JESSICA BALOWSKI, LLMSW
CLINICAL THERAPIST

Hello!

I appreciate you taking the time to fill out the following intake form in its entirety. Please be aware that all forms and policies are in effect and cover both in person and virtual sessions. The following link can be used for any and all virtual sessions: doxy.me/balowski. If at any time you have a question about your appointment time, insurance, or any other concerns, please contact the office at 734-639-2262.

I look forward to meeting with you!

Jessica Balowski

Humanistic Wellness Center
750 S. Monroe St.
Monroe, MI 48161

Email: balowskimsw@gmail.com
Tel. No.: 734-639-2262

# Intake Form

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

*Please print out this form and bring it to your first session or allow yourself 30 minutes prior to your appiontment to complete this form in the office.*

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if client is a minor):

_____
(Last) (First) (Middle Initial)

Birth Date: ____/_____/_____ Age: _____ Gender: ____ Male ____ Female ____ Prefer not to answer

Marital Status:
___ Never Married ___ Partnered ___ Married ___ Separated ___ Divorced ___ Widowed

Number of Children: _____

Home Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) - May we leave a message? ___ Yes ___No
Cell/Other Phone: ( ) - May we leave a message? ___ Yes ___No

E-mail: _____ May we email you? ___ Yes ___ No
*Please be aware that email might not be confidential.

Referred by: _____

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ___ Yes ___ No

Have you had previous psychotherapy? ___ Yes ___ No
If yes, name of previous therapist's name _____

Are you currently taking prescribed psychiatric medication (antidepressants or other)? ___ Yes ___ No
If yes, please list: _____
If no, have you been previously prescribed psychiatric medication? ___ Yes ___ No
If yes, please list: _____

HEALTH AND SOCIAL INFORMATION

How is your current physical health? (please circle):

Poor Unsatisfactory Satisfactory Good Very Good

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

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? ___ Yes ___ No
If yes, check where applicable: ___ Easting less ___ Eating more ___ Binging ___ Restricting
Have you experienced significant weight change in the last two (2) months? ___ Yes ___ No

Do you regularly use alcohol? ___ Yes ___ No
In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

How often do you engage in recreational drug use? ___ Daily ___ Weekly ___ Monthly ___ Rarely ___ Never

Have you had suicidal thoughts recently? ___ Frequently ___ Sometimes ___ Rarely ___ Never
Have you had any 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, how would you rate the quality of your current relationship? _____

In the last year, have you experienced any significant life changes or stressors:
_____

Have you ever experienced:

| | |
|---|---|
| Extreme Depressed Mood | yes/no |
| Wild 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 Disorders | 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 |
| Suicide Attempt | yes/no |

OCCUPATIONAL INFORMATION:

Are you currently employed? ___ No ___ Yes, I am currently employed as a(n) _____

If yes, are you happy at your current position?_____

Please list any work-related stressors, if any: _____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? ___ No ___ Yes, my faith is _____
If no, do you consider yourself to be spiritual? ___ Yes ___ No

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 the family member(s), e.g., sibling, parent, uncle, etc.):

| | | |
|---|---|---|
| Depression | yes/no | _____ |
| Bipolar Disorder | yes/no | _____ |
| Anxiety Disorder | yes/no | _____ |
| Panic Attacks | yes/no | _____ |
| Schizophrenia | yes/no | _____ |
| Alcohol/Substance Abuse | yes/no | _____ |
| Eating Disorder | yes/no | _____ |
| Learning Disabilities | yes/no | _____ |
| Trauma History | yes/no | _____ |
| Suicide Attempts | yes/no | _____ |

OTHER INFORMATION:

What do you consider to be your strengths?

What are effective coping strategies that you've learned?

What are your goals for therapy?

# LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

**Duty to Warn and Protect**

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

**Abuse of Children and Vulnerable Adults**

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

**Prenatal Exposure to Controlled Substances**

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

**Minors/Guardianship**

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

**Insurance Providers (when applicable)**

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

Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

*I agree to the above limits of confidentiality and understand their meanings and ramifications.*

_____ Date: _____

.Client Signature (Client's Parent/Gaurdian if under 18)

JESSICA BALOWSKI, LLMSW
CLINICAL THERAPIST

**CONSENT FOR SERVICES**

I, _____ , the undersigned: **INITIAL**

voluntarily consent to therapeutic services for myself and/or my family and understand that I am free to withdraw my consent and discontinue services at any time. _____

understand and have agreed to the fee policy established for the services provided for myself and/or other family members. _____

**FINANCIAL AGREEMENT**

I understand that I am responsible for all fees for services, and agree to pay any fees not covered by my insurance. _____

I agree to pay these fees on the day services are rendered _____

I understand a LATE CANCEL (less than 24 hours notice of a cancellation) or a NO SHOW (no appearance for a scheduled appointment; in person or virtual) that I will be subject to a $125.00 charge when either occurs, which will not be covered by insurance. _____

I understand there is a $25.00 service charge on all returned checks. _____

I understand that a 30% collection fee will be added to all delinquent accounts that are turned over to an outside agency in attempt to collect outstanding balances. _____

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____ _____

Client Signature (parent/guardian if minor) Date

_____ _____

Witnessed By Date

Humanistic Wellness Center
750 S. Monroe St.
Monroe, MI 48161

Email: balowskimsw@gmail.com
Tel. No.: 734-639-2262

# Client Personal Information

Name: _____
Address: _____
City: _____ State:____ Zip:_____
Home Phone:_____
Cell Phone: _____

Date of Birth:_____
S.S#: _____
Email: _____
Occupation: _____
Employer: _____

## PRIMARY INSURANCE

Name of Insured: _____
Relationship to Client: _____
Insured's Birthdate: _____
S.S. #: _____
Address: _____
City: _____ State: ____ Zip: _____
Primary Phone: (____) _____
Employer: _____
Occupation: _____
Insurance Company: _____
Ins. Co. Phone #: _____
Group #: _____
Plan #: _____
Contract #: _____

## SECONDARY INSURANCE

Name of Insured: _____
Relationship to Client: _____
Insured's Birthdate: _____
S.S. #: _____
Address: _____
City: _____ State: ____ Zip: _____
Primary Phone: (____) _____
Employer: _____
Occupation: _____
Insurance Company: _____
Ins. Co. Phone #: _____
Group #: _____
Plan #: _____
Contract #: _____

## DISCLOSURE STATEMENT

I understand that, Jessica Balowski, LLMSW is a clinical social worker in independent practice and is solely responsible for her practice. All matters including therapeutic issues, financial issues, etc. are the responsibility of the social worker.

## AUTHORIZATION AND RELEASE

I authorize and request my insurance company to pay directly to the provider.
I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.
I authorize my doctor to act as my agent in helping to obtain payment from my insurance companies.
I authorize release of information to all my insurance companies.
I permit a copy of this authorization to be used in the place of the original.
I authorize use of this form on ALL my insurance submissions.
NOTE: If unable to keep appointment, kindly give 24 hour notice. Otherwise a charge will be made for the time reserved, which will not be covered by your insurance company. A 30% fee will be added to all delinquent accounts that are turned over to an outside agency in an attempt to collect money owed. Credit/debit cards are gladly accepted for payment, however a fee of 3.5% will be added to the amount charged.

X_____ Date: _____

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently.

# Credit card Authorization

Name (as it appears on card): _____
Card Number: _____
Expiration Date: _____ CVV:_____ Billing Zip: _____
Card Type: ___ Visa ___ MasterCard ___ Amex ___ Other
Phone: (_____) _____

By signing below I authorize Jessica Balowski, LLC to use this information to process charges for services rendered. I acknowledge that these charges may include fees related to co=payments, co-insurances, deductibles, and/or outstanding sessions fees. I authorize Jessica Balowski, LLC to process these charges on the date of service. I acknowledge that it is my responsibility to inform Jessica Balowski, LLC of any changes to my consent of billing information.

X_____ Date: _____

JESSICA BALOWSKI, LLMSW
CLINICAL THERAPIST

TERMINATION

The end of a relationship can be difficult. Therefore, it is important to have a termination process in order to provide some level of closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the sessions are not being effectively used or if you are in default on payment. I will discuss the reasons and purpose for termination with you. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified referrals. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client Signature _____ Date _____

Parent Signature (if client is under 18) _____ Date _____

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