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New Client Intake Form

Today's Date:_____ Referred by_____

Name: _____ Date of Birth: ___ /___ /____

Add'l Client Names_____ Date of Birth: ___/____/____

Your Physical Address: _____City:_____ Zip Code:_____

Mailing Address (if different):_____

Optional - Email for communication:_____

Home phone: ( )_____May leave messages: □ Yes □ No

Work phone: ( )_____May leave messages: □ Yes □ No

Cell phone: ( )_____ May leave messages: □ Yes □No

Do you want text messaging as a short communication option with me on your cell? □ Yes □No

Responsible Party if different _____Date of Birth (of resp. party): ___/___/____

In case of emergency who may I contact on your behalf: Name_____

Phone Number_____Relationship_____

Treatment of Minor Child:

Parent or Legal Guardian Name _____Grade_____

School _____ Teacher_____

INSURANCE INFORMATION (If applicable) This is a fee for service or cash pay practice. If you request, I will prepare a super-bill, which is a monthly insurance claim form, for you to submit to your insurance company. I will need a copy of both sides of your health insurance card.

I am not a Medicare Medical provider. If you are Medicare/Medical eligible or become Medicare/Medical eligible during your treatment, your initial acknowledges that you understand that Medicare/Medical will not reimburse you. Initial here _____

Insurance Certification and Assignment: I hereby certify that the information given by me in applying for payment under the title XIX of the Social Security Act, by insurers, or by any other third party is correct. I understand that I am responsible for payment of any health insurance deductible(s), co-insurance, or any other charges incurred, which are not paid by any insurance or third party payers.

Release of Information: I authorize the release of any medical or other information necessary to process any insurance claim for services rendered.

Fee For Service Understanding: I understand that all the charges incurred are my responsibility, regardless of insurance coverage or third party agency. For collection I agree to pay all reasonable court costs and collection fees. I understand that all judgments in a court of law may bear interest at the legal rate.

XX Patient/Guardian Signature: _____Date: _____

XX Patient/Guardian Signature: _____Date: _____

Biographical Information

Occupation: _____ Religious/Spiritual preference:_____

Physician: _____ Date of last visit to MD: _____

Relevant medical conditions: (history, current condition, changes in condition) _____

_____

_____

Please List Medications & Prescribing Doctor:_____

_____

_____

□ Married □ Single □ Widowed □ Partner - Names & relationship _____

Children – names, ages, _____

_____

_____

History of counseling, psychiatric hospitalizations, alcohol or other drug problems:_____

_____

_____

What is your primary reason for coming here:_____

_____

_____

How long has this been a concern?_____

_____

What have you tried so far?_____

_____

__Always tired
__Always worried
__Ambition problems
__Anger/Temper
__Anxiety
__Being a parent
__Bereavement/Grief
__Career choices
__Change in appetite
__Children problems
__Depression
__Difficulty with friends
__Disturbing thoughts
__Divorce problems
__Drug or alcohol use
__Family conflict
__Fear of things I shouldn't
__Feel like crying
__Feeling lonely
__Feeling sad
__Feeling worthless
__Fears
__Financial problems
__Headaches
__Health problems
__Inferiority feelings
__Insomnia/Sleep problems
__Legal matters
__Marriage problems
__Memory problems
__Nervousness
__Nightmares
__Panicky feelings
__Performance Fear
__Phobias
__Previous suicide attempts
__Public Speaking Phobia
__Relaxation problems
__Self control problems
__Self inflicted wounding
__Separation problems
__Sexual problems
__Shyness
__Stage fright
__Stomach problems
__Stress
__Strong dislike of criticism
__Suicidal thoughts
__Test anxiety
__Trauma history
__Tremors or Tics
__Trouble concentrating
__Unable to get interested
__Unable to make decisions
__Unhappiness
__Unusual thoughts
__Work problems

Psychotherapy Services Agreement

Fees

- I operate a fee for service, immediate pay business. I no longer bill directly to most insurance companies. You may request a super bill that you can turn into your insurance company or flex account for possible reimbursement.
- My contract is with you not with your insurance company. I am not responsible for the reimbursement rates of your insurance company or flex account or how your insurance company will handle your claim.
- I will bill directly for Victims of Crime, Veterans Administration and Workers Compensation.
- If a written report is necessary a preparation fee will be prorated at $150.00 per 50 min.
- Court testimony requires a subpoena and advanced payment of fees. Fees for testimony are charged at $1200.00 for each half-day. An additional charge for travel time outside Sacramento County for testimony is based at the hourly rate of $210.00 plus transportation and travel costs.
- Telephone Calls: There is no charge for brief telephone calls such as to set or change appointments and occasional crisis.
- Payment is expected by cash, check, Master Card, Visa, American Express at the beginning of each session. Prepayment is available online at http://marysreigelmsmft.fullslate.com.
- Merchant charge receipts in office are label "The Grief STEP™ Programs" for my training programs.

Scheduling and Cancelling Appointments

- You may schedule appointments online at http://marysreigelmsmft.fullslate.com. Full Slate maintains a HIPAA compliant online service. For more information go to https://www.fullslate.com/hipaa.
- I require credit card information to reserve your appointment times. You will not be charged until the time of service and you are free to use another form of payment at your session. (Same reservation requirement as used by Inns, Motels, & Hotels) I will charge your credit card the cost of the time I reserved exclusively for you.
- For single sessions, canceling within *24 hours* notice will avoid being charged in full.
- For double sessions, canceling within *48 hours* notice will avoid being charged in full.
- If you need to cancel or reschedule Monday appointments please cancel by Friday.
- Frequent cancellations, even with proper notice, disrupt treatment and should be avoided.
- *If you are unable to come for your appointment, consider a session by phone.*
- Be sure to double-check your calendar for any conflicts with your reserved appointment times.

_____ ***Please initial that you understand the payment and cancellation policies.***

Confidentiality

- All information shared in our therapy sessions will be kept confidential except when referred for non-confidential therapy (e.g. referred for mediation or evaluation) or in the event of such mandated reports as suspected child abuse, danger to self or others, elder abuse and other issues mandated by law (please read the Notice of Privacy Laws on my website or ask for a copy).
- If you want me to share information on your behalf, you will have to give me specific written instructions.

Emails, Cell Phones, Computers and Faxes

- It is very important to be aware that computers, e-mail and cell phone communication can be relatively easily accessed by unauthorized people and, hence, can compromise the privacy and confidentiality of such communication.
- E-mails in particular are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Though faxes to my office are confidential they can be sent erroneously to a wrong number.
- Please be aware of these issues when you use cell phones, send email or fax my office.

Arrival at the Office

- I will usually be in a session when you arrive at the office. There is a row of light switches on the left wall as you walk in. The first light switch has my name on it, switch it on, as it will let me know you have arrived. Have a seat in the waiting room, and I will be with you soon.
- If you have a child with you please do the best you can to keep the child quiet as there maybe several therapy sessions going on in the building. Please arrange for childcare for young children.
- **I tend to be punctual and keep to my schedule. So unless I have an emergency, I will start our appointment on time and end it on time, *even if you arrive late*.**
- In the rare case I am running late, I will usually poke my head into the waiting room within five minutes after our appointment time and let you know how many minutes I will be. Please be assured I do not take long waits for my clients casually – your time is as important as mine.
- If you cannot print out the forms you need to fill out before our first appointment, be sure to arrive 10 minutes early to allow time for the paperwork. Do call me if you need paperwork as I will need to leave a New Client clipboard out for you in the waiting room.
- If the office is locked when you arrive, it probably means that I will be right back or you are my first appointment and I will arrive soon.
- If there is a mix up in appointment time or an emergency and I was unable to contact you, please leave a message on my voice mail and I will call you as soon as I am able.

Emergency Procedures

- If you need to contact me due to an emergency please listen to my outgoing voice mail message and leave a message on my office phone (916) 366-8026. I check my phone often during the workday, less often on weekends or holidays. Part of my voice mail message will instruct you what to do if I am not available.
- On weekends and holidays you may be able to reach me faster by email – just keep the message to "call me" and your phone number. I recommend you use "mary@stagejitters.com".
- If you cannot wait until I return your call, call Sacramento County's 24-hour crisis line at (916) 368-3111 to talk about your concern. If you are having a life-threatening emergency dial 911 or go to the nearest emergency room.

1. I have read the above policies and procedures and will abide by the terms described above.
2. I have received, been offered or know that a copy of the HIPAA required forms "Psychotherapy Services Agreement" (included above) and "Notice" (on website) are available and that provide they provide further information to augment this form.

_____

Your Signature Date

Cancellation Policy Agreement

Today's Date: _____

Dear Client,

As a self employed professional I have to maintain a cancellation policy that encourages clients to remember their scheduled appointments. Unlike other types of businesses, I cannot fill a late cancelled or forgotten appointment time slot at the last minute. I need lead time to fill open appointment times.

Therefore, I require a minimum of 24 hours notice for a single session and 48 hours notice for a double session. If less than 24 hours notice for a single session or less than 48 hours notice for a double session is given I need to charge for my time to maintain my business.

Just as in many service industries (e.g. Inns, Motels & Hotels), I require credit card information to be kept in order to guarantee payment for reserved appointments that are not cancelled or rescheduled in the time specified. You will not be charged until the time of service and you are free to use another form of payment at your sessions.

- Please note that frequent cancellations, even with proper notice, disrupt treatment and should be avoided.
- If you are unable to come to my office for your appointment, consider a session by phone.
- Be sure to double-check your calendar in a timely way for any conflicts with your reserved appointment times.
- Your credit card information will be kept in a secure location, as are all my files.

Name on Card: _____ Zip Code:_____

Credit Card #_____Expiration Date:_____

Security Code_____

By signing below, you accept the terms of our cancellation/rescheduling policy.

Patient Signature: _____

Parent/Guardian Signature (under 17 years of age): _____