New Beginnings Counseling LCSW P.C.

Adult Intake Form

Client initial:_____

Date: _____

Name: _____ Date of birth: _____

Preferred Name: _____ Pronouns: she/her, he/him, they/them, other: _____ Biological Sex (required by insurance companies):__ F / ___M

Marital Status: Single _____Married_____(years) Divorced ____Separated___ Widow(er)_____
Children: Y __/___N How many children? N/A ____ or _____ children ages _____ and gender/sex_____.

Address:

_____

City: _____State: _____Zip: _____
Phone (cell): _____ Phone (home):_____

Alternative Address or PO Box: _____

Text ok? __Y /__ N

Voicemail ok? __Y/___ N

E-Mail:_____ Emergency Contact: _____
Relationship: _____Phone: _____

Electronic Communication Policy: We try our best to ensure the privacy and confidentiality of email and text messaging, however, this is not something we can guarantee. We ask that text messaging only be used for scheduling purpose unless otherwise specified by your clinician. Our appointment system will send you an appointment reminder via email and you will have the option to opt out. This email is not sent by your individual clinician. By signing below, you agree to use these modes of electronic communication.

Sign here: _____

New Beginnings Counseling LCSW P.C.

Client initial:_____

Acknowledgement of New Beginnings Counseling LCSW P.C. Policies Checklist

*Please complete this page after signing the following pages of this intake packet:

● Cancellation policy I verify that I have read and agree to the cancellation policy. _____ Initials

● Payment and insurance policy: I verify that I have read and agree to the payment and insurance policy. ____ Initials

● Electronic communication policy I verify that I have read and agree to the electronic communication policy. _____ Initials

● Informed consent I verify that I have read and signed the informed consent form. _____ Initials

● HIPAA Notice I verify that I have received the HIPAA Notice of Privacy Practices. _____ Initials

● Release of Information I verify that I have read and signed the release of information form if relevant. _____ Initials

● Telehealth Policy I verify that I have read and signed the telehealth policy form if relevant _____Initials

● Termination policy I verify that I have read and signed the termination policy form if relevant.

● Card On File, payment for services including agreement to be billed if no show. _____Initials

Print Name: _____ Date: _____

New Beginnings Counseling LCSW P.C.

client initial_____

Insurance, Payment and Claims Authorization Policy Cancellation Policy

Therapy is a commitment between a clinician and a client. When a client and clinician begin treatment, they are making a commitment to a therapeutic process and also to a specific and reserved time. If you miss an appointment or are unable to provide at least 24 hour notice (unless due to illness or an emergency) when you cancel, you will be charged a **$70.00** cancellation fee.

Payment and Insurance Policy: Our office will be glad to complete and submit any and all insurance forms, but payment and follow-up are the responsibility of the contract holder. **Payment** and **copayments** are due at the time services are rendered. It is the obligation of the client to make payment and not that of the insurance carrier unless otherwise explicitly stated by a provider agreement signed in this office.

If no insurance, who is responsible for payment? _____
Claims Authorization: "I hereby authorize the release of any medical or other information necessary to process this claim. If my coverage is under a group contract held by an employer, an association, a trust fund, a union, or similar entity, this authorization also permits disclosure to them for the purposes of utilization, review or audit. This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with the insurer, including a reasonable time thereafter, until its final consummation."

Signature: _____Date: _____Print Name: _____

New Beginnings Counseling LCSW P.C.

client initial:_____ date:_____

Informed Consent to Individual Psychotherapy

This form documents that I, _____, give my consent to _____ (the "psychotherapist") to provide psychotherapeutic treatment to me. While I expect benefits from this treatment, I fully understand that no particular outcome can be guaranteed. I understand that I am free to discontinue treatment at any time but that it would be best to discuss with the psychotherapist any plans to end therapy before doing so. Our discussion about therapy has included the psychotherapist's evaluation and diagnostic formulation of my problems, the method of treatment, goals and length of treatment, and information about record-keeping. I have been informed about and understand the extent of treatment, its foreseeable benefits and risks, and possible alternative methods of treatment. I understand that therapy can sometimes cause upsetting feelings to emerge, and that I may feel worse temporarily before feeling better, and that I may experience distress caused by changes I may decide to make in my life as a result of therapy. I understand that the psychotherapist cannot provide emergency services. The psychotherapist has told me whom to call if an emergency arises and the psychotherapist is unavailable. In any case, I understand that in any emergency, I may call **911** or go to the nearest hospital emergency room. I have received the HIPAA Notice of Privacy Practices from the psychotherapist which is also available on the New Beginnings Counseling LCSW P.C. website(www.newbeginningscounseling.us). I understand that information about psychotherapy is almost always kept confidential by the psychotherapist and not revealed to others unless I give my consent.

There are a few exceptions as noted in the HIPAA Notice of Privacy Practices. Details about those exceptions follow:

1. The psychotherapist is required by law to report suspected child abuse or neglect to the proper authorities.

2. If I tell the psychotherapist that I intend to harm another person, the psychotherapist must try to protect that person, including by telling the police or the person or other health care providers. Similarly, if I threaten to harm myself, or my life or health is in any immediate danger, the psychotherapist will try to protect me, including by telling others such as my relatives or the police or other health care providers, who can assist in protecting or assisting me.

3. If I am involved in certain court proceedings the psychotherapist may be required by law to reveal information about my treatment. These situations include child custody disputes, cases where a therapy patient's psychological condition is an issue, lawsuits or formal complaints against the psychotherapist, civil commitment hearings, and court-related treatment.

4. If my health insurance or managed care plan will be reimbursing me or paying the psychotherapist directly, they will require that I waive confidentiality and that the psychotherapist give them information about my treatment.

5. If my account with the psychotherapist becomes overdue and I do not pay the amount due or work out a payment plan, the psychotherapist will reveal a limited amount of information about my treatment in taking legal measures to be paid. This information will include my name, social security number, address, dates and type of treatment and the amount due.

In all of the situations described above, I understand that the psychotherapist will try to discuss the situation with me, or notify me, before any confidential information is revealed, and will reveal only the least amount of information that is necessary.

If I am participating in a managed care plan, I have discussed with the psychotherapist the plan's limits, if any, on the number of therapy sessions. I have discussed with the psychotherapist my options for continuation of treatment when my managed care benefits end. I understand that I have a right to ask the psychotherapist about the psychotherapist's training and qualifications and about where to file complaints about the psychotherapist's professional conduct. By signing below I am indicating that I have read and understood this form and that I give my consent to treatment.

Signature_____ Date:_____ Print Name: _____

New Beginnings Counseling LCSW P.C.

client initial:_____ date:_____

Informed Consent to Telemental Health

I _____, hereby consent to participate in telemental health with _____ (name of provider) as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risk and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at _____ to discuss since we may have to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency. Emergency Protocols I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a lifethreatening emergency only.

This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____
and my emergency contact person's name, address, phone: _____
_____ I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

Signature of client/parent/legal guardian: _____

Date:_____

Signature of Therapist: _____

Date: _____

New Beginnings Counseling LCSW P.C.

client initial_____ date:_____

Client Health Form

Do you have any current ongoing medical problems or concerns?

_____

_____

Medical Hospitalizations: Y___/____N Dates:_____ Name of hospital: Admitting reason:

_____

Psychiatric Hospitalizations: Y__/___N Dates:_____ Name of hospital:_____ Admitting reason:_____

Do you have allergies? Yes___ No___ If yes, what are you allergic to? _____

COVID 19 vaccination: ___Y/___N If yes, name of vaccine and dates of vaccination:_____

_____

Are you pregnant or breastfeeding? Y ___/ ____N

Primary Care Provider: _____

Psychiatrist or Psychiatric Nurse Practitioner Name, Phone Number and Address:

_____

Psychiatric Diagnosis: _____

Have you previously received Psychotherapy? __Y/___N Explain:_____

Please list any medications that you are currently taking including Medication Assisted Treatment including: Methadone/Suboxone/Vivitrol, etc. and others for recovery from addiction

Medication_____dosage/frequency_____

Medication_____dosage/frequency_____

Have you taken psychotropic medications such as antidepressants or anti-anxiety?

Medication_____dosage/frequency_____

Medication_____dosage/frequency_____

Do you have a Narcan Kit? Y _____/N_____ Vitamins/Minerals: Y___/N__

Over the counter medications: _____

New Beginnings Counseling LCSW P.C.

Card on File: Authorization Form

Information to be completed by cardholder:

The undersigned agrees and authorizes medical practice to save the credit card indicated below on file. The use of this form is optional and for your convenience.

Medical Practice: _____

Name as it appears on card: _____

Type of Credit Card: ☐ MasterCard ☐ Visa ☐ Discover

Card Number: _____

Security Code: _____

Expiration Date: _____

I _____ authorize the above medical practice to process the above credit card as "Card on File". I understand this authorization will remain in effect until the expiration of the credit card account. Patient may also revoke this form by submitting a written request to the practice.

_____ _____

Cardholder's Signature Date

New Beginnings Counseling LCSW P.C.

client initial: _____ date:_____

Termination Policy

To Whom This May Concern:

Svetlana Buryakov, LCSW-R has the right to terminate therapy sessions for the following reasons (this may be subject to change):

- **Not showing up for more than three scheduled appointments.**
- **Not following through with therapeutic interventions.**
- **Failure of payment to New Beginnings Counseling LCSW P.C**
- **Services are no longer required or meet the needs of the client.**
- **If this therapist leaves New Beginnings Counseling LCSW P.C. practice.**

I _____ (client name) have the right to terminate therapy at anytime. I am not obligated to continue therapy for any reason.

If the therapeutic relationship has come to an end call your insurance company to schedule an appointment with a different therapist, clinician (if needed) such as a Nurse Practitioner and/or Psychiatrist for continuity of services. If you have further questions regarding this policy contact New Beginnings Counseling LCSW P.C. for further instructions and/or assistance.

Signature:_____Date:_____