Client Intake Questionnaire

Please fill in the information below and bring it with you to your first session.
Please note: information provided on this form is protected as confidential information.

Personal Information

Name: _____ Date: _____
Parent/Legal Guardian (if under 18): _____
Address: _____
Home Phone: _____ May we leave a message? □ Yes □ No
Cell/Work/Other Phone: _____ May we leave a message? □ Yes □ No
Email: _____ May we leave a message? □ Yes □ No
**Please note: Email correspondence is not considered to be a confidential medium of communication.*
DOB: _____ Age: _____ Gender: _____
Marital Status:

□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Referred By (if any): _____

History

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No □ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? □ Yes □ No
If yes, please list:

_____
_____

Have you ever been prescribed psychiatric medication? □ Yes □ No
If yes, please list and provide dates:

_____
_____

General and Mental Health Information

1. How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing: _____

_____

2. How would you rate your current sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

_____

3. How many times per week do you generally exercise? _____
What types of exercise do you participate in? _____

4. Please list any difficulties you experience with your appetite or eating problems: _____

_____

5. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately how long?_____

6. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe: _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

_____

11. What significant life changes or stressful events have you experienced recently? _____

_____

_____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes / no	
Anxiety	yes / no	
Depression	yes / no	
Domestic Violence	yes / no	
Eating Disorders	yes / no	
Obesity	yes / no	
Obsessive Compulsive Behavior	yes / no	
Schizophrenia	yes / no	
Suicide Attempts	yes / no	

Additional Information

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation? _____

Do you enjoy your work? Is there anything stressful about your current work? _____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief: _____

3. What do you consider to be some of your strengths? _____

4. What do you consider to be some of your weaknesses? _____

5. What would you like to accomplish out of your time in therapy? _____

Thomas Franco, MSW, LCSW

EMERGENCY CONTACT INFORMATION

Patient's Name: _____

Emergency Contact:

Name:
Address:
Phone #1:
Phone #2:
Relationship to Patient:

Consent for Treatment
and Limits of Liability

Limits of Services and Assumption of Risks:

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Limits of Confidentiality:

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect
If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults
If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

Prenatal Exposure to Controlled Substances
Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers
Insurance companies and other third-party payers are given information that they request regarding services to the clients.

The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

THOMAS FRANCO, MSW, LCSW
590 MADISON AVENUE, 21ST FLOOR
NEW YORK, NY 10022
101 HUDSON STREET, 21ST FLOOR
JERSEY CITY, NJ 07302
1001 19th STREET NORTH, SUITE 1200
ARLINGTON, VA 22209
Tel.: (646) 762-0477

Information About My Practice

Appointment Cancellations and Appointments Missed without Prior Notice: It is necessary to provide a minimum of 48 hours notice in the event that an appointment is not kept. Appointments not cancelled with 48 hours notice, and appointments missed without prior notice, are charged at the full rate of $250 per hour. Please note that insurance will not reimburse for missed appointments. Clients may utilize voice mail, at the number listed above, 24 hours a day to leave a message of the necessity to cancel.

Miscellaneous Charges: Please be advised that therapist time spent in client-related professional services (such as report writing, phone consultation with clients or others exceeding 10 minutes, face to face consultations with others exceeding 10 minutes, etc.) are charged at the rate of $250 per hour. These services are prorated in quarter hour units with the minimum of 10 minutes charted at the quarter hour rate of $62.50. These services are charged directly to the client and are not billable to insurance. In addition, please note that an administrative fee of $35 will be charged when a request to change an appointment date and/or time is made less than 48 hours prior to the appointment.

Your Health Plan: Please notify me of any changes in your health plan status. Please contact your health plan to confirm coverage for mental health services, whether you have managed mental health benefits, and if pre-authorization is required prior to your appointment. If necessary, clinical information will be provided to your health plan in order to obtain further authorization for evaluation and/or treatment.

If you have a deductible that has yet to be met, it is expected that you will pay any fees in full until the deductible is met. If your health plan has a visit fee or co-payment, it is expected that you will pay this amount at the time of each visit. If for any reason your health plan does not reimburse me for services, you are responsible for full payment of all fees incurred. Payment may be made by cash or credit card. No checks are accepted.

My signature below indicates that I have had an opportunity to ask questions about the above information, and that I have read, understand, and agree to abide with the above.

Signature of Client	Print Name	Date
Signature of Client	Print Name	Date
Signature of Client's Representative (if applicable)	Relationship to Client	Date

Thomas Franco, MSW, LCSW

FINANCIAL POLICY AGREEMENT

Patient's Name: _____ **DOB:** _____

Social Security Number: _____

Payment is required at the time of service. This includes all copayments and self-pay fees.

You will also be responsible for any **coinsurance, deductibles, and non-covered services**.

> Individual insurance policies have varied coverage for things like frequency of visits, telehealth services, etc. While we make every available effort to assist you, **understanding the details of your coverage is your responsibility**. **This includes an understanding of both in-network and out-of-network benefits coverage**.

Visits and Telehealth Services:

Most visits and telehealth services are generally covered by your insurance at the contracted fee schedule. However, because some insurances require a copayment or deductible, you will incur these charges if applicable. If you prefer to address these in a separate visit or telehealth session, please inform me and my practice manager or I we will be happy to schedule an additional appointment to discuss them.

If you have any questions about our payment policies, please ask to speak with our billing staff.

_____ _____

Signature of Patient/Guarantor/Authorized Guardian Date

_____ _____

Print name Relationship

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.

5. If this office initiated this authorization, you must receive a copy of the signed authorization.

6. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.*** HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

   In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.

Thomas Franco, MSW, LCSW

Consent to use or disclose information for Treatment, payment and Health Care Operations (TPO)

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your records in order to provide treatment to you, to obtain payment for services I provide and for other professional activities (known as "health care operations"). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. I reserve the right to revise the Notice of Privacy Practices at any time. If I do so, the revised Notice will be posted in the office. You may ask for printed copay of the Notice at any time.

You may ask me to restrict the use and disclosure of certain information in you record that otherwise would be disclosed for treatment, payment or health care operations; however, I do not have to agree to these restrictions. If I do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary. You may refuse to sign it. However, I am permitted to refuse to provider health care services if this consent is not granted or if the consent is later revoked.

I hereby consent to the use or disclosure of my Protected Health Information as specified above.

_____

Signature/Name of Client (Please Sign and Print Name)

_____

Today's Date

TOM FRANCO MSW, LCSW
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice
Patient Name
of Privacy Practices.

_____
Patient Signature Print Name Date

_____
Provider Signature Print Name Date

I am a parent or legal guardian of _____ . I have received a copy of
Patient Name
this office's Notice of Privacy Practices.

_____
Parent Signature Print Name Relationship to Patient Date

_____
Provider Signature Print Name Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign

____ An emergency situation prevented us from obtaining acknowledgement

____ Other (please specify)

_____
_____
_____
_____

Authorization for Credit Card Use

PRINT AND COMPLETE THIS AUTHORIZATION AND RETURN.
All information will remain confidential

Name on Card: _____

Billing Address: _____

_____

Credit Card Type: _____ Visa _____ Mastercard ____ Discover _____ AmEx

Credit Card Number: _____

Expiration Date: _____

Card Identification Number: _____ (last 3 digits located on the back of the credit card)

Amount to Charge: $ On File (USD)

I authorize Tom Franco Therapy and Consulting to charge the amount listed above to the credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder – Please Sign and Date

Signature: _____

Date: _____

Print Name: _____

Return the completed and signed form to the following:

_____

_____

_____

_____