

find yourself. & be that

Client Intake Form

Legal Name _____ Preferred Name & Pronoun _____

Today's Date _____ Date of Birth _____ Age _____ SSN _____ (for insurance)

Contact Phone _____ Contact E-mail _____

Address _____

Emergency Contact _____ Relationship _____ Phone _____

Relationship Status _____ Partner(s) Name _____

Do you have any children? ___Yes ___No If yes, please list their names, ages, and where they live.

Current Employer _____ Position _____ Years Employed _____

Highest degree completed & Areas of study _____

If client is a Minor: Parents' names, DOBs, & Phones _____

How did you hear about us? _____ Insurance ID# _____

Presenting Concern: Briefly state why you are seeking my services, & history of present concern

Current Medical Problems _____

Medications, Drugs, Vitamins, Supplements, & Holistic Medicines you currently take, and reason for taking

Have you ever experienced an addiction or dependence on a substance? If yes, which substance?

Family history of illness or addiction? _____

Have you ever experienced episodes of epilepsy or seizure? _____

Have you ever seen a coach, counselor, therapist, psychologist, or psychiatrist before? _____

If yes, when and for what reasons? _____

Did you find it helpful? Why or why not? _____

Have you, in the past year, ever considered suicide? _____ Have you ever attempted suicide? _____

Do you have a spiritual or religious affiliation? If yes, please describe. _____

Presently, are you involved in any legal problems? _____ Have you had any legal problems in the past? _____

If yes to either, please explain _____

Name 5-10 things you love and/or enjoy doing.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Transmission of Privileged Client Information

It is my policy not to release financial or personal information by answering machine, home, work, or cell phone unless specifically instructed by you, the client. In order to leave specific information, I require permission from you. Please indicate below how i may release sensitive information about you. You may change this at any time by signing a new Release of Privileged Client Information Form.

Phone number provided _____ Yes ___ No ___ Voicemail or answering machine Yes ___ No ___

Text message Yes ___ No ___ Email address provided _____ Yes ___ No ___

Release of Privileged Information

Information can only be released to the client, their guardian the older of their power of attorney or those specifically authorized by the client. Please list the names of those authorized to receive privileged information about you. _____

Print name _____ Client or guardian's signature _____ Date _____

I hereby state that all information on this form is true to the best of my knowledge.

Client signature

Date

I authorize my credit card to be charged 50% or 100% of my therapist's fee for sessions that are missed per the policy outlined in the office policies.

Client or Guardian's signature _____
Date

Credit Card Information

Your completion of this authorized form helps us to protect you from credit card fraud. All information entered on this form will be kept strictly confidential.

Name on Card: _____

Billing Address: _____

Card Type: ____ Visa ____ Mastercard ____ American Express

Card # _____ Expiration Date _____ CVC _____

I understand the policy regarding paying for counseling services and/or missed appointments as described above. I agree to be bound by the policies, terms, and conditions for counseling services.

Cardholder signature: _____

Attach a photocopy of the front and back of the signed credit card.

Acknowledgement of the Receipt of the Office Policies and Review of the HIPAA Notice of Privacy Practices

By signing this form, I acknowledge that:

- **I have reviewed a copy of the office policies;**
- **I have reviewed the HIPAA notice of privacy practices;**
- **I have been offered an opportunity to review both of these documents and ask all of the questions I had about these policies and procedures; and,**
- **I am in agreement with the stated terms and conditions.**

Client Signature _____ Date _____

Social Media Policy Acknowledgement

By signing below, I acknowledge that I have read, understood, and retained a copy of the Social Media Policy which outlines office policies related to use of Social Media. I understand that if I have questions about this policy, I can bring them up when I meet with my therapist. I understand there may be times when this policy may need to be updated. I understand I will be notified in writing of any policy changes and will be provided with a copy of the updated policy.

Client Name _____

Client Signature _____ Date _____

Consent to Treatment

I, _____ (client), hereby authorize Sara Edwards, M.Ed., M.Ed., LPC (herein Counselor) to provide professional services to myself/my child. As such, I understand that the Counselor is qualified in the assessment and treatment of mental health and other problems in living, which can include individual, couples, family, or group therapy. I understand that the Counselor may recommend referral to another professional service provider if that is deemed to be in my best interest.

I consent to treatment and professional clinical practices with the Counselor freely of my own will if I am 14 years of age or older. I may grant authorization for a child of mine under the age of 14 to receive professional services. In matters of a child's treatment when that child's parents are separated or divorced and custody matters are at issue, I understand that both parents' rights will be respected, that the child will be considered the client, and that the Counselor shall treat the child from a stance of neutrality over the parents and in the best interest of the child. I understand that I may contact my managed care or insurance provider to obtain the names of other qualified professionals who may provide services to me.

Client's Signature

Date

Client's Parent/Guardian Signature (under 14)

Date

Client's Parent/Guardian Signature (under 14)

Date

ONLINE CONFIDENTIALITY NOTICE

To my clients:

By choosing to use the convenience of ONLINE (Email, Skype, FaceTime, Google Chat/Hangout, Venmo, Cashapp, Paypal) communication with me, you understand and agree to the following:

The use of online communication may pose risks to the confidentiality of your health information. The Internet is an open network and provides no inherent protection for confidential information. While my internet, email and computer are password protected, I can not guarantee 100% protection. You accept, and are responsible for these risks and agree that shall not be held responsible if a breach of confidentiality occurs. You agree to indemnify and hold harmless Find Yourself Be That, LLC and Sara Edwards M.Ed., M.Ed., LPC from any claims, losses, damages and expenses arising from any breach related to my use of online communication(s).

You must contact me by telephone or in person about critical or time-sensitive issues. There will be times when I will not have access to e-mail. Be sure to contact my office by telephone (657-235-2656) when necessary.

Currently, Skype, Google Chat/Hangout, and FaceTime are not HIPAA compliant. There is no inherent protection for confidential information when utilizing online communication. Please view your HIPAA Privacy Practice Notice for more information on HIPAA compliance.

By signing this form you are agreeing to the risks of online communication.

Printed Name

Signature

Date