General Client Intake Form

Please complete the following information to the best of your ability.

Client Information

Client Name: ______________________________ **Date of Birth:** ______________

Sex: (*please circle*): M F Intersex **Gender**: ____________ **Sexual Orientation:** ______________

Preferred Pronoun Usage: ____________ **Race/Ethnicity:** ____________ **Marital Status:** ____________

Who suggested you see a therapist?
❒ Self Referred ❒ Friend ❒ Family ❒ Work ❒ Partner ❒ Other ________________

How did you hear about us?
❒ Psychology Today ❒ Google ❒ Insurance Company ❒ Friend/Family ❒ Other ________________

Contact Information

Address: ____

Home Phone: ______________________ **Work Phone:** ______________________

Cell Phone: ______________________ **Preferred Means of Contact:** ❒ Home ❒ Work ❒ Cell

Email: ______________________

Can we leave a message at home? ❒ Yes ❒ No **At work?** ❒ Yes ❒ No **On cell?** ❒ Yes ❒ No

Emergency Contact

Name: ______________________________ **Relationship to you**: ______________

Address: ____

Phone: ________________

I give my therapist permission to communicate with my emergency contact regarding my health and treatment.

❒ Yes ❒ No **Comments**: ______________________ **Initials**: ________ **Date**:________

Primary Care Doctor

❐ I do not have a primary care doctor

❐ I have a primary care doctor, but do not wish to share their information at this time.

Name: ____

Address: ____

City/State/Zip: ____

Phone: ______________________ **Fax:** ______________________

I give my therapist permission to consult with my healthcare provider regarding my health and treatment.
❐ Yes ❐ No **Comments**: ______________________ **Initials**: __________ **Date**:__________

Current Medical Information

Allergies: ____

Please list all conditions currently monitored by a healthcare provider.

____

____

Medications (current & past use)
In the table below, please list any medications including pharmaceuticals and antibiotics that you are currently or have previously taken.

Medication	Prescribed For	Dosage	Frequency	Dates/Duration
e.g. Wellbutrin	*depression*	*100mg*	*2x day*	*2010-present*

Breaking Free Services
Center for Wellness
Treating the Mind, Body & Spirit

Medical Health History

List & include dates & treatments. Add pages if necessary.

Surgeries:____
____

Accidents (physical & psychological): ____
____

Major Illnesses: ____
____

Women

Last Pap: _________________________ **First day of last menstrual period:** ______________________

Marital/Partner History: ___________________________________ **Number of Children:** ____________

Ages of Children: ___________________________________ **Number of Pregnancies:** _______________

Complications: ____

Use of Contraceptive: ❒ Yes ❒ No **If so, what type?** ____

Abortions/Miscarriages? ____

Family Medical History

Please give age, lists of any illnesses, or if deceased. If deceased, list cause of death & age of death.

Mother

Father

Siblings

Maternal Grandparents

Paternal Grandparents

Use of Non-Pharmaceutical Substances

Substance	Current	Past	Times Per Week/Last Use	Comments
tobacco	❐	❐		
alcohol	❐	❐		
marijuana	❐	❐		
cocaine	❐	❐		
heroin	❐	❐		
synthetic marijuana	❐	❐		
ecstasy/MDMA	❐	❐		
methamphetamine	❐	❐		
opiates	❐	❐		
PCP/ketamine	❐	❐		
LSD	❐	❐		
other	❐	❐		

Have you ever sought treatment for substance abuse? ❒ Yes ❒ No **If so, please list locations and dates.**

____

____

Please list family history of substance abuse.

Mother

Father

Siblings

Maternal Grandparents

Paternal Grandparents

Current Mental Health Status

Please share a little bit about how you hope we can be helpful for you. What brings you into therapy now?

____

____

____

____

What are some of your self-defeating behaviors? Is there anything you do that just seems to make things worse, or is unhelpful?

____

____

____

What are your strengths? What are your passions and interests? What do you like about yourself? Who or what in your life acts as a support for you?

____

____

____

How would you describe the mood you feel the majority of the time? ______________________________

How many meals do you eat per day? Have you noticed any changes to your eating habits lately? ________

____

How many hours of sleep do you get per night, on average? Have you noticed any changes to your sleeping habits lately? ____

____

Have you noticed any significant weight gain/loss recently? ❒ Yes ❒ No **If yes, how much?** ____________

Have you noticed any significant changes to your hygiene routine lately? ❒ Yes ❒ No **If yes, what has changed?**

____

Mental Health History

Have you ever sought mental health counseling before? ❒ Yes ❒ No
If yes, please list dates, location, & reason for past treatment below.

Dates	Location	Inpatient/Outpatient?	Reason

Please list any past diagnoses you have been given.

____

____

Do you have any history of attempting suicide or of self-injurious behaviors? If so, how many times previously & when was the most recent incident?

____

____

Have you ever been a victim of abuse? Please check all that apply.

❒ No ❒ Physical ❒ Sexual ❒ Emotional ❒ Neglect ❒ Prefer not to say at this time

Have you experienced any other traumatic events in your life? (car accidents, fires, combat zones, etc.)

____

____

Family Mental Health History

Please list family history of mental health, including diagnoses (if known) & treatment received.

Mother

Father

Siblings

Maternal Grandparents

Paternal Grandparents

Informed Consent for Treatment

Please initial next to each section.

By signing this form, I am agreeing to and acknowledging the following:

__ Breaking Free Services Center for Wellness, LLC. will provide outpatient counseling, evaluation, information, and/or referral.

__ No drug or alcohol screening or "search and seizure" methods will be employed.

__ **Patient/Service Fees**: Intake sessions are 60 minutes with insurance, 90 minutes if self pay. Regular session length is 45-50 minutes. Therapist rates vary by therapist, from $100-150. Emergency/crisis sessions are 75-90 minutes & cost $150-$225, depending on the therapist. Additional session time or phone calls are billed in 10 minute increments of $15-$25, depending on the therapist.

__ **Payment of Fees for Services**: By signing below, you accept financial responsibility for all charges in accordance with the fee schedule in place at the time services are rendered. YOU UNDERSTAND THAT OUR FEE SCHEDULE IS SUBJECT TO CHANGE AND ANY CHANGES WILL AUTOMATICALLY APPLY TO YOUR ACCOUNT. Breaking Free Services will provide you with the current fee schedule at your first visit. Client is expected to pay for services when services are rendered. If a check is returned for insufficient funds, you will be required to pay any bank service charges in addition to the check amount. Clients are aware that if they choose to use a credit or debit card to pay for sessions, they will be subject to a 3% service fee.

__ **Cancellation & No Show Policy:** Except in cases of emergency, **cancellations must be made 24 hours in advance**. Cancellations with less than 24 hours notice shall be charged a $25 fee. No shows will be charged a $50 fee. If you are more than twelve (12) minutes late to a session, you will be considered a "no show" for that session and you must schedule a new session to see one of our therapists. Our therapists will not extend session time to make up for late arrivals. You understand that cancellations are to be done by a phone call directly to the therapist & that you are responsible for knowing when your appointment is. *Note that insurance carriers will not issue payment for cancelled and/or "no show" sessions, so BFS clients are solely responsible for payment for late cancellations and/or "no show" sessions.*

__ **Substance Use Policy:** Clients must not be under the influence of alcohol or illegal substances at the time of the scheduled session. Should a client be under the influence of substances other than prescribed medication, the session will be cancelled by the counselor and the client will be expected to pay for the session at the usual agreed upon fee.

__ **Professional Services Agreement** (*Related to using insurance*): To the extent that fees for professional services rendered to the patient are payable, the undersigned hereby assigns to said professionals and authorized payment directly to said professionals all insurance benefits, including major medical, for professional services rendered to the patient. The undersigned is financially responsible to the service provider for fees not paid pursuant to this agreement.

__ **Insurance Payments**: You understand that an insurance policy is a contract between you and your insurance company. Any balance remaining after your insurance company submits payment to us is your financial responsibility. In the event your insurance company has not made payment in ninety (90) days, you will be expected to pay your balance. Please keep in mind that some or all of our services may not be covered and some or all of our services may not be considered reasonable and/or necessary under your insurance policy. You understand that insurance have up to two (2) years to conduct an audit of your account and may request that we collect additional payment from you and/or request that we return payments. In such cases, any additional amount due must be paid prior to your next session. *You understand that you are solely responsible for communicating with your insurance company regarding coverage of your services.*

__ **Acknowledgement** (*Related to using insurance*): I understand and agree that Breaking Free Services, LLC 1) may at its discretion make contact with an insurance company regarding insurance benefits, 2.) does not in any way guarantee any insurance health benefits, 3.) has not and does not guarantee that the professional services charges are covered by insurance. This will authorize Breaking Free Services to release general medical as well as psychiatric, alcohol, drug abuse, HIV and/or AIDS information from my health record in accordance with Florida Statutes 394.459.90.503, 396.112, and/or 381.609 (3)(F) and Federal regulations (42 CFR Part 2) to the above named insurance company(ies) if necessary for the payment of insurance claims. I understand I have the right to refuse this authorization. If I approve, the facility named above is released from all legal liability that may arise from the release of the information requested.

__ **Prohibition on Redisclosure**: This information has been disclosed from records whose confidentiality is protected by State/Federal law, which prohibits any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by State/Federal law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. This consent is subject to revocation at any time except to the extent that the program, which is to make the disclosure, has already taken action in reliance on it. This authorization will expire at termination of services.

__ **Confidentiality**: You understand that any communications between clients and Breaking Free Services, LLC are confidential, including all verbal communications, clinical records, and therapy notes. Your Breaking Free Services therapist cannot, and will not, share any information about you, including a confirmation that you are even a client. If you desire to waive this confidentiality for any reason, you must sign a release of information and identify any party that you desire to have and/or receive your information. Once you have signed such a release it is your sole responsibility to notify us in the event you desire to revoke the release.

__ **Limitations to Confidentiality:** Client's right to confidentiality will be observed at all times, with the following exceptions:

- __ In case of probable imminent danger to self or others
- __ In cases of alleged child or elder abuse, including sexual abuse
- __ Communicable diseases must be reported by the counselor to the appropriate county health department
- __ When you, the client, request that we release information. Information is shared with the other entities (ie, doctors, insurance companies, etc.) when requested by signing an authorization to release information form. In accordance with HIPAA privacy regulations, any information shared will reveal only the basic minimum information necessary. We reserve the right to release only a treatment summary instead of detailed case notes.

__ **Recordkeeping:** You understand that any and all records of Breaking Free Services are stored electronically.

__ **Records Requests:** A minimum requirement of 72 hours is needed for medical records, once a written request is received.

__ **Method of Communication:** Breaking Free Services and your therapist prefer to communicate with you by phone. However, if you prefer to communicate via text and/or email, you understand that you must initiate the communication and you must state your name and address for verification purposes. Because each therapist maintains a client schedule, each therapist's response time may vary. Text messages and emails shall be used solely for the purpose of exchanging information such as referrals, resources, appointment times, billing matters, etc. and shall not be used for any counseling related discussion.

__ **Social Media Communication:** Communication with your therapist via social media sites such as Facebook, LinkedIn, or other similar platforms associated with the term "social media" is strictly prohibited. In addition, your therapist will not respond and/or request to "friend" or become associated with any client via social media. Your therapist may perform an internet search related to you if clinically appropriate and if your therapist discorvers information about you while searching the internet, you will receive notice at a time that is clinically appropriate.

__ **Legal Involvement:** The undersigned will neither individually or jointly involve Breaking Free Services Center for Wellness, LLC. and its staff in any litigation. The undersigned will neither request nor require that Breaking Free Services Center for Wellness, LLC. or any of its staff provide testimony in court. The reason for this is so that treatment is not compromised, that the therapeutic relationship with the family is maintained, and that the client can experience their therapist in a clear,

consistent therapeutic role and not as an assessor or detective. If the services of a mental health professional are desired for court purposes, the services of a person outside of Breaking Free Services Center for Wellness, LLC. must be enlisted.

__ **Counseling Recordings/Artwork**: The use of videotaping or photography is sometimes necessary in therapy. Any type of recording is used to provide feedback to you, the client, or for therapist training purposes. Your confidentiality is protected and recordings are erased after every session unless your permission is given for another use. In the case of video or audio taping, you will be informed ahead of time and your written permission will be needed.

__ **Hours of Operation**: By appointment only. Currently days, evenings, and some weekends are available.

__ **After Hours Emergencies:** You understand that Breaking Free Services does **not** maintain a 24-hour on call service. You understand that if you have an emergency, you must act as follows:

- __ Call 911 or go to the nearest emergency room; or
- __ Contact 211 to speak with a crisis counselor; or
- __ Contact the suicide hotline at 1-800-SUICIDE (1-800-784-2443).

__ **Acknowledgement**: I authorize the Release of Medical Information necessary for my insurance company to process my claim. I also authorize the payment of benefits to Breaking Free Services, Inc. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered.

__ **Child/Adolescent Consent for Treatment:** I certify that I am the parent/legal guardian of the named client and that I do have legal custody of the named client, who is under the age of 18. I hereby give my authorization and consent for the above named child/adolescent to receive outpatient assessment/therapy from Breaking Free Services, LLC & its associates. I am aware that it is the responsibility of the parent/guardian signing this form to notify any other parents/guardians that their child is participating in counseling.

__ **Divorce/Legal Separation Collection Policy:** It is the policy of Breaking Free Services, LLC that the parent/guardian bringing a child/adolescent to our office tor treatment is responsible for the payment of services rendered at that time. If you have a financial arrangement for the payment of the child/adolescent's medical care, either oral or written, with the child/adolescent's other parent or responsible party, you will be expected to pay for the child/adolescent's care at the time of service and arrange for your personal reimbursement with the other party. In the event of a true emergency, treatment will not be denied to your child/adolescent.

__ **Informed Consent**: I/we understand the following:

- __ That I/we have been fully informed about the nature of the treatment, the risks & benefits, & the available treatment options.
- __ That I/we have had the opportunity to have all questions answered to my/our satisfaction.
- __ That this consent is given voluntarily.
- __ That I am legally competent and have the authority to provide consent for treatment for myself/my child.
- __ That I have the right to withdraw my consent for this treatment at any time by submitting a written request.
- __ That withdrawing consent for this treatment will not prejudice my continued treatment relationship.

I certify this information is true and correct to the best of my knowledge. I will notify Breaking Free Services Center for Wellness, LLC of any changes to this information. By signing this form, I am acknowledging receipt of a copy of this paper and agreement to the terms and conditions as provided by Breaking Free Services, Inc.

Print Client Name: ____

Print Guardian Name: ____

Client/Guardian Signature: ____

Date: ____________________

Consent to Release Verbal & Written Information

One form must be completed per request.

I, the undersigned, or my legal guardian, hereby authorizes Breaking Free Services to release and receive verbal and/or written information from my confidential patient file to/from the following party:

___ **Family/Significant Other** ___ **Facility or Agency Representative** ___ **Clergy**

___ **Attorney** ___ **Therapist or MD** __**Other**

Contact Information

Contact Name: ____

Address: ____

Phone: ____________ **Fax**: ____________ **Email**: ____________________

Information to be Released

___ Billing Information (including dates of office visits) ___ Patient Records (see exception below)

Consent & Signatures

This right is subject to certain legal restrictions. It does not apply to psychotherapy notes or to information compiled for judicial hearings.

I understand that I have a right to view or get copies of my health information. I understand that the information released may be mental health or substance abuse related. I understand that I will be charged a reasonable cost-based fee for expenses such as copies and staff time.

I further understand that the above consent can be withdrawn by me, in writing, at any time. I cannot, however, hold exception to actions that took place before I withdrew my consent. I understand that the information that is being disclosed is from records which are protected by Federal Law. Regulation 42-CRF Part 2 prohibits disclosure without the written consent of the person to whom it pertains.

Print Client Name: ____

Client Signature: ______________________________ **Date**: ____________

Witness SIgnature: ____

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