Relationship 3
COMMUNITY ▪ FAMILY ▪ YOU

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New Client Intake Forms

Welcome to my practice. I look forward to helping you reach your goals. Please take a few minutes to complete this form and review my policies.

Name:_____ Date:_____ DOB:_____

Street Address:_____

City, State, Zip:_____

Home/Cell Phone:_____ Okay to contact you there? ***Yes*** ***No***

Employer:_____ Occupation:_____

Length of time at current employment (if applicable):_____

Email Address:_____ May I email you? ***Yes*** ***No***
(Please be aware that email might not be confidential)

Insurance

I am not contracted with insurance companies (with the exception of MHN/Health Net), but I can submit a superbill for you if you have a PPO. Here are the questions you need to ask your insurance company to determine if they will reimburse out of network behavioral health services:

- Do I have a deductible for out of network services? If so, what is the amount? _____
- What percentage do you reimburse once my deductible has been met? _____
- When do my benefits start over? (Calendar year, or some other date?) _____

If you would like me to submit a superbill to your insurance, please complete the following information:

Insurance Company:_____ Policy ID:_____

Electronic billing ID (you will need to contact them to get this number): _____

Policy holder name and DOB (if not you):_____

Important information about using your insurance:

- Insurance requires a diagnosis in order to cover the cost of services
- You are responsible for the full fee at the end of each session
- I will submit a superbill (if applicable) at the end of the month for all sessions during that month

Personal Information

Relationship Status (indicate the length of time):

□ SINGLE _____ □ WIDOWED _____
□ IN A RELATIONSHIP _____ □ SEPARATED _____
□ MARRIED _____ □ DIVORCED _____

If in a relationship or married, indicate your overall level of satisfaction with the relationship:

DISSATISFIED ***CONTENT*** ***VERY*** ***SATISFIED*** ***UNSURE***

Have you had a physical exam within the last year?: ***Yes*** ***No***

Name of primary care physician:_____ Phone:_____

Name of psychiatrist (if applicable):_____ Phone:_____

Do you currently have any health concerns?_____

Medications/Drugs currently prescribed/used:_____

Please list any traumas, or very difficult situations, that you have experienced in your life.

_____

_____

How were emotions dealt with in your family of origin?_____

_____

Who do you currently use for emotional support?_____

Do you have a spiritual or religious affiliation? ***Yes*** ***No***

How would you describe your spirituality/spiritual life?_____

_____

Have you received counseling in the past? When?_____

Have you ever been hospitalized for psychiatric reasons? If so, when?_____

Do you have thoughts of hurting yourself or others?_____

What are the goals you would like to achieve through counseling?_____

_____

Who referred you to my practice?_____

Please provide the name and phone number(s) of whom I may contact in case of emergency:

Name:_____ Phone Number(s):_____

Name:_____ Phone Number(s):_____

Office Policies

TREATMENT PHILOSOPHY

I believe in providing goal-directed treatment. This means that a treatment goal or several goals are established after a thorough assessment. All treatment is then planned with the goal in mind and progress is made toward accomplishing that goal in a time-efficient manner. If you ever have any questions about the nature of the treatment or anything else about your care, please don't hesitate to ask.

CONFIDENTIALITY

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

1. The client authorizes release of information with his or her signature.
2. The client presents a physical danger to self.
3. The client presents a danger to others.
4. Child/elder abuse or neglect is suspected.

In the latter two cases, I am required by law to inform potential victims and legal authorities so that protective measures can be taken.

FINANCIAL TERMS

All fees are to be paid at the time of service unless other arrangements have been made in advance. Sessions are typically 45-50 minutes in length. For clients with insurance coverage, you are responsible for any applicable co-pays or deductibles at the time of your appointment. If your insurance provides out-of-network coverage, you are responsible to pay at the time of service and you will be issued a Superbill which you can submit to your insurance for reimbursement, or you can request I submit it for you.

CANCELLED/MISSED APPOINTMENTS

A scheduled appointment means that time is reserved only for you. ***If an appointment is missed or cancelled with less than 24-hours notice, for any reason, you will be billed directly for the cost of the session.*** If you are sick, and another session is available that same week, you can reschedule without imposing a fee. You are also welcome to request a phone session in place of coming to the office.

Please initial here to indicate that you have read the above statement:_____

EMERGENCY PROCEDURES

If you have an emergency situation and need to contact me, please leave me a message at 949-293-9643 and your call will be returned. Please state that your call is an emergency. Please do this for true emergencies only. There will be a charge for telephone consultations lasting longer than 10 minutes.

Client Consent

AGREEMENT OF OFFICE POLICIES

I have received a copy of Keira Merkovsky's office policies. I understand and agree to all policies and procedures.

RELEASE OF INFORMATION

I authorize the release of information regarding my care to my health plan for the payment of claims, certifications/case management decisions, and other purposes related to the administration of benefits for my health plan.

CONSENT FOR TREATMENT

I further authorize and request that my treating provider carry out mental health examinations, 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 understand that I have the right to terminate treatment at any time for any reason. I understand and agree to all of the above information.

_____

Name – Printed

_____ _____

Signature **Date**