Kraja Counseling and Consulting, LLC

CLIENT INTAKE FORM

Name:

Address:

Phone:

Email:

DOB:

Emergency Contact Person:

Emergency Contact Phone:

Leave messages at the above phone numbers? ☐YES ☐NO

Contact via text messaging? ☐YES ☐NO

Describe the issues/problems that led you to counseling:

KRAJA COUNSELING AND CONSULTING, LLC POLICIES AND CONSENT TO TREATMENT

FINANCIAL POLICY Full payment is due at time of service (unless prior arrangements have been made). Please feel free to ask if you have any questions about our financial policy. Understanding our financial policy is important to our relationship. You are responsible for the timely payment of your Account.

CANCELLATION POLICY Please help us to serve you and others better by keeping your scheduled appointments. If you need to cancel or reschedule, please give us as much notice as possible so we can offer that time to someone else. Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal counseling session. This will be billed to you. We may require prepayment in order to schedule a subsequent appointment.

CONFIDENTIALITY Federal and State laws protect your confidentiality (See 42 U.S.C. 290dd-3 and 290ee-3 for Federal laws and 42 CFR Part 2, 491.0147 FL). Your counselor will not share information with any person outside of Kraja Counseling and Consulting, LLC without your written permission, except as required by law. Information obtained from minors is not generally shared with parents without permission. HIPPA (Health Insurance Portability and Accountability Act) laws allow you access to your file and protect the electronic transfer of information.

Exceptions to Confidentiality: Federal regulations do not protect from disclosure of information related to a client's involvement in a crime against property or personnel. We are required under State law to report suspected abuse of a child, elderly person, or individual with a disability. We may share limited information in the event of a medical emergency or in the event of a specialized court order signed by a judge. Your counselor has the option of breeching confidentiality if you report a specific plan or intent to cause serious bodily harm to an identifiable person.

CONSENT TO TREATMENT I am voluntarily seeking outpatient counseling at Kraja Counseling and Consulting, LLC and I understand that I have rights and responsibilities regarding my participation in treatment, including the right to discontinue therapy. I am strongly encouraged to discuss my treatment plan and status in treatment with my counselor. Counselors will also discuss alternatives, procedures, qualifications, and drawbacks to therapy. With my signature below, I acknowledge that I have read, understand, and agree to all of the above. I also acknowledge that I have been given a copy of HIPPA/Privacy Practices implemented here at Kraja Counseling and Consulting, LLC.

Individual counseling sessions are intended to be 45-52 minutes in length.

Please note: We do not provide emergency services. In crisis/emergency call 911.

With my signature, I acknowledge that I understand the above information and consent to treatment at Kraja Counseling and Consulting, LLC.

Date:

Printed Name:

Signature:

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