

Client Intake Form

Date _____

A. Client's Name _____ Age _____ Birth date _____

If client is a minor, Parent/Guardian's Name(s) _____ Age(s) _____

Client's Address _____
Street City State Zip

Phone (Home) _____ (Cell) _____ Best time to call _____

Marital Status _____ First Marriage _____ 2nd _____ 3rd _____ Other _____

Education _____ Occupation _____

Spouse's Name _____ Age _____ Birth date _____

Spouse's Education _____ Spouse's Occupation _____

B. Please list name, age, sex, and relationship of all significant people in household

Name	Age	Relationship	Sex
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

C. Who is coming for counseling? _____ Any prior counseling? _____

If yes, please provide the following information.

Date	Name of Therapist or Institution	Nature of Problem	Result of Treatment
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you or any other family member currently seeing a psychiatrist or another therapist? _____

If so, what family member? _____

Name of Psychiatrist or Therapist _____

For what purpose? _____

Person to contact in case of an emergency (Name, Relationship, Phone, Address)

Please Fill Out the Following as it Applies to the Client

D. State the nature of the problem in your own words:

What is your most difficult relationship right now? _____

What is your most difficult emotion right now? _____

E. Crisis Information: Are you having any suicidal thoughts, feelings, or actions? Y/N

If yes, explain: _____

Any current homicidal or assaultive thoughts or feelings, or anger control problems? Y/N

If yes, explain: _____

Any past problems, hospitalizations, or jailings for suicidal or assaultive behavior? Y/N

If yes, explain: _____

Any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.) Y/N

If yes, explain: _____

F. Medical Information: Doctor's name, address, and phone:

Are you currently taking any medication? _____ If so, please list the following:

Name of Medication	Dosage	Results
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any problems with: eating ____ sleeping ____ chronic pain ____ recent weight change ____

Describe any answers checked above: _____

Any other medical problems? _____

Have you or any of your family been hospitalized for mental or emotional illness? Y/N

If yes, explain: _____

Kimberly Capstraw, LMFT
1417 N. Semoran Blvd.; Suite 201
Orlando, FL 32807

407-227-9245
FAX 407-282-0552

Insurance Company _____
Insurance Phone Number _____ Co-pay \$ _____
Policy or ID Number _____ Group Number _____
Authorization Number _____ # of Sessions Authorized _____
Authorized from _____ to _____.

Insured's Name _____
Insured's Date of Birth _____ Insured's Social Security Number _____

Patient's Name (If different) _____
Patient's Date of Birth _____ Patient's Social Security Number _____

I hereby authorized the release of any information necessary to process my insurance claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

Signed _____ Date _____

I hereby authorize payment of mental health and/or EAP benefits to Kimberly Capstraw, LMFT for psychological services rendered.

Signed _____ Date _____

Party responsible for payment, if other than client:

NAME: _____ RELATIONSHIP TO CLIENT: _____
FIRST MI LAST

ADDRESS: _____
NUMBER STREET
CITY STATE ZIP CODE

MINOR CONSENT Please check below to indicate the current situation regarding the parental responsibility of the minor child:

- Parents are married to each other and are the legal parents and natural guardians of the child (*one signature required*)

- I am a single parent and have sole parental responsibility of the child (*one signature required*)

- My ex-partner/spouse and I share parental responsibility of the child (*both signatures required*) Will he/she agree to treatment of the child? Yes No

- The child is in the custody of the State of Florida.
County _____ .

- I am the mother of a child born out of wedlock and no court order related to parental responsibility has been entered.

I hereby grant my consent for my child, _____ to be treated by Kimberly Capstraw, LMFT. This permission will remain in force until revoked by me in writing.

Signature of Legal Guardian Date _____

Signature of Legal Guardian Date _____

MINOR AGREEMENT The involvement of children and adolescents in therapy can be highly beneficial to their overall development. Very often, it is best to see them with parents and other family members; sometimes, they are best seen alone. I will assess which might be best for your child and make recommendations to you. Obviously, the support of all the child's caregivers is essential, as well as their understanding of the basic procedures involved in counseling children. The general goal of involving children in therapy is to foster their development at all levels. At times, it may seem that a specific behavior is needed, such as to get the child to obey or reveal certain information. Although those objectives may be part of overall development, they may not be the best goals for therapy. Again, I will evaluate and discuss these goals with you. Because my role is that of the child's helper, I will not become involved in legal disputes or other official proceedings unless compelled to do so by a court of law. Matters involving custody and mediation are best handled by another professional who is specially trained in those areas rather than by the child's therapist. The issue of confidentiality is critical in treating children. When children are seen with adults, what is discussed is known to those present and should be kept confidential except by mutual agreement. Children seen in individual sessions (except under certain conditions) are not legally entitled to confidentiality (also called privilege); their parents have this right. However, unless children feel they have some privacy in speaking with a therapist, the benefits of therapy may be lost. Therefore, it is necessary to work out an arrangement in which children feel that their privacy is generally being respected, at the same time that parents have access to critical information. This agreement must have the understanding and approval of the parents or other responsible adults and of the child in therapy. This agreement regarding treatment of minors has provisions for inserting individual details, which can be supplied by both the child and the adults involved. However, it is first important to point out the exceptions to this general agreement. The following circumstances override the general policy that children are entitled to privacy while parents or guardians have a legal right to information.

Confidentiality and privilege are limited in cases involving child abuse, neglect, molestation, or danger to self or others. In these cases, the therapist is required to make an official report to the appropriate agency and will attempt to involve parents as much as possible.

Minors may independently enter into therapy and claim the privilege of confidentiality in cases involving abuse or severe neglect, molestation, pregnancy, or communicable diseases, and when they are on active military duty, married, or officially emancipated. They may seek therapy independently for substance abuse, danger to self or others, or a mental disorder, but parents must be involved unless doing so would harm the child.

Any evaluation, treatment, or reports ordered by, or done for submission to a third party such as a court or a school is not entirely confidential and will be shared with that agency with your specific written permission. Please also note that I do not have control over information once it is released to a third party.

The normal procedure for discussing issues that are in my child's/children's therapy will be joint sessions including my child/children, the therapist, and me and perhaps other appropriate adults. If I believe there are significant health or safety issues that I need to know about, I will contact the therapist and attempt to arrange a session with my child/children present. Similarly, when the therapist determines that there are significant issues that should be discussed with parents, every effort will be made to schedule a session involving the parents and the child/children. I understand that if information becomes known to the therapist and has a significant bearing on the child's/children's well-being, the therapist will work with the person providing the information to ensure that both parents are aware of it. In other words, the therapist will not divulge secrets except as mandated by law, but may encourage the individual who has the information to disclose it for therapy to continue effectively. *I will do my best to ensure that therapy sessions are attended and will not inquire about the content of sessions. If my child prefers/children prefer not to volunteer information about the sessions, I will respect his/her/their right not to disclose details. Basically, unless my child has/children have been abused or is/are a clear danger to self or others, the therapist will normally tell me only the following:*

- whether sessions are attended
- whether or not my child is/children are generally participating
- whether or not progress is generally being made

Signature of Legal Guardian _____ Date _____

Signature of Client (Minor) _____ Date _____

TREATMENT & FINANCIAL POLICIES

What is therapy and how does it work?

Therapy is the process of solving emotional problems by talking with a person professionally trained to help people achieve a more fulfilling individual life, marital relationship, or family relationships. The process of change will, in many ways, be unique to your particular situation. Who you are as a person will help to determine the ways in which you go about changing your life. The process of change begins by first clearly defining the problem, and then discussing your thoughts and feelings, understanding the origin of the difficulty and developing new skills and healthy attitudes about yourself and others. As the client, you have the right to ask your therapist questions about his or her qualifications, background, and therapeutic orientation. The most important factor in the success of therapy is good communication between therapist and client. That being said, each person's experience is different while in therapy, change cannot be guaranteed and each person's change can vary. In addition, not all individuals benefit from therapy or working with a particular therapist. If at any time during the therapy you have questions about whether or not the treatment is effective, feelings about something your therapist has said or suggested or need clarification of our goals, do not hesitate to bring this up in your session.

Confidentiality and Release of Records

All information regarding clients is considered strictly confidential and will not be given out to anyone without your written consent. The only way your records may be accessed without your consent is if a court orders the therapist to do so. In the event of request for transfer of records, the records will be forwarded upon completion of a consent form.

After Hours Emergency

Your therapist may be reached between the hours of 9am to 7pm Monday through Friday. Your therapist may be reached at 407-227-9245. Please leave a message if there is no answer and your therapist will return your call as soon as possible. In the event of an emergency or if you need immediate assistance please call **911**.

Therapy Session

Therapy sessions are **50 minutes** in length. A therapy hour is 50 minutes of client time spent with the therapist and 10 minutes of the therapist constructing the therapy notes from the session after the client leaves.

Financial Policy

Kimberly Capstraw accepts **cash and checks** as a form of payment. Sorry, no credit cards are accepted at this time.

There will be a \$30 fee for returned checks.

Payment is due at the time services are rendered. If client fails to pay at the time services are rendered, a \$30 late fee will be added.

Preparation of forms and reports

These require chart review and often, discussion with the client. There will be a minimum charge of \$35 up to a maximum of \$140 per hour.

Cancellations

Kimberly Capstraw requires 24 hour notice of cancellations. If a client is a “no show” or does not give 24 hours notice they will be charged \$50 for the missed appointment.

Insurance and Billing

Kimberly accepts **Cigna** insurance and any other PPO plans which allow for out-of-network benefits.

I have read and understand all of the above information on treatment and financial policies and agree to them:

Signature: _____ Date: _____

HIPPA- Health Insurance Portability and Accountability Act

Policies and Practices to Protect the Privacy of Your Health Information

In order for counseling services to be effective, issues of confidentiality in regards to what is discussed in your meeting with your therapist are extremely important. This notice describes how psychological and medical information about you may be used and disclosed and how you can obtain access to this information. Please review this notice carefully and feel free to ask any questions if you have concerns or confusion regarding HIPAA.

Under the Health Insurance Portability and Accountability Act (HIPAA), which is a federal law, I am required to maintain the privacy of your protected health information and provide you with notice of my legal duties and privacy practices with respect to such protected health information.

How I May Use or Disclose Your Health Information

The following describes the purposes for which I am permitted or required by law to use or disclose your health information without your consent or authorization. Any other uses or disclosures will be made only with your written authorization and you may revoke such authorization in writing at any time. Under the HIPAA privacy rule, the disclosure of medical records information is limited to the **minimum** necessary to accomplish the purpose of the disclosure.

Treatment: I may use or disclose your psychological records to provide, coordinate or manage health care and treatment. An example of this would be if I need to consult with another health care provider, such as your family physician, or another therapist regarding your case

Insurance: I can communicate information with an insurer regarding your healthcare. Examples are when I disclose information contained in your medical records to your health insurer to assist you in obtaining reimbursement for your counseling sessions, only if you are requesting reimbursement.

Additional Disclosures with Neither Consent nor Authorization

I may use or disclose information related to your care without your consent or authorization in the following circumstances:

Serious Threat to Health or Safety: When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, I may communicate relevant information concerning this to the potential victim, appropriate family members, law enforcement or other appropriate authorities.

Child Abuse: If I know, or have reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that I report such knowledge or suspicion to the Florida Abuse Hotline.

Adult and Domestic Abuse: If I know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, I am required by law to immediately report such knowledge or suspicion to the Florida Abuse Hotline.

Health Oversight: If a complaint is filed against me with the Florida Department of Health on behalf of the Board 491, the Department has the authority to subpoena confidential mental health information from me relevant to that complaint.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Patient's Rights Related to HIPAA and Protected Health Information (PHI)

Right to a Paper Copy - You have the right to obtain a paper copy of this notice from me. If you would like a paper copy of this notice, please request one from me.

Uses and Disclosures Requiring Authorization

Any further disclosure of client information not mentioned above, that you wish be known to a particular individual will be done only through signing a release of information form. This form will be valid for one year from the original signature date. This form may at any time be revoked in writing by the person who granted the consent.

I have read and understood the above HIPPA privacy policy.

Signature of Client/Parent _____ Date _____

Consent for Release of Information

I, (Name) _____, authorize the exchange of information regarding (client's name) _____ care to (name of person receiving info.) _____. This person is to have access to the following information: _____. I understand that my records are protected under the Federal and specific State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time and that this consent expires automatically one year from the signature date below. I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

Signature of Client _____ Date _____

I would like to revoke my consent for release of information.

Signature of Client _____ Date _____