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PATIENT INTAKE QUESTIONNAIRE

General Information:

Patient Name _____
Birthdate _____ Social Security # _____
Street Address _____
City _____ State _____ Zip _____
Home phone _____ Cell phone _____
May a voicemail or text message be left at the above number? _____
(Please indicate voice and/or text)

Responsible Party for Patient (if different than above):

Name _____ Relationship to the patient: _____
Street Address _____ City _____ State _____ Zip _____
Home Phone Number _____ Cell Phone Number _____

Emergency Contact:

Person to contact in emergency _____ Relationship to you _____
Phone(s) _____ Address _____

Relationship Information:

List the persons with whom you are now living and their relationship to you (include ages of children) _____

List the names, ages and location of children who do not reside with you at this time?

Relationship Status Married Single Divorced Widowed Other

Social Information:

Occupation _____ Education level _____

Employer _____ Work phone _____

Address _____

Length of employment at above _____

Were/are you a member of the armed services? _____ If so, when? _____

What branch? _____

If you are actively involved in a community of faith/church, please indicate which one?

Who referred you to Elizabeth's practice? _____

Medical Information:

Describe any physical problems you have that require medication or physical care:

Are you currently under a physician's care? No Yes

Name of physician: _____ Date of last physical examination:

_____ Are you currently under psychiatric care? No Yes

Name of psychiatrist _____:

Please list any medications you are currently using.

Do you have a past history of substance abuse or addiction? _____ No _____ Yes

If yes, please describe any past treatment, length of sobriety and any current concerns with substance use? _____

Therapeutic History:

Have you had any prior counseling? _____ How helpful was your previous counseling? _____

Current stressors:

(In the fields below please note areas of stress and rate the intensity on a scale of 1-10, 1 being barely noticeable and 10 being extremely distressing):

Marriage and home _____

Children/parents _____

Work/school _____

Financial _____

Social _____

Spiritual _____

Sexual _____

Other _____

Major present stressors _____

List any current or past legal history or current legal problems (trouble with the law)?

Please explain any childhood history of abuse (physical, sexual, emotional or spiritual)?

In your own words, briefly describe the main problem that prompted you to seek therapy?

How can therapy be most helpful to you? _____

What would you like to change about your situation? (e.g., goals) _____

What have you done so far to find solutions to the problem? Has anything been helpful?

Is there anything else that you believe might be important for your therapist to know at this time?

**This is a strictly confidential client medical record.
Re-disclosure or transfer is expressly prohibited by law.**

Insurance Information (If you have a copy of your insurance card you may disregard this section.)

PRIMARY INSURANCE: _____

Group No.: _____ Ins. I.D. Number: _____

Policy Holder: _____

Relationship to Patient: _____ Birthdate: _____

Effective Date: _____ Employer: _____

City & State: _____

SECONDARY INSURANCE: _____

Group No.: _____ Ins. I.D. Number: _____

Policy Holder: _____

Relationship to Patient: _____ Birthdate: _____

Effective Date: _____ Employer:

City & State: _____

Please see the next page for consent and assignment of benefits.

INFORMATION AND CONSENT TO TREATMENT

Thank you for entrusting your therapeutic care to Elizabeth Kennard, MSW, SWLC. Elizabeth provides client centered, confidential, psychotherapeutic counseling to individuals. She will help individuals look at many aspects of their life; physical, emotional, mental, relational, and spiritual using professional clinical training. Elizabeth promotes inner healing and wholeness according to the needs of each person, and believes in the dignity, value and worth of each individual life. She believes there is hope even in the most challenging life circumstances.

Elizabeth is a Social Worker Licensure Candidate, practicing under the supervision of Jennifer Walrod, LCSW. As such, billing will be processed under Jennifer Walrod, LCSW and this may reflect on your billing receipts.

I acknowledge that I have received, have read (or have had read to me), and understand the privacy policy and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in behavioral health treatment with Elizabeth Kennard, MSW, SWLC.

- I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest.
- I agree to play an active role in this process.
- I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.
- I understand that the intake diagnostic fee is \$175 with subsequent session fees at \$125/per clinical hour. If insurance is billed, you are responsible for co-pay amounts at the time of services. These fees also apply to the preparation of assessment reports, court appearances, consultations, or meetings you have authorized as part of your therapeutic process. If payment for the services I receive is not made, Elizabeth, though reluctantly, may stop my treatment. **Please contact your insurance company prior to treatment to understand any copay or deductible you may be responsible for.**
- I have the right and responsibility to choose a therapist and treatment modality that best suits my needs and purposes.

- Once sessions begin, the duration and termination of therapy is something that should be a joint decision. Thoughts and feelings around wanting to stop therapy are important and encourage you to raise these concerns in counseling sessions.
- I am aware that I may stop my treatment with Elizabeth Kennard, MSW, SWLC, PLLC at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered).
- I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel and do not show up, I will be charged the full amount for that appointment.
- Records maintained by Elizabeth Kennard, MSW, SWLC, PLLC are considered medical records and protected health information. She places a high value on confidentiality and will make every effort to ensure your privacy. Consultation with individuals or organizations regarding your treatment will require your written consent. There are, however, some exceptions and limitations to confidentiality as required by law. These specific situations are:
 1. Any known or reasonably suspected cases of child abuse or neglect.
 2. Any known or suspected intentions of harming oneself (suicide).
 3. Any known or suspected intentions of harming others.
 4. When written consent is given by the client to release information.
 5. When charges are brought against a counselor in response to a subpoena from a court of law or administrative agency.

Privacy Policy and Assignment of Benefits

The **HIPAA Notice of Privacy Practices and Authorization to Disclose Limited Mental Health Information** provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I acknowledge receipt of this document and my signature below indicates that I understand and consent to treatment under these conditions.

I acknowledge and authorize Elizabeth Kennard, MSW, SWLC, PLLC to use and disclose my individual identifiable health information for the purpose of providing treatment to me, receiving payment from responsible parties for behavioral health care services rendered and / or engaging in behavioral health care operations. My signature below allows Elizabeth Kennard, MSW, SWLC, PLLC to receive all benefits which are or shall become payable from any third-party payer. I authorize and direct all third-party payers to pay all benefits directly to Elizabeth Kennard, MSW, SWLC, PLLC.

I understand that I have the right to request a restriction on the use or disclosure of my Health information. I further understand that I have the right to revoke this consent, in writing. I acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices from Elizabeth Kennard, MSW, SWLC, PLLC which provides a description of the uses and disclosures of protected health information.

With my signature I acknowledge I have read and understand the nature of counseling services, my rights, responsibilities, HIPAA Notice of Privacy Practices and hereby consent to treatment with Elizabeth Kennard, MSW, SWLC, PLLC.

Signature of patient (or authorized representative)

Date

Printed name

Relationship to client

PLEASE SUBMIT PAYMENT AT TIME OF SERVICE