Serenity Counseling LCSW PLLC

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Patchogue, New York 11772
Phone 704-458-3025
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INDIVIDUAL INTAKE

Therapist Name: _____ Date: _____

Client's Name: _____ DOB: _____

Address: _____ City: _____ Zip: _____

Social Security Number: _____ School: _____

Parent/Guardian 1 Name: _____ Address: _____

Telephone: Home: _____ Cell: _____Work: _____

Drivers License #: _____ Email Address: _____

Parent/Guardian 2 Name: _____ Address: _____

Telephone: Home: _____ Cell: _____Work: _____

Drivers License #: _____ Email Address: _____

Emergency Contact: _____ Telephone: _____

Referred By: _____

INSURANCE

Check Type of Insurance: ☐ Private ☐ Medicare ☐ EAP ☐ None Insurance Company: _____

Policy #: _____ Group #: _____ Relationship to Insured: _____

Policy Holder: _____ Insured's DOB: _____ Insured's SS#: _____

EAP Name: _____EAP Authorization #: _____ EAP Phone #: _____

Client Name: _____ Date: _____

FINANCIAL RESPONSIBILITIES (Please Initial)

Co-Payments are due at the time of service _____.

I hereby assign payment of insurance benefits directly to Serenity Counseling LCSW PLLC. While Serenity Counseling LCSW PLLC will bill my insurance company, I will be responsible for any charges incurred if my insurance company does not pay _____.

It is my responsibility to contact my insurance company to obtain the proper authorizations if required. If I fail to do this and charges are denied I will be responsible for all charges _____.

If my portion of the bill is not paid within 90 days from the last date it was incurred a letter will be sent giving you 14 days to pay your account or to arrange for a payment plan. If you do not respond you will be sent to collections _____.

Client Name: _____ Date: _____

While Serenity Counseling LCSW PLLC will provide me with a courtesy insurance benefits check, I am still responsible for understanding what my insurance covers and verifying this coverage _____.

I will be billed for phone consultations, letters and/or medical record copies at the therapists standard rate by 15 minute increments _____.

A 1% interest will be added to your portion of the bill that remains unpaid after 30 days _____.

Returned check fees $35.00 and the check amount _____.

You will be charged $95 for missing an appointment: no-show/not giving at least 24 hours prior notice to cancelling an appointment _____.

I have received the treatment agreement and disclosure statement. I understand and agree to abide by my financial responsibilities. I understand that information will be released to my insurance company, if necessary, and any charges that my insurance company will not cover I am responsible for.

To enable my therapist with accurate and confidential services please complete the following:

Please be aware that fax transmissions arrive at Serenity Counseling LCSW PLLC office and are distributed to the individual therapist. Confidentiality is maintained with these records, as with all records in our office.

Messages regarding appointments may be left on my voicemail _____Yes _____No.

The following individuals may schedule and/or confirm appointments _____.

Client Name: _____ Date: _____

HIPPAA LAW: Notice of Privace Practice Achnowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to …

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly or indirectly.
- Obtain payments from third-party payers.
- Conduct normal health care operations such as but not limited to quality assessments and physician certifications.

I have received, red and understand the Notice of Privacy Practices containing more complete descriptions of the uses and disclosure of my health information. I understand that a professional entity has the right to change its Notice of Privacy Practices from time to time and that I may contact that professional at the address above to obtain a current copy of this information.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Client Name (print): _____ Client Signature: _____

Parent/Guardian (print): _____ Parent/Guardian Signature: _____

What brings you to counseling and what goals/skills do you hope to gain?

Stregnths Assessment: Please check all items that you think apply to you

Trustworthy	Stable Employment	Kind	Religious/Spiritual Community
Good Sense of Humor/Fun	Flexible	Spontaneous	Open to Grow
Courageous	Forgiving	Physical Health	Creative
Exercises	Calm	Enjoys Learning	Resourceful
Happy Most of the Day	Good Communication Skills	Living for a Purpose	Living to the Fullest Potential
Family Support	Decisive	Organized	Participation in Hobbies
Confident	Financially Stable	Does Not Make Assumptions	Does Not Take Things Personally
Do Your Best Most of the Day	Friendly	Team Player	Relaxes
Eats Nutritional Foods	Articulate	Generous	Accepting

Client Name: _____ Date: _____

Needs Assessment: Please check individual items you want to address

Please circle the two most important

Marriage Concerns	Intimacy	Career/Job	Improve Communication Skills
Health Problems	Concentration	Bowel Trouble	Stomach Trouble
Self-Esteem	Hopelessness	Guilt	Sexual Difficulties
Temper	Depressed	Self-Control	Drug Use
Harm to Self	Finances	Impulsivity	Alcohol Use
Harm to Others	Antisocial Behavior	High Energy	Low Energy
Suicidal	Unhappy	Headaches	Lack of Focus
Lack of Motivation	Memory Impairment	Legal Matters	Anger
Sleep Problems	Repetitive Thoughts	Chest Pain	Abuse
Avoiding People	Nightmares	Trauma	Nervousness
Anxiety	Fears	Physical Fighting	Shyness
Meaningless	Crying Spells	Appetite/Weight	Unresolved Grief
Spiritual Concerns	Use of Time	Panic Attacks	Negative
Eating/Food/Hoarding	Stress	Infidelity/Affairs	Aggression
Jealousy	Divorce/Transition	Housing	Non-Compliance
Cyber Addiction	Disorientation	Elevated Mood	Withdrawing
Loneliness	Gambling	Hallucinations	Delusions
Heart Palpitations	Irritability	Judgement Errors	Phobias
Sexual Addiction	Often Sick	Trembling	Sleeping Difficulties
Disorganized Thoughts	Dizziness	Drug Dependency	Mood Shifts
Worry	Fatigue		

HEALTH INFORMATION

Name of your Primary Care Physician: _____ May we contact? YES NO
Phone Number: _____ When were you last seen? _____
I give consent or do not give consent (circle one) for my therapist, _____
to release my records to my primary physician to discuss my treatment,

_____ _____ _____
Print Name Signature Date

Are you receiving care by a Psychiatrist? Circle One Please **YES** **NO**
If yes, please enter Name and Phone Number: _____

List all current medications and vitamins/dosage: _____

_____

List all current health problems including allergies: _____

_____

Past Psychiatric History (mental health and chemical dependency): hospitalizations (please explain)

_____

Prior outpatient therapy (include previous practitioners, dates of treatment, previous treatment interventions, response to treatment and/or medications:

_____

Client Name: _____ Date: _____

RISK ASSESSMENT (Please Circle)

Suicidal Ideation: None Noted Thoughts Only Plan Means Attempt

Homicidal Ideation: None Noted Thoughts Only Plan Means Attempt Accomplished

Self Injurious Behavior: None Noted Thoughts Only Plan Means Attempt Accomplished Engaging In Currently

DRUG AND ALCOHOL ASSESSMENT

Are drugs or alcohol used by yourself or someone else a significant factor in why you are coming to our office? (Please Circle) Yes No

If yes, self/other and their relationship to you: _____

Frequency of Alcohol Use:

_____Never _____Less than 1 time/month _____1-4 times per month _____2-3 times per week ____daily

Usual Alcohol Consumption:

_____Never _____1-2 drinks _____3-4 drinks per sitting _____5 or more drinks per sitting

Frequency of Use to Levels of Intoxication:

_____Never _____Less than 1 time/month _____1-4 times per month _____2-3 times per week ____daily

Self-Perception of Alcohol Use: (Check all that Apply):

___Occasional or Social ___Problem Use ___Psychological Dependence

___Addicted-Cannot Stop ___Do Not Want to Stop ___Motivated to Stop

History of Treatment Attempts: (Check all that Apply):

___None ___Stopped on Own ___ Attended AA/other 12 Step Program

___Attended Outpatient Program ___Attended Inpatient Program ___Attended Community Based Program

Please Describe any Drug-related Problems (ex. legal, job, physical, or social): _____

Self Perception of Drug Use: (Check all that Apply)

___Occasional or Social ___Problem Use ___Psychological Dependence

___Addicted-Cannot Stop ___Do Not Want to Stop ___Motivated to Stop

History of Treatment Attempts: (Check all that Apply):

___None ___Stopped on Own ___ Attended AA/other 12 Step Program

___Attended Outpatient Program ___Attended Inpatient Program ___Attended Community Based Program

List a Community Resource You are Currently Benefitting from: _____

Client Name: _____ Date: _____

Have you ever thought you should cut down on your drinking? **YES** **NO**

Have you ever felt bad or guilty about your drinking? **YES** **NO**

Has anyone in your life asked you to cut down on your drinking? **YES** **NO**

Have people annoyed you by criticizing you of your drinking? **YES** **NO**

Does drug use impact your relationships or work functioning? **YES** **NO**

Do you use any kind of substance to deal with stress? **YES** **NO**

Risk Factors to Include:

Non-Compliance with Treatment	Domestic Violence	Eating Disorder
AMA/Elopement Potential	Child Abuse	Suicidal/Homicidal
Prior Behavioral Health Inpatient Admissions	Sexual Abuse	Other:

Legal Information:

Do you have a probation officer or case worker? If yes, what is his/her Name, Phone number and Address:
_____

Do you have an attorney? If yes, what is his/her Name, Phone number and Address:
_____

Marital Information:

Married ___ Widowed ___ Widowered ___ Divorced ___ Living Together ___ Separated ___ Single ___

If other please explain: _____

List Dates and Lengths of Previous Marriages: _____

Children's Names and Ages: _____
_____

Please list any family mental health issues:
_____
_____

Write 3 of your beliefs that Support your Life: _____
_____
_____

Signature of Understanding

Please sign below to indicate that "I have read the above policies and I understand and agree to comply with them. The information shared is true and accurate. I further agree that I am personally responsible for all financial obligations incurred. I also consent to receive treatment by a Serenity Counseling LCSW provider."

_____
Print Name Date

_____
Sign Name Date

Client Name: _____ Date: _____

****FOR OFFICE USE ONLY*****

Disclosure Statement Signed- Yes No	Insurance Card Copied- Yes No
CCA Completed and signed- Yes No	Treatment Plan Completed and Signed- Yes No
Intake Paperwork with HIPAA and Minor Consent form Completed and Signed- Yes NO	Release Form to Speak with Physician Completed and Signed- Yes No N/A
Billing Diagnosis Is:	For Billing: Consumer is Entered into System- Yes No

Client Name: _____ Date: _____