Live Free Therapy
Kayla Diorio, LCSW
56 Main Street Suites 6 & 7, Warwick, NY 10990
Phone: 845-551-2942 Fax: 845-920-7655

CLIENT INTAKE FORM

Client's Name: _____

Client's DOB: _____ Age: _____ Gender: _____ Ethnicity: _____

Client's Address: _____

Phone Number: _____

Email (of Client or Parent if Child): _____

Referred by: _____

Prior Mental Health Treatment: _____

Hospitalizations Relating to Mental Health: _____

Medications: _____

Primary Care MD: _____

Emergency Contact: _____

Marital Status (of Client or Parent if Child):_____

Education Level (of Client or Parent if Child): _____

Occupation (of Client or Parent if Child): _____

Employer (of Client or Parent if Child):_____

Household Composition

Name	Age	Relationship	Occupation / School

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Why are you (or your child) seeking therapy at this time?

_____
_____
_____
_____

How long has this been a problem and what have you tried in the past?

_____
_____
_____
_____

What are your (or your child's) goals for therapy?

_____
_____
_____
_____

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Please read the following document carefully, as it contains important information regarding the treatment you and/or your family will receive in this clinic. After careful review, please sign your acknowledgement of our policies and procedures.

Confidentiality: The information you share with me is held in the strictest confidence and may not be released to anyone without your written consent, as prescribed by law. There are a few exceptions to this, which are also regulated by State law. For example, in cases of suspected child or elderly abuse, or if a person poses a serious and imminent danger to her/himself or to someone else, I am required by law to report this information to the proper authorities. Information subpoenaed by a valid court order is usually not protected by this limit on confidentiality. These situations rarely occur and are the only exceptions to otherwise 100% confidentiality of what you talk about during therapy. In addition, some insurance companies require very brief and limited treatment information including diagnosis, and in some cases, information about presenting symptoms and treatment planning. Upon signing consent to release information, you are encouraged to discuss the amount, type, and purpose of information to be released if you have any concerns in this area. My policy is to allow you to maintain the highest possible level of confidentiality.

Insurance: I am a licensed clinical social worker (LCSW) in the State of New York. I am fully credentialed as an Out-of-Network provider for most insurance plans. I have chosen not to take insurance directly for a number of reasons. (The Insurance Industry has gained so much power and influence that its primary interest is to make money and not in providing the best quality patient care. In order to rationalize denial of or limit of care, they have become intrusive into the privacy of the therapy process, often requiring that detailed notes on clients be sent to them.) Using your Out-of-Network benefits can be a better option for you as a consumer both financially and in protecting your confidentiality. You can contact your insurance company and ask specifically about your Out-of-Network benefits for therapy with an LCSW. I will be happy to help you devise a plan so that you can maximize your potential benefits while still seeking the quality care of a professional.

Attendance Policy: After 6 weeks of not being seen or scheduling an appointment, your case will be closed due to non-attendance. If you re-schedule an appointment more than twice in a row your case will be closed.

Fees/Billing: Each client (parent/ legal guardian for minors) is responsible for managing the finances of the therapy relationship. Please note that each client is responsible for payment for services rendered the day of the appointment. Cash or checks are both acceptable payment methods. There is an additional fee for Credit or Debit cards.

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The fee schedule is as follows:

• Initial Consultation (1 hour): $200

• Individual / Family Session (45 minutes): $150

• School staffing participation (via phone) = $50.00/per 15 minutes

• No-show fee = ***Full session rate**

*Since I reserve your appointment time, there will be a charge for any appointments missed without prior notification. It is essential for you to cancel your appointment at least 24 hours in advance to avoid this charge.

Phone calls and other contacts: The scheduling and canceling of appointments are handled through the same phone number (though follow-up appointments will generally be set up at the end of the previous session). If you need to reschedule your appointment, please leave a message on my voicemail, and I will return your call by the end of the next business day. You may also leave a message on the voicemail to cancel appointments within 24 hours of your scheduled time. Please include your name, the appointment time, and a contact phone number.

I recognize that there may be times when you need to speak to me outside of your scheduled appointment. If a need for this does arise, please feel free to leave me a message at the same number. I will make every effort to return your call by the end of the next business day. Please reserve these messages to times when the matter is urgent, as it is necessary to devote most of my time to direct patient care. If you simply need to pass along information to me and do not need a response, feel free to contact me via email. I check my mailbox daily and this is generally the best method of communication between sessions. My email address is **kdioriolcsw@gmail.com**.

In the event of an emergency, I recommend you contact your medical doctor (or after hours number if their office is closed) or call 911, whichever is most appropriate for the situation. I can assist you with referrals for a medical or psychiatric consultation if needed.

X_____ **Date:** _____

Signature of client or parent/guardian if client is a minor

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NOTICE OF PRIVACY PRACTICES

Receipt and Acknowledgement of Notices

Client's Name _____

DOB: _____

I have read Kayla Diorio, LCSW's **Terms of Care** and agree to follow all policies and procedures as described.

X_____ **Date:** _____

Signature of client or parent/guardian if client is a minor

I read a summary of the Privacy Practices of Kayla Diorio, LCSW. I acknowledge that a copy is available upon my request.

X_____ **Date:** _____

Signature of client or parent/guardian if client is a minor

Client Refuses to Acknowledge Receipt:

Signature of Therapist Date

_____ _____