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| INTAKE INFORMATION | | |
| CLIENT NAME: | | **TODAY’S DATE:** |
| PREFERRED CLIENT NAME: | | **DATE OF BIRTH:** **AGE:** |
| GUARDIAN: |  | **GENDER:** |
| ADDRESS:  TOWN, STATE, ZIP CODE: |  | Is it ok to mail here:  No  Yes |
| HOME PHONE: |  | Is it ok to call here:  No  Yes |
| CELL PHONE: |  | Is it ok to call and/or text here:  No  Yes |
| EMAIL: |  | Is it ok to email here:  No  Yes |
| REFERRED BY: |  | Referral’s Number: |
| INFORMATION PROVIDED BY: |  | Self  Parent  Guardian  Other |
| WHAT ARE YOU HOPING TO GAIN FROM COUNSELING AT THIS TIME?  CURRENT MEDICATIONS AND ANY PREVIOUS DIAGNOSES: | | |

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| --- | --- |
| CONTACTS | |
| Primary Care Provider: | Phone: |
| Emergency Contact: | Phone: |

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| --- | --- |
| PRIMARY HEALTH INSURANCE | |
| TYPE: |  |
| MEMBER ID #: | GROUP #: |
| PHONE NUMBER ON BACK OF CARD: | |
| INSURER’S NAME: | INSURER’S DATE OF BIRTH: |
| EMPLOYER & ADDRESS | |
| CO-PAY AMOUNT: | |

|  |  |
| --- | --- |
| SECONDARY HEALTH INSURANCE | |
| TYPE: |  |
| MEMBER ID #: | GROUP #: |
| PHONE NUMBER ON BACK OF CARD: | |
| INSURER’S NAME: | INSURER’S DATE OF BIRTH: |
| EMPLOYER & ADDRESS | |
| CO-PAY AMOUNT: | |

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| AUTHORIZATION FOR BEHAVIORAL HEALTH AND PRIMARY CARE PROVIDER  TO SHARE CONFIDENTIAL INFORMATION |
| I give permission to Laurie Hochman, LICSW and my Primary Care Provider (PCP) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to share information about my diagnosis and/or treatment related to substance abuse, mental health, or medical history. I understand the purpose of sharing information is to help me receive better care. I have the right to refuse to sign this authorization. PCP phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_  This consent form expires one (1) year from the date of signing and I can choose to cancel it at any time.   |  |  |  | | --- | --- | --- | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Printed Name of Individual/Guardian/Authorized Representative | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date | |  |  |  | |

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| AUTHORIZATION FOR BEHAVIORAL HEALTH AND PSYCHIATRIC PROVIDER  TO SHARE CONFIDENTIAL INFORMATION |
| I give permission to Laurie Hochman, LICSW and my Psychiatric Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to share information about my diagnosis and/or treatment related to substance abuse, mental health, or medical history. I understand the purpose of sharing information is to help me receive better care. I have the right to refuse to sign this authorization. Provider phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_  This consent form expires one (1) year from the date of signing and I can choose to cancel it at any time.   |  |  |  | | --- | --- | --- | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Printed Name of Individual/Guardian/Authorized Representative | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date | |  |  |  | |

**WELCOME! PLEASE READ THE FOLLOWING POLICIES AND PROCEDURES CAREFULLY.**

* Your session is reserved just for you. Please attend all appointments as scheduled, arrive on time to ensure adequate clinical time, and email me if you will be late. At least 24 hours notice is required to cancel your appointment and avoid the $100 cancellation fee. This fee also applies to missed appointments.
* Payment is expected at the time of service. There will be fees associated with other services provided, such as letter writing and meetings. You will be responsible to remit payment for sessions and services which insurance companies fail to pay.
* There are limits to confidentiality as dictated by law, including disclosure of abuse or neglect, and threats to harm self or others. The law mandates reporting of these incidents to the appropriate agencies.
* There will be no communication or contact through any social media with current or past clients.
* Please do not send detailed clinical information via email or text. This means of communication is to arrange or modify appointments.
* In case of an emergency, please contact 911 or go directly to the emergency room at your local hospital.
* I am not a forensic psychologist or a disability specialist. If you require documentation, court or legal appearances, I can refer you to an appropriate provider.

**I have read, understand, and agree to the above policies.**

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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Printed Name | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date |
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**INFORMED CONSENT FOR TREATMENT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of client) agree to participate in behavioral healthcare offered and provided by Laurie Hochman, LICSW, a Licensed Independent Clinical Social Worker. I understand that I am consenting and agreeing only to those services that this provider is qualified and licensed to provide. If a person is under the age of eighteen (18) or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent to treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature Date

**INSURANCE AUTHORIZATION AND PAYMENT**

I authorize Laurie Hochman, LICSW to disclose any necessary information to my health insurance provider/agency and related billing agencies pertaining to my identity, diagnosis, and treatment to process claims. This may include any information in my client record including information relating to alcohol, drug abuse, or HIV. I understand that my records are protected under the Federal Law (42 CFR) and cannot be disclosed without my written consent unless otherwise provided for by law. I understand that I do not need to consent to this disclosure of information. However, I do choose to, willingly and voluntarily, for the purpose of my treatment. This authorization will expire upon settlement of the claim(s) with my insurance company. I understand that I may revoke it at any time except to the extent that the action has been taken in reliance on my consent. I authorize and request that my insurance company pay this provider that amount which is due under the insurance contract for eligible charges incurred in connection with services furnished by this provider.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature Date

**ACKNOWLEDGEMENT OF RECEIPT OF CLIENT’S RIGHTS AND RESPONSIBILITIES**

By signing below, I acknowledge that I have been offered and/or read a copy of my rights and responsibilities of treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature Date

**ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES**

By signing below, I acknowledge that I have been offered and/or read a copy of the Notice of Privacy Practices and have therefore been advised of how health information about me or my family may be used and disclosed by Laurie Hochman, LICSW and how I may obtain access to and control the information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature Date

**TELETHERAPY INFORMED CONSENT**

* “Teletherapy” includes emails, telephone, text messaging, using interactive audio, video, or data communications.
* The laws that protect the confidentiality of my medical information apply to teletherapy. Our teletherapy exchange is confidential. I will not include others in the session or have others in the room unless agreed upon.
* I accept that teletherapy does not provide emergency services. If I am experiencing an emergency, I will call 911 or proceed to the nearest hospital emergency room for help.
* If teletherapy is not in my best interests, my therapist will suggest some alternative options better suited to my needs.
* I understand there are risks and consequences from teletherapy, including, but not limited to, the possibility that: the transmission and/or the electronic storage of my information could be interrupted and/or accessed by unauthorized persons. I am responsible for information security on my computer.

**I have read, understand, and agree to the information above.**

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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date |
|  |  |

**Client Name: DOB:**

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| This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability. | | |
| Relationship Status:   |  |  |  |  | | --- | --- | --- | --- | | Single | Married | Divorced | Widowed | | | **Do you have children?**   |  |  |  |  | | --- | --- | --- | --- | | No | Yes | If yes, how many children? |  | |
| Highest level of education completed:   |  |  | | --- | --- | | Grades K-8  Grades 9-11  Grade 12  GED | Trade School  Some College  College  Graduate School | | | **Employment Status:**   |  |  | | --- | --- | | Student | Retired | | Part-Time | Disabled | | Full-Time | None | | Unemployed | Other: | |
| Please describe previous treatment history, including type of treatment (outpatient counseling, partial hospitalization, hospitalization, psychiatry), approximate dates of treatment, reason for treatment | | |
|  | | |
| Are you being prescribed psychotropic medication(s)? No Yes  If yes, please list current medication(s) and prescriber(s) | | |
|  | | |
| Do you have any medical concerns? No Yes  If yes, please describe. | | |
|  | | |
| Family History of Behavioral Health Concerns   |  |  |  |  | | --- | --- | --- | --- | | Depression | Anxiety | Bipolar | ADD/ADHD | | Alcohol Use | Substance Use | Suicide | Trauma | | Other: |  |  |  | | | |
| What is your reason for seeking treatment at this time? | | |
|  | | |
| Year of First Episode: | **Most Recent Onset:** | |
| Frequency of Symptoms   |  | | --- | | Not at all | | Several days | | More than half the days | | Nearly every day | | **Status:**   |  | | --- | | New Episode | | Improving | | In Remission | | Unchanged | | Worsening | | |

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| --- | --- | --- | --- | --- |
| 1. In the past 2 weeks, how often have you been bothered by the following problems? | Not at all | Several days | More than half the days | Nearly every day |
| 1. Having little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 1. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 1. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 1. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 1. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 1. Feeling badly about yourself—or that you’re a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 1. Trouble concentrating on things | 0 | 1 | 2 | 3 |
| 1. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual. | 0 | 1 | 2 | 3 |
| 1. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |
| 1. Feeling nervous, anxious, or on edge | 0 | 1 | 2 | 3 |
| 1. Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 1. Worrying too much about different things | 0 | 1 | 2 | 3 |
| 1. Trouble relaxing | 0 | 1 | 2 | 3 |
| 1. Being so restless it is hard to sit still | 0 | 1 | 2 | 3 |
| 1. Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| 1. Feeling afraid or as if something awful might happen | 0 | 1 | 2 | 3 |
| 1. Difficulty meeting home, work, or social obligations | Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |

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| |  |  |  | | --- | --- | --- | | 1. I am experiencing or have experienced… | YES | NO | | 1. Conflict or stress at home or work |  |  | | 1. Relationship Problems |  |  | | 1. Abuse or Violence or Neglect |  |  | | 1. Recent Pregnancy or Childbirth |  |  | | 1. Unemployment |  |  | | 1. Panic Attacks |  |  | | 1. Trauma |  |  | | 1. Compulsive thoughts or behaviors |  |  | | 1. Avoiding people or places |  |  | | 1. Financial worries |  |  | | 1. Death of a friend or a loved one |  |  | | 1. Alcohol Use |  |  | | 1. Substance use |  |  | | |  |  |  | | --- | --- | --- | | 1. I am feeling… | YES | NO | | 1. Guilty |  |  | | 1. Lonely |  |  | | 1. Grief or feelings of loss |  |  | | 1. Impulsive |  |  | | 1. Overwhelmed |  |  | | 1. Angry, irritable, or hostile |  |  | | 1. Euphoric, energized, highly optimistic |  |  | | 1. More talkative |  |  | | 1. Indecisive |  |  | | 1. Daily tasks require more effort |  |  | | 1. Anxious, fearful thoughts |  |  | | 1. Other: |  |  | |

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| |  |  |  | | --- | --- | --- | | 1. Symptoms are aggravated by | | | | Nothing | Lack of sleep | Traumatic memories | | Alcohol use | Medications | Winter season | | Other: | Menses | Conflict or stress at  home or work | | |  |  |  | | --- | --- | --- | | 1. Symptoms are relieved by | | | | Nothing | Drugs | Medication | | Alcohol | Exercise | Spontaneously | | Cessation of menses | Light | Spring season | | Conversing | Rest | Other: | |

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| 6. For Females, “How ­many times in the past year have you had 4 or more drinks in a day?”  For Males, “How many times in the past year have you had 5 or more drinks in a day?” | | | | | |
|  | | | | □ NEVER  □ LESS THAN ONCE A MONTH \*  □ ONE TO THREE TIMES PER MONTH \*  □ ONE TO THREE TIMES PER WEEK \*  □ MORE THAN THREE TIMES PER WEEK \* | |
| 7. How many times in the past year have you used an illegal drug or used a prescription medication for  non-medical reasons? | | | | | |
| □ NEVER | □ LESS THAN ONCE A MONTH \* | □ ONE TO THREE TIMES PER MONTH \* | □ ONE TO THREE TIMES PER WEEK \* | | □ MORE THAN THREE TIMES PER WEEK \* |