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 read and understand the good faith estimate and understand I can ask for a specific estimate pertaining to my own individual situation should I choose to;**
- **I have been offered an opportunity to review 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 Find Yourself Be That LLC (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

By choosing to use the convenience of ONLINE (Email, Online Messaging, Videoconferencing, Phone Calls, Texting, Online Payment Methods, FaceTime, Google Chat/Hangout/Meet, Zoom, Venmo, Cashapp, Paypal, Zelle, Square, etc.) communication with me, you understand and agree to the following:

1. I understand that I will be participating in counseling using telehealth services.
2. My health care provider explained to me how the video conferencing technology that will be used to conduct our meetings will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my healthcare provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regards to these procedures. My questions have been answered and the risks, benefits, and any practical alternatives have been discussed with me in a language in which I understand.
6. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.
7. Telehealth using platforms such as phone calls or Google Meet is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
8. The use of online communication may pose risks to the confidentiality of my health information. The Internet is an open network and provides no inherent protection for confidential information. While my practitioner's internet, email and computer are password protected, I acknowledge this cannot guarantee 100% protection.
9. I accept, and are responsible for these risks and agree that my practitioner shall not be held responsible if a breach of confidentiality occurs. I agree to indemnify and hold harmless Find Yourself Be That, LLC and my counselor from any claims, losses, damages and expenses arising from any breach related to use of online communication(s).
10. Currently, communicating using virtual means such as by phone or video call may not be HIPAA compliant. There is no inherent protection for confidential information when utilizing online communication. I have reviewed the HIPAA Privacy Practice Notice for more information on HIPAA compliance.

_____ _____ _____

Printed Name **Signature** **Date**