Time to Heal
Counseling & Consulting Services LLC

Client Intake Questionnaire

Please fill in the information below and bring it with you to your first session.
Please note: information provided on this form is protected as confidential information.

Personal Information

Name:_____ Date: _____
Parent/Legal Guardian (if under 18): _____
Address: _____
Home Phone: _____ May we leave a message? □ Yes □ No
Cell/Work/Other Phone: _____May we leave a message? □ Yes □ No
Email: _____ May we leave a message? □ Yes □ No *Please note: Email correspondence is not considered to be a confidential medium of communication.
DOB: _____ Age: _____ Gender: _____
Martial Status:
□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed
Referred By (if any): _____
Primary Care Physician: _____
Primary Insurance: _____
ID#: _____
Secondary Insurance: _____
ID#: _____
Relationship to Patient: _____

History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No □ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? □ Yes □ No If yes, please list:
_____
_____

Have you ever been prescribed psychiatric medication? □ Yes □ No If yes, please list and provide dates:
_____
_____

General and Mental Health Information

1. How would you rate your current physical health? (Please circle one)
Poor Unsatisfactory Satisfactory Good Very good Please list any specific health problems you are currently experiencing: _____
_____ 2. How would you rate your current sleeping habits? (Please circle one)
Poor Unsatisfactory Satisfactory Good Very good Please list any specific sleep problems you are currently experiencing:
_____
_____

3. How many times per week do you generally exercise? _____
What types of exercise do you participate in? _____

4. Please list any difficulties you experience with your appetite or eating problems: _____
_____

5. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes If yes, for approximately how long?_____

6. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? □ No □ Yes
If yes, please describe: _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes
If yes, for how long? _____ On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?
_____

11. What significant life changes or stressful events have you experienced recently? _____
_____
_____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

Please Circle List Family Member

Alcohol/Substance Abuse yes / no _____ Anxiety yes / no _____
Depression yes / no _____ Domestic Violence yes / no _____ Eating Disorders yes / no _____ Obesity yes / no _____ Obsessive Compulsive Behavior yes / no _____ Schizophrenia yes / no _____
Suicide Attempts yes / no _____

Additional Information

1. Are you currently employed? □ No □ Yes
If yes, what is your current employment situation? _____
_____ Do you
enjoy your work? Is there anything stressful about your current work? _____
_____
_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes
If yes, describe your faith or belief: _____
_____

3. What do you consider to be some of your strengths? _____
_____
_____
_____

4. What do you consider to be some of your weaknesses? _____
_____
_____
_____

5. What would you like to accomplish out of your time in therapy? _____
_____
_____

CONSENT TO TREATMENT

Thank you for choosing Time to Heal as your healthcare partner. In order to provide you with quality care, we believe that healthy boundaries are important. We have a number of client expectations about the professional relationship we embark on with each client. This consent to treatment outlines these expectations.

- We expect you to keep your appointments. Please remember that someone else may want this time. Please give our other clients and your clinician the courtesy of a 24 hour notice if you must cancel an appointment; otherwise, you will be charged our standard cancelation rate of $150. We always consider broken appointments individually and understand that emergencies do arise. Insurance will not pay for broken appointments.

However, as a general rule of thumb, 3 broken appointments within a 6 month time period may result in discharge from our practice.

- Payment for your session is due at the time of service. We accept cash, personal checks, and credit cards. We work with a number of insurance companies via managed care contracts and we are responsible for filing claims for our services; you must pay your co-pay at the time services are rendered. There are no exceptions. Other insurance plans (out of network) are accepted but you may be required to pay the difference.

- Our current fees are the following.
    - - Psychotherapy: $150 per session

- We also charge for our time when you require written correspondence. This is billed according to the amount of time utilized with a minimum fee of $20. This would include correspondence such as letters to other practitioners, disability applications, etc. Insurance will not pay for correspondence.

- Telephone consults are also billed at regular rates. The first 5 minutes we consider a professional courtesy to our relationship; thereafter, the time is billed at regular rates to the nearest quarter hour. Sessions are generally 55 minutes in length. Our clinicians take a few minutes between clients to relax, let go of the last session and prepare for the next one.

- Our clinicians will keep confidential anything you say with the following exceptions: a) you direct the therapist to speak about you with someone, b) The therapist determines that you are a danger to yourself or others, or c) there is evidence of child or elder abuse. In the event of the latter two exceptions, the therapist will contact family, friends, DFS and/or law enforcement authorities to attempt to prevent harm from coming to anyone.
- Our clinicians attend peer consultation with colleagues regularly. They may discuss the work occurring in your session in these sessions while maintaining your anonymity.

- ***If you are in a life and death emergency situation, dial 911 for assistance or go immediately to your local emergency department.***

I do hereby seek and consent to take part in the treatment provided by this agency. I am aware that I (or my child) may stop treatment with TTH at any time. I am aware that an agent of my insurance company or other third-party may be given information about the type(s), cost(s), and providers of any services I receive. I understand that if payment for the services I receive here is not made, TTH may stop treatment.

My signature below shows that I understand and agree with all of these statements. I have been given the opportunity to ask questions regarding this information.

client)

Relationship to Client: _____

_____

Date

_____

_ Signature of Client (or person acting for

I, the staff member, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of Staff Member

_____

Date

_____

NOTICE OF PRIVACY AND CONFIDENTIALITY

Privacy and confidentiality is a cornerstone of psychotherapy. Discussions between a therapist and client are confidential. No information will be 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; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; fee disputes between the therapist and the client; a negligence suit brought by the client against the therapist; or the filing of a complaint with the state licensing board or other regulatory body. If you have any questions about confidentiality, you should bring them to my attention so that we can discuss the matter further. By signing this consent form, you are giving your consent to me to share confidential information with all persons mandated by law and with the agency that referred you and the managed care company and/or insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing me and holding me harmless from any departure from the right of confidentiality that may result.

For all patients, I keep records describing the patient's clinical condition and treatment, but I avoid documenting potentially embarrassing personal information if I can do so in a manner consistent with medical responsibility. Psychotherapy notes will have a higher level of protection under the HIPAA (Health Insurance Portability and Accountability Act of 1996) privacy regulations that took effect in April 2003. Their contents may not be divulged without your specific authorization, which is not permitted to be required as a condition of insurance coverage. (Other exceptions to the special protection of psychotherapy notes under law are to prevent harm to the patient or others, for the therapist's defense in legal actions, regulatory actions, regulatory oversight of the therapist's professional status, confidential supervision in

training situations, or investigation by a medical examiner in the event of a patient's death.)

I serve as the Privacy Official and Contact Person as required by HIPAA. I keep both paper and electronic medical records. Paper records are locked at all times when the office is closed, and any electronic files are password protected to protect your information. You have the right to view your general medical record (but not psychotherapy notes) and request amendments within a reasonable period of time. Records will be retained at least as long as required by law. If you give consent for release of medical information from your genera! medical record, in compliance with HIPAA, I will disclose only the minimum amount of information necessary to serve the purpose for which the request has been made. Also under HIPAA regulations, 1 will provide you with a notice of privacy practices. I must ask you to sign a separate consent form and acknowledgement that I have given you this notice.

Under HIPAA your consent is not required for physicians to release information for treatment, payment, or healthcare operations. However, I have the right to offer you the opportunity to withhold consent for release of any or all information, with the understanding that if you withhold consent, it may not be possible for me to communicate with your doctors or to submit insurance claims or give supporting clinical information without further action on your part to give consent. I believe that it is important for doctor-patient relationship to offer you the choice of giving or withholding consent, rather than assuming that you accede to the HIPAA regulation's automatic consent.

CONFIDENTIALITY AND THIRD PARTY PAYERS You should realize that any information given at your request to an insurance company or managed care company is thereafter beyond my control. Health insurance companies sometimes give information to the Medical Information Bureau, which may affect your future eligibility for life, disability, or other insurance. Some employers obtain identifiable data from administrators of their health insurance. Medicare and other insurance plans have the right to inspect the medical records of subscribers who file claims. In my experience, such events are rare, and I would resist them to the greatest extent legally possible, but it is important that you know that this can happen if you choose to file claims for insurance. Other breaches of privacy could occur in extreme situations that are beyond my control, are required by law, or are essential to prevent imminent, serious harm.

Client Signature: _____ Date: _____

Authorization for Release of Information

Patient Name: _____ Date of Birth: _____

Phone Number: _____

I authorize Time to Heal to provide patient information to:	I authorize Time to Heal to obtain patient information from:
Name of Provider/Facility:	**Name of Provider/Facility:**
Address:	**Address:**
City, State, Zip Code:	**City, State, Zip Code:**
Phone/Fax (include area code):	**Phone/Fax (include area code):**

Purpose of this request: (check one): Healthcare Insurance Personal Other

Type of Records Authorized: Psychiatric/Psychological Evaluation and/or Treatment
Drug/Alcohol Evaluation and/or Treatment

Specific Information Authorized: (select one or more, if applicable)
Assessments Progress Notes Diagnostic Impression
Discharge Summary Treatment Plans Treatment Summary
Other: (please describe)

One-time Use/Disclosure: I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified. **My authorization will expire:**
Upon information transfer 90 days from this date Other:

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document.
My authorization will expire:
Upon cessation of services from TTH One year from this date Other:
I understand that:
• I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
• I may cancel this authorization at any time by submitting a written request to Time to Heal, except where a disclosure has already been made in reliance on my prior authorization. • If the person of facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed. • If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations. • If the medical record information is not sent to another care provider, there may be a charge of the requested records.

Signature of Patient or Representative: _____

Date: _____

Relationship to Patient (if requester is not the Patient): Parent Legal Guardian Other:

Credit Card Authorization Form

Time to Heal requires the collection of payment at the time of service. You may pay by check or cash. If you intend to pay by credit/debit card, please fill out this form and return it with your paperwork. Your credit/debit card number is securely stored in our electronic patient record system and will be securely encrypted on your patient billing record. At each session, your card will automatically be charged unless you choose to pay for your session with another form of payment.

Payment InformationClient Name:_____

Name on the Card: _____

Card Number: _____

Exp. Date: _____

Sec. Code (last 3 numbers on back of card's signature panel): _____

Billing Address Associated with Card: _____
(including Zip code) _____

Email Address: _____

I agree to allow Time to Heal Counseling & Consulting LLC to charge my credit/debit card for payments or services received. I understand that this agreement can be revoked by me at any time in writing. All of my information will remain confidential.

Signature: _____