CALM & SENSE THERAPY

INTAKE AND INSURANCE FORM

Date: _____

Client Name: _____ Client Date of Birth: _____

Gender: _____ Primary Language:_____

Race or Ethnicity:_____

Street Address: _____

City/State/Zip: _____

Home Phone: _____ Leave Message: Yes or No Work Phone: _____ Leave Message: Yes or No

Mobile Phone: _____ Leave Message: Yes or No

Email: _____

Marital Status: Single Married Widowed Divorced

Would you like to receive our monthly newsletter? Yes or No

How did you hear about Calm and Sense Therapy?_____

Insurance Company:_____

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Plan/Group #: _____

Member ID#: _____

Relationship of Policyholder to Client: _____

Policyholder Address (if different than client): _____

Name, Phone & Relationship of a close relative/friend to alert in an emergency:

_____

CALM & SENSE THERAPY

Consent for additional participants in Treatment

If you anticipate that any additional family members and/or identified support systems will be joining sessions at any point in your treatment with us, we ask that you identify these parties in advance, in order to give us permission to involve them in treatment as needed.

Please note that you have the right to cancel this consent at any time except when your therapist has already taken action on it. If you wish to cancel this consent, you need to ask your therapist for instructions. Otherwise, this consent will be valid from the date of the authorization until termination of treatment with Calm and Sense Therapy.

1. Name, Phone & Relationship of a close relative/friend:

_____

2. Name, Phone & Relationship of a close relative/friend

_____

3. Name, Phone & Relationship of a close relative/friend

_____

*In addition, please note that if you have additional family members in treatment with Calm and Sense, it is common practice that the involved clinicians may collaborate as needed to ensure high quality care. If you are uncomfortable with this, please advise your clinician.*

CLIENT INFORMATION

Please describe what brings you to treatment today?_____

_____

Medical Information:
Do you have a primary care physician? Yes or No
Date of last physical? _____
Please list any medical concerns: _____
Please list any medications you have been regularly prescribed for a medical reason and specify if past or current: _____
_____
Do you have any known allergies? Yes or No
If yes, please list here: _____
Do you have a history of head trauma or concussions? Yes or No
If yes, when was the most recent concussion?_____

Psychiatric Information:

Have you had any previous mental health treatment, including treatment programs and hospitalizations? If yes, when and for how long? _____

_____

Reason for previous mental health treatment: _____

Have you considered any previous treatment to be helpful? If yes, why? _____

_____

Please list any medications you have been regularly prescribed for a mental health reason and specify if past or current: _____

_____

I understand that if I have recently been psychiatrically hospitalized or in detox in the last 30 days, I am required to provide documentation related to completion of a step down in care, ie. Partial or Intensive Outpatient hospitalization. This will be a requirement in the event that any type of higher level of care takes place during the course of treatment at Calm and Sense Therapy.

Family History of mental health issues:

Paternal Family: _____

_____

Maternal Family: _____

_____

Everyone encounters difficulties from time to time. Please check all that you believe pose a particular challenge for you at this time:

Anxious/Excessive Worry[ ] Binge/Purging[ ] Chest Pain[ ] Chronic Pain[ ] Decreased Appetite[ ] Decreased Energy[ ] Depressed Mood[ ] Dependence/Increase in Alcohol/Drug Use[ ] Disorganized Thoughts ] Disorientation[ ] Distractibility[ ] Dizziness[ ] Elevated mood[ ] Fatigue[ ] Food Restriction[ ] Frequent Stomach Aches[ ] Grief [ ] Headaches[ ] Homicidal Thoughts[ ] Hopelessness[ ] Impulsivity[ ] Increased Appetite[ ] Irritability[ ] Isolation[ ] Loneliness[ ] Loss of Interest[ ] Low Self-Esteem[ ] Memory Impairment[ ] Mood Shifts[ ] Nausea[ ] Obsessions/Compulsions[ ] Panic Attacks[ ] Paranoia[ ] Phobias/Fears[ ] Racing Thoughts[ ] Recurring Thoughts[ ] Sleep Disturbances[ ] Social Withdrawal[ ] Speech Problems[ ] Suicidal Thoughts[ ] Trembling[ ] Unable to Enjoy Activities[ ] Weight Gain[ ] Weight Loss[ ]

Other: _____

Have you ever had feelings or thoughts of wanting to hurt yourself: Yes or No If yes, please explain: _____

Alcohol/Drug Use: Yes or No

If yes, what substance(s) and how often: _____

Do you smoke cigarettes or use tobacco products? Yes or No

If yes, how often and have you ever attempted to quit?_____

Have you had previous substance abuse treatment, including hospitalizations and detox? Yes or No

If yes, when and where? _____

Did you find treatment to be successful? _____

Do you have any family history of substance abuse? Yes or No

Have you ever been a victim/perpetrator of physical, sexual or emotional abuse: Yes or No

Have you experienced trauma? Yes or No

History of legal charges:
Yes or No
If yes, please explain: _____
_____

Employment/School
Current Employment (if applicable): _____
Highest Grade Completed in School/Current grade in school: (ie. High School junior/college first-year) _____

Family History/Social Supports
Who do you currently live with? _____
Please list any identified social supports: _____
_____
Please list any religious, cultural or spiritual practices that you would like to make your clinician aware of: _____
_____

**----------OFFICIAL USE ONLY----------**

**Therapist Signature: _____ Date: _____**

**Calm & Sense Therapy DX: _____**

COORDINATION OF CARE CONSENT

In order to coordinate care, do we have your permission to contact your primary care provider? Yes or No

If yes, please fill out the following:
I hereby authorize Calm and Sense Therapy to discuss, release, or receive my health information with my primary care provider whose contact information is as follows:

Doctor's Name: _____
Doctor's Address: _____
Telephone Number: _____

I understand that I have the right to cancel this consent for release of information at any time except when my therapist has already taken action on it. If I wish to cancel this consent, I need to ask my therapist for instructions. Otherwise, this consent will be valid from the date of the authorization until termination of treatment with Calm and Sense Therapy.

Client Signature:_____
Parent/Guardian Signature (if client under 18yo):_____
Date:_____

FINANCIAL POLICY and Billing Information

Below are the terms of agreement regarding payment for sessions at Calm and Sense:

If I, the client, fail to appear for an appointment without a 24 hour notice of cancellation, a missed appointment fee of $75 will be charged and I will be responsible for payment.

I understand that if I'm late to a session, that session will end at the time originally scheduled. It is my responsibility to arrive on time.

• I authorize my health insurance to provide payment of benefits to Calm and Sense

• I understand record of my treatment may be shared with my insurance carrier when necessary to process claims.

• I understand I am responsible for payment if my insurance company declines payment.

•I understand that I am required to pay my copay at the time services are rendered

• We ask that all clients add a valid credit card to their files to handle any unpaid balances. If there is a balance on your account that has not been paid within 1 billing cycle, the credit card on file will be used to pay the balance owed.

As a courtesy, we are willing to check with your insurance to see what your benefits are for our services. Please be advised that this is only an estimate. Our information is only that which is offered by your insurance and may not always be accurate or up to date. You as the member, have every right and responsibility to verify your benefits prior to your first session.

I have reviewed this document and understand the contingencies stated above.

Client / Client Guardian Signature: _____
Print name:_____ Date:_____

Please add a credit card to your file to handle any copays, coinsurance, or deductibles that may be due after your insurance processes your claims.

Name On the card :_____ Credit Card No. _____ CVV:_____Expiration Date: _____

CALM & SENSE THERAPY

# LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. However, the noted exceptions are as follows:

**Duty to Warn and Protect**

Duty to warn is “a threat of imminent, serious physical violence against a readily identifiable individual or against oneself.”

When a client discloses intentions or a plan to harm another individual, the clinician is required to warn the intended victim- or the police where the intended victim lives. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client to support with making appropriate arrangements for psychiatric evaluation and/or hospitalization.

**Abuse of Children and Vulnerable Adults**

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

**Prenatal Exposure to Controlled Substances**

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful to the appropriate social service and/or legal authorities.

**Minors/Guardianship**

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

**Clinical Quality Review**

We take our commitment to maintaining high quality care for all of our clients very seriously. To this end, please be aware that your case could be confidentially presented to a practice Clinical Supervisor by your clinician, but only on an as- needed basis for the sake of additional oversight.

**Inter office clinical collaboration:**

In instances where a Calm and Sense client refers a family member to the practice or a Calm and Sense clinician refers a client to another in-house clinician for additional specialized support, the involved clinicians may provide relevant clinical updates and collaborate for the sake of ensuring high quality care. If you are not comfortable with this practice please alert your clinician to discuss alternatives.

**Insurance Providers(when applicable)**

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications

Client Signature:_____

(Client's Parent/Guardian if under 18) :_____
Today's Date: _____