) Eating less ( ) Eating more ( ) Bingeing

( ) Restricting

Have you experienced significant weight change in the last 2 months? ( ) no ( ) yes

Do you regularly use alcohol? ( ) no ( ) yes

In a typical month, how often do you have 4 or more drinks in a 24 hour period?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you engage recreational drug use?

 ( ) daily ( ) weekly ( ) monthly ( ) rarely ( ) never

Do you smoke cigarettes or use other tobacco products? ( ) yes ( ) no

Have you had suicidal thoughts recently?

( ) frequently ( ) sometimes ( ) rarely ( ) never

Have you had them in the past?

( ) frequently ( ) sometimes ( ) rarely ( ) never

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Are you currently in a romantic relationship? ( ) no ( ) yes

If yes, how long have you been in this relationship? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale of 1-10 (10 being the highest quality), how would you rate your current relationship? \_\_\_\_\_\_\_\_

In the last year, have you experienced any significant life changes or stressors? If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever experienced any of the following?

|  |  |
| --- | --- |
| Extreme depressed mood | Yes / No |
| Dramatic mood swings | Yes / No |
| Rapid speech | Yes / No |
| Extreme anxiety | Yes / No |
| Panic attacks | Yes / No |
| Phobias | Yes / No |
| Sleep disturbances  | Yes / No |
| Hallucinations  | Yes / No |
| Unexplained losses of time | Yes / No |
| Unexplained memory lapses | Yes / No |
| Alcohol/substance abuse | Yes / No |
| Frequent body complaints | Yes / No |
| Eating disorder | Yes / No |
| Body image problems | Yes / No |
| Repetitive thoughts (e.g. obsessions) | Yes / No |
| Repetitive behaviors (e.g. frequent checking, hand washing | Yes / No |
| Homicidal thoughts | Yes / No |
| Suicidal attempts | Yes / No If yes, when? |

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**OCCUPATIONAL INFORMATION**

Are you currently employed? ( ) no ( ) yes

If yes, who is your currently employer/position? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, are you happy with your current position? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any work-related stressors, if any \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**RELIGIOUS/SPIRITUAL INFORMATION**

Do you consider yourself to be religious? ( ) no ( ) yes

If yes, what is your faith? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, do you consider yourself to be spiritual? ( ) no ( ) yes

**FAMILY MENTAL HEALTH HISTORY**

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

|  |  |  |
| --- | --- | --- |
| **Difficulty** | **Yes / No** | **Family member** |
| Depression | Yes / No |  |
| Bipolar disorder | Yes / No |  |
| Anxiety disorder | Yes / No |  |
| Panic attacks | Yes / No |  |
| Schizophrenia | Yes / No |  |
| Alcohol/substance abuse | Yes / No |  |
| Eating disorders | Yes / No |  |
| Learning disabilities | Yes / No |  |
| Trauma history | Yes / No |  |
| Suicide attempts | Yes / No |  |
| Chronic illness | Yes / No |  |
|  |  |  |

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**OTHER INFORMATION**

What do you consider to be your strengths?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What do you like most about yourself?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What are effective coping strategies that you have learned?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What are your goals for therapy?

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Is there anything else you think I should know?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Release of Private Health Information**

|  |  |
| --- | --- |
| **Client name:** | **DOB:** |
| **Address:** | **Phone number:** |

**I give permission for Successful Therapy to release/receive information from:**

|  |
| --- |
| **Person or Agency:****Address:****Phone number:****Fax/Email:** |

**The following information regarding the client/family: (check box)**

|  |  |
| --- | --- |
|  | Initial Assessment |
|  | Information on Progress in Therapy |
|  | Treatment Plan |
|  | Medical Information |
|  | Termination Summary |
|  | Other: |

**For the purpose of:**

|  |  |
| --- | --- |
|  | Coordination of Services |
|  | To Assist in Evaluation |
|  | To Provide Continuity of Treatment |
|  | Other: |

I understand that I can revoke this authorization at any time, except to the extent that action has already taken place. If not revoked at an earlier date, this authorization will expire one year from the date signed.

I understand that the specific type of information to be disclosed may include a history of DRUG or ALCOHOL, ABUSE, or MENTAL HEALTH TREATMENT.

Client name Date

Parent/ Legal Guardian Date