Somatic Intention & Affiliates Intake Form

787 West Locust
Dubuque, Iowa 52001

CONTACT INFORMATION

Name: _____
Birth Date: _____
E-mail Address: _____
Home Address: _____
City: _____
State: _____
Zip: _____
Cell Phone: _____

REFERRED BY

Please share who referred you to Somatic Intention & Affiliates: _____

DEMOGRAPHICS

Age:_____
Gender: ☐ Female ☐ Male ☐ Non-binary ☐ Transgender ☐ Intersex ☐ Other_____
Pronouns: ☐ She/Her/Hers ☐ His/Him/His ☐ They/Them/Theirs ☐ Other _____
Race: ☐ African American or Black ☐ American Indian or Alaskan Native ☐ Asian ☐ Hispanic or Latino ☐ Native Hawaiian or Other ☐ Pacific Islander ☐ White ☐ Other _____
Marital Status: ☐ Single ☐ Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Student Status: ☐ Full Time ☐ Part Time ☐ Not a Student **School** _____
Employment Status: ☐ Full Time ☐ Part Time ☐ Not Working
Employer_____

PARENT/GUARDIAN INFORMATION ☐ Not applicable

Note: The guardian who brings the child to treatment will be responsible for payments.

Mother's Name: _____ Cell Phone: _____

Father's Name: _____ Cell Phone: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

COMMUNICATION

Please check the ways in which I can communicate with you: ☐Cell Phone ☐Text Message

We use an online system through Therapy Notes to schedule appointments and bill insurance. Through Therapy Notes you can receive appointment reminders through e-mail or text message. If interested, please select one or two of the options below:

E-mail Appointment Reminders: ☐Yes ☐No E-mail Address: _____
Text Appointment Reminders: ☐Yes ☐No Cell Phone: _____

CURRENT MEDICATIONS ☐Not Applicable

Medication:_____ Doctor:_____ Date Started:_____
Medication:_____ Doctor:_____ Date Started:_____
Medication:_____ Doctor:_____ Date Started:_____

INSURANCE INFORMATION

Primary Insurance Information	Secondary Insurance Information
Insurance Company:	Insurance Company:
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:
Employer:	Employer:
Subscriber ID:	Subscriber ID:
Policy #:	Policy #:
Group #:	Group #:
Copay Amount:	Copay Amount:
Subscriber Relationship to Client:	Subscriber Relationship to Client:

CREDIT CARD INFORMATION

Each client must have a credit card on file. After each session your card will be processed for your co-pay or private pay. Please fill in the information below.

Type of card ☐ MasterCard ☐ Visa ☐ Capital One ☐ Other _____
Name on Card: _____
Credit Card Number: _____
Expiration Date: _____
CVV Code: _____
Billing Address: _____
City: _____ State: _____ Zip: _____

By your signature on this form, you authorize charges to your credit card through CardPointe via Therapy Notes for services rendered. You have the right to request a paper copy of this document. I authorize Somatic Intention & Affiliates to charge my credit card through CardPointe.

I also agree that my credit card can be charged for any session that is not cancelled at least 24 hours prior to the scheduled session (with exception to Iowa Medicaid policy holders).

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Somatic Intention & Affiliates in writing of any changes in my account information or termination of this authorization.

I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my bank or credit card company as long as the transactions correspond to the terms indicated in this authorization form. I acknowledge that credit card transactions could be linked to Protected Health Information.

_____ _____
Cardholder Signature Date

PRIVATE PAY INFORMATION

If insurance is not an option or you prefer not to use insurance, the following rates are available below:

- Intake Session - $175.00
- 60 Minute Session - $150.00
- 45 Minute Session - $125.00
- 30 Minute Session - $100.00

MARRIGE COUNSELING

Insurance typically does not cover couples therapy as it is not considered a medically necessary service. While couples may be significantly affected by the quality of their relationship, there is no specific diagnosis or disorder recognized by insurance that pertains to their challenges or treatment. As a result, couples therapy is a service paid for out-of-pocket.

TREATMENT PHILOSOPHY

Somatic Intention & Affiliates believe in providing a holistic approach to treatment that is goal orientated. After a thorough assessment, goals will be discussed and accomplished in a time-efficient manner that suits your needs and wants.

CONFIDENTIALITY

All information between provider and client is held strictly confidential unless:

- The client authorizes release of information with his/her signature, or parent/guardian signature.
- The client presents a physical danger to self and/or others.
- Child or Adult abuse/neglect is suspected. We are required by law to inform potential victims and legal authorities of potential dangers.
- The client understands their therapist may be under supervision, where limited information may be shared to the supervisor, with the intention to assist the client's treatment process.

FINANCIAL TERMS

Upon verification of health plan/insurance coverage and policy limits, your insurance carrier will be billed for you and we will be paid directly by the carrier. You will be responsible for any applicable deductibles and co-payments. If you are not eligible at the time services are rendered, you are responsible for full payment. A requirement of a personal credit card that is up to date must be in your personal file and able to cover any co-pays or private pays for each session. Once your session is billed and processed, your credit card will be charged accordingly.

CANCELLED/MISSED APPOINTMENTS

This office operates under the policy that scheduled appointments are reserved exclusively for each client. If an appointment is missed or cancelled with less than twenty-four (24) hours' notice, a fee of $75 will be billed for the missed appointment. Failure to provide any communication regarding a missed appointment may result in removal from the scheduling system.

Furthermore, if there are two instances of a no call, no show appointment—regardless of the reasons—the client will be automatically removed from the scheduling system.

Please ensure to provide ample notice if you need to cancel or reschedule an appointment to avoid any inconvenience or fees.

LEGAL AND/OR COURT INVOLVEMENT

It is Somatic Intention & Affiliate's intention to refrain from any participation in legal and/or adversarial situations. Services are provided in the interest of symptom relief, healing, and growth. Any time spent on legal documentation or court involvement will be billed at a rate of $125 per hour.

EMERGENCY PROCEDURES

In the event of an emergency and you feel your mental health needs immediate attention, you should report to the emergency room of the local hospital and request mental health services. If you are in crisis and need to speak with someone, please call the national crisis hotline at 988. If you have a medical or life-threatening emergency, please call 911. If you need to contact your therapist, leave a message according to the instructions on the phone messaging system and your call will be returned.

RELEASE OF INFORMATION

By signing your intake, you authorize the release of information regarding your care to your health plan for the payment of claims, certifications/case management decisions, and other purposes related to the administration of benefits for your health plan while being seen at the Ramos Therapy & Affiliates.

CLIENT RIGHTS AND RESPONSIBILITIES

No list of client rights can ensure the respect of those rights. It is the intent of Somatic Intention & Affiliates to make sure that all aspects of treatment and service reflect concern and respect for client's rights as well as high ethical standards.

- Each client has the right to considerate care with the client's safety and personal dignity being of prime importance.
- Each client shall have reasonable access to care, regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability.
- Each client has the right to have his or her cultural, psychological, spiritual and personal values, beliefs, and preferences respected.
- Each minor client has the right to include his or her parent/family member/guardian in treatment.
- Each client has the right to privacy, confidentiality, and security, in accordance with agency, state and federal regulations governing the confidentiality of information. Client confidentiality will be maintained during case consultations, clinical supervision and all internal or external audits of clinical records. All records reviewed by auditors, external entities and business associations, will be noted on the accounting summary form for HIPAA purposes.
- Treatment services are provided regardless of whether authorization for release of information is signed.
- Each client and when appropriate the family, has the right to complete information about treatment including, but not limited to: Limits of confidentiality, Treatment planning, Risks of Treatment, Alternatives to Treatment, Cost of Service and/or any changes in treatment recommendations (including changes in clinical staff).
- Each client has the right to access, request amendment to, and receive an accounting of disclosures regarding his or her own clinical/service information as permitted under applicable law. (Please see Notice of Privacy Practices)
- Each client who seeks services voluntarily has the right to refuse and/or terminate care, treatment or services at any time.

GOOD FAITH ESTIMATE

Under Section 2799B-6 of the Public Health Service Act, health care providers are required to inform individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage both orally and in writing of their ability, upon request to receive a "Good Faith Estimate" of expected charges.

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost. Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services. You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs such as session fees, medical tests, prescription drugs, equipment, and hospital fees.

- Your health care provider has a duty to provide you with a Good Faith Estimate in writing at least 1 business day before your medical services. You may also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule a service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you may dispute the bill.
- Please save a copy or picture of your Good Faith Estimate. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises

CONSENT FOR TREATMENT

Please read the following statement and sign below: I authorize and request that the professional staff at Somatic Intention & Affiliates carry out mental health examinations, therapy, counseling, evaluations, treatments, and/or diagnostic procedures, which now or during the course of my care are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable. I hereby acknowledge that I am willing and without coercion, taking part in these mental health related procedures.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature (if applicable) Date

PRIVACY NOTICE ACKNOWLEDGEMENT

Somatic Intention & Affiliates 787 West Locust Dubuque, IA 52001 I hereby acknowledge that Somatic Intention & Affiliates has provided the Privacy Notice as required by the Health Insurance Portability and Accountability Act of 1996.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature Date

TERMS AND CONDITIONS

By signing below, I understand and agree to the terms and conditions of Somatic Intention & Affiliates that has been provided and described in the intake.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature Date

PLEASE SEE NEXT PAGE

Symptoms Checklist

Please review the following list of symptoms and check any that you have experienced in the past few weeks or months. Your responses will help guide therapy planning and ensure we address your current concerns. If you are unsure about any item, please discuss it during your intake session.

Emotional Symptoms:

☐ Feeling sad or down
☐ Confused thinking or reduced ability to concentrate
☐ Excessive fears or worries
☐ Extreme feelings of guilt
☐ Extreme mood changes (highs to lows)
☐ Suicidal or self-harming thoughts
☐ Feeling hopeless, worthless or guilty
☐ Irritability, anger or aggression
☐ Obsessive or fixated thinking

Behavioral Symptoms:

☐ Withdrawal from friends and activities
☐ Significant tiredness, low energy or problems sleeping
☐ Detachment from reality (delusions), paranoia or hallucinations
☐ Problems with alcohol, drugs and/or sex
☐ Major changes in eating habits
☐ Changes in sex drive
☐ Excessive anger, hostility or violence
☐ Trouble understanding and relating to people or situations
☐ Inability to cope with daily problems or stress
☐ Racing thoughts, ruminating thoughts or overthinking
☐ Flashbacks
☐ Neglecting hygiene or daily tasks
☐ Trouble concentrating or making decisions
☐ Procrastination or avoidance
☐ Insomnia or difficulty sleeping
☐ Change in appetite (increase or decrease)
☐ Neglecting basic needs (hydration and/or nutrition)
☐ Trouble with logical reasoning or problem-solving

Physical Symptoms:

☐ Stomach pain
☐ Back pain
☐ Headaches
☐ Unexplained aches or pains
☐ Feeling off balance
☐ Involuntary movements