CLIENT INTAKE INFORMATION FORM

Client Name_____________________________ Date of first Appointment ___/ ___/ ___

Date of Birth _____/______/_____ Age ______ Gender _________ Pronouns_______

Address____

City________________State_____ Zip__________ Phone (____)______-_______

Persons also residing in the home:

Name	Age	Gender	Relationship

**In cases of divorce with children: Please provide a copy of the court order that outlines the parental rights for allowing your child's access to mental health care.*

By signing below, I give consent for the following:

Email communication including Protected Health Information (PHI).

I understand that email is not to be used for emergency situations including but not limited to suicidal thoughts or plans.

Telephone messages including PHI information.

_____I do not give consent for communication via email or leaving telephone messages.

Signed:_______________________________________Date:____________________

Name:_______________________________________Date:_____________________

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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 counseling or psychotherapy?
( ) yes, with (previous therapist)___________________________________
( ) no

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

If yes, please list:
____

Prescribed by: ____

Vitamins or Supplements? ____

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.:
____
____

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

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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

Any significant weight change in the last 2 months? ( ) yes ( ) no

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

In a month, do you have 4 or more drinks in a 24 hour period? ( ) yes ( ) no

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

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

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

Please use this space, if needed, to explain further:

____

____

____

____

____

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OCCUPATIONAL INFORMATION

Are you currently employed? ( ) yes ( ) no

If yes, who is your current employer/position? ___________________________

If yes, are you happy with your current position? __________________________

Please list any work-related stressors, if any __________________________________

____

RELIGIOUS/SPIRITUAL INFORMATION

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

If yes, what is your faith? ____________________________

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	
Other________________		

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OTHER INFORMATION

What do you consider to be your strengths?

____

____

____

What do you like most about yourself?

____

____

What are effective coping strategies that you have learned?

____

____

____

Are you color blind? ( ) yes ( ) no

Allergies to ( ) Wheat ( ) Gluten ( ) Dairy ( ) Nuts ( ) Other _____

What are your goals for therapy? (What would you like to see improve?)

1.____

2.____

3.____

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Client Policy Information

Appointments

Your therapy time is reserved for you. Any appointments cancelled without 48-hour notification will result in your being charged a $145.00 fee. Obviously, unexpected illnesses and emergencies sometimes do occur please call and let us know if you or your child need to reschedule due to illness or unforeseen circumstances. Failure to notify or "no show" occurrences will lead to termination of care. Please note that sixty days without having an appointment you are discharged from care. All fees are payable in full at the end of each therapy session.

Confidentiality

Although it is the goal of the undersigned therapist to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law: Confidentiality and exceptions to confidentiality are discussed below. In the event disclosures of your records or testimony is required by law you will be responsible for and shall pay the costs involved in producing the records and therapist's hourly rate for the time involved in giving testimony, travel, and reviewing records.

Discussions between a therapist and a client are confidential. No information is released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include, but are not limited to, the following situations: child abuse, abuse of the elderly or disabled, abuse of patients in mental health facilities, sexual exploitation, child custody case suits in which the mental health of a party is in issue, fee disputes between the therapist and the client, and in a negligence suit brought by the client against the therapist. If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss the matter further. By signing the information and consent form, you are giving your consent to the undersigned therapist to share confidential information with all persons giving you mental care services and payment for those services, and you are releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result.

By signing this information and consent form, you are further giving your consent to ______________________________(therapist) to contact any person the therapist deems reasonably necessary to protect me or a third party from harm including but not limited to the following person(s):

___________________________________ ______________________________
Emergency Contact Phone Number

_________________________________ ______________________________
Signature Date

Emergencies

If immediate treatment is needed, call 911, go to the closest Emergency Room or the hospital covered by your insurance. If I should be out of town at any time, I will leave the name and number of another therapist who will be available to you in case of emergency. If you need an appointment as soon as possible I keep emergency times available.

National Suicide Prevention Lifeline 1-800-273-8255

Suicide Text line: 741 741

National Suicide Prevention Chat - https://suicidepreventionlifeline.org/chat/

Frequency of Sessions: 2 x week 1x week 2 x month 1 x month PRN

Type of Therapy recommended : Art Therapy Cognitive Behavioral Therapy

Dialectical Behavioral Therapy Trauma Focused ________________________

Initial goals of treatment.

1. ____

2. ____

3. ____

I have read, understand, and agree to the policies and conditions of treatment listed above. Should I decide to not undertake treatment by __________________________, I may contact any of the referrals provided to me or give notice that I decide not to participate in any treatment at this time.

__________________________________ __________________________________
Signature Date

__________________________________ __________________________________
Therapist Date

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RELEASE OF INFORMATION

Name of client____

Client ID# ___________________________ DOB _______________________

I, ____, authorize reciprocal

disclosure between ________________________________(therapist) and

Name:________________________________Contact:____________________________

Of the following information for
_____ My personal records
_____ Photography of artwork made in art therapy
_____ Sharing with other healthcare providers as needed
_____ Supervision purposes with LPC Associate or ATR-P
_____ Other:
____

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that this consent shall expire 60 days after the date of patient discharge unless another date is specified.

Specification of the date, event, or condition upon which this consent expires:

_____ Date of expiration ____/____/_____

TO THE RECIPIENT: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2.

____ _____________________
Individual or Legal Representative (please print) Date

____ _____________________
Signature of Individual or Legal Representative Date

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HIPPA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to it. Please review carefully.

1. Your medical records are used to provide treatment, bill and receive payments, and conduct healthcare operations. Examples of these activities include but not limited to review of treatment records to ensure appropriate care, electronic or mail delivery of billing for treatment to you or other authorized payers, appointment reminder telephone calls, and records review to ensure completeness and quality of care. Use and disclosure of medical records is limited to the internal used outlined above except required by law or authorized by the patient or legal
2. Federal and State laws require abuse, neglect, domestic violence and threats to be reported to social services or other protective agencies. If such reports are made they will be disclosed to you or your legal representative unless disclosure increases risk of further
3. Disclosed information will be limited to the minimum necessary. You may request an account for any uses or disclosures other than those described in Sections 1 and Sections 2.
4. You, or your legal representative, may request your records to be disclosed to yourself or any other entity. Your request must be made in writing, clearly identify the person authorized to request the release, specify the information you want disclosed, the name and address of the entity you want the information released to, purpose and the expiration date of the authorization. Any authorization provided may be revoked in writing at anytime. Psychotherapy notes are part of your medical records. We have 30 days to respond to a disclosure request and 60 days if the records is stored off site.
5. You may request corrections to your records.
6. A request for disclosure may be denied under the following circumstances: disclosure would likely endanger the life or physical safety of you or another person, requested information references other persons, except another healthcare provider, or if released to a legal representative would likely result in harm.
7. If a request for disclosure is denied for reasons outlined in Section 6, you or your legal representative may request review of the denial. A review will be conducted by another licensed healthcare provider appointed by the original reviewer, who was not involved in the original decision to deny access. A review will be concluded within 30 days.
8. You may request that we restrict uses and disclosures outlined in Section 1. However, we are not required to agree to the restrictions. If an agreement is made to restrict use or disclosure, we will be bound by such restriction until revoked by you or your legal representative orally or in writing except when disclosure is required by law or in an emergency. We may also revoke such restrictions but information gathered while required by law or in an emergency. We may also revoke such restrictions but information gathered while the restriction was in place will remain restricted by such an agreement.
9. If you wish to complain about privacy related issues you may contact the Secretary of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington DC, 20201. In any case there will not be any retaliation against you or your legal representative for filing a complaint.
10. This agreement may be modified or amended as required by law or in the course of health care operations.

I HAVE READ AND UNDERSTOOD THIS PRIVACY NOTICE AND MY RIGHTS CONCERNING USE AND DISCLOSURE OF PROTECTED HEATLH CARE INFORMATION.

______________________________ ______________

Individual or Legal Representative (please print) Date

______________________________ ______________

Signature of Individual or Legal Representative Date

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Payment Policy

Primary Insurance information

Insurance carrier___________________________ ID# ____________________________

Subscriber Name______________________________ DOB ____/_____/________

Provider hotline (on back of card) (_____)_________-__________________

My co-payment amount per session is $______.

My deductible amount per year is $___________.

Have you met your deductible for this year? ( )YES ( ) NO

Secondary Insurance information

Insurance carrier___________________________ ID# ____________________________

Subscriber Name______________________________ DOB ____/_____/________

Provider hotline (on back of card) (_____)_________-__________________

My co-payment amount per session is $______.

My deductible amount per year is $___________.

Have you met your deductible for this year? ( )YES ( ) NO

1. I understand that I will be charged a LATE CANCELLATION fee of $145 if I fail to give at least 48 hour notice prior to cancelling my appointment (does not apply if client is currently enrolled in MEDICAID).
2. I understand that I will be charged a fee of$145 if I fail to show for my appointment.
3. I understand that if I arrive late to the appointment, I will still have to end the session at the allotted time. By signing this, I am agreeing to the above stated terms and stipulations regarding the services I receive from this therapist.

____ ____/______/_______

Signature Date

____

Relationship to Client (Self/ Guardian/ Caregiver)

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INFORMATION AND CONSENT FORM

Davis Art Therapy and Counseling offers individual and group art therapy and counseling to children, adolescents and adults.

Fee: $200 Intake
$125.00 per 30min. $145.00 per 45-52 min. $160.00 per 53+ min.

I understand that my fee will be due at time of service.

I understand that failure to show for an appointment without a 48-hour notice will result in a $145.00 fee. I understand that these charges are an out of pocket expense and that my insurance carrier will not cover "no show" charges.

I understand that I am responsible for knowing the coverage of my insurance policy including co-payment amount and deductible amount. I understand that I will be responsible for any fees not paid by my insurance policy.

I understand that I have the right to make a complaint and receive a fair response from my therapist in a reasonable amount of time. I am also aware that anyone who wishes to file a complaint against a healthcare professional in this state may contact:
Texas Behavioral Health Executive Council at 1801 Congress Ave., Ste. 7.300 | Austin, Texas 78701, (512) 305-7700.
Investigations/Complaints 24-hour, toll-free system (800) 821-3205

I have completely read and understand this information and have had an opportunity to ask for any clarification that I might need. I, therefore, give my informed consent for ___________________________to treat me________ my child_________.

Client's Signature ___________________________________ Date ______________

Therapist's Signature ________________________________ Date ______________

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Intake Notes - *(therapist use)*

( ) Lifeline
( ) KFD
( ) DAP
( ) PHQ9

____

____

____

____

Describe your caregivers:

Parent Name:____

____

____

____

____

Parent Name: ____

____

____

____

____

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