INTAKE FORM

Name:_____ Age:_____ DOB:_____

Address:_____

Number & Street City, State, Zip

Home Phone:_____Work:_____Cell:_____

What number is your preferable method of contact? H / W / C

SSN:_____-_____-_____Occupation/Grade:_____

Primary Insurance Company:_____

Address:_____

Mental Health Phone Number:_____

Name of Insured:_____ SSN:_____DOB:_____

Policy/ID: _____Group:_____

Secondary Insurance Company:_____

Address:_____

Mental Health Phone Number:_____

Name of Insured:_____ SSN:_____DOB:_____

Policy/ID: _____Group:_____

Person to Contact in Case of Emergency:_____

Phone #:_____ Relationship:_____

Who Referred you to our Office?_____

AUTHORIZATION OF TREATMENT

Consent to Treatment

I authorize and consent feely to the evaluation and treatment of _____.

I understand that recommendations for treatment will be given to me. I understand that the results will depend upon the willingness of the client(s) to make the changes agreed upon. Treatment requires a cooperative agreement and honest disclosure by all the participants. I also am aware that homework given is vital to the client's progress and that it is the client's responsibility to complete it. I understand that because of the many factors present, results cannot be guaranteed. I am aware that consistency and responsibility are an important part of treatment. I am aware that payment is required at the time of services.

Receipt of Patient's Bill of Rights and Responsibilities

By my signature on this document, I acknowledge that I have been given an opportunity to review a Patient's Bill of Rights and Responsibilities pursuant to Florida Law, prior to or at the time of treatment. I have been advised that a copy is available for me upon my request. **Initials**:_____

Receipt of Notice of Privacy Practices

By my signature on this document, I acknowledge that I have received the office's Notice of Privacy Practices.

Emergency Medical Care

It is my understanding that situations occur when the staff of this office feels a medical emergency exists, and it is in my best interest to be transported to the local emergency room for medical care. Should a medical emergency arise, the staff of this office has my permission to contact the appropriate until for transportation. I agree with this arrangement and understand that I will be responsible for any fees incurred during or as a result of this transportation.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature (if applicable) Date

_____ _____

Witness Signature Date

ASSIGNMENT OF BENEFITS AGREEMENT

I agree that I personally am responsible for all the charges for all services rendered by Vicky Kijanski, LCSW to my dependent or to me. I understand that a statement will be sent to me every month in which a balance is due. Any charge not paid at the time of service will appear on that statement.

If my dependent or I is eligible to receive reimbursements for covered services pursuant to an insurance policy or other plan, I hereby direct this plan to pay Vicky Kijanski, LCSW. I agree to pay Vicky Kijanski, LCSW all co-payments and deductibles required under my plan. If I have coverage through a second plan, I agree to notify Vicky Kijanski, LCSW and complete an Assignment of Benefits Agreement for that specific plan. I understand that I am ultimately responsible for fees incurred as a result of the services provided.

I understand that missed appointments or those not cancelled with 24 hours notice will result in a charge to me of $35. I also understand that this charge is not reimbursable through my insurance plan. I understand that if a check is returned, I am responsible for a $15 charge as well as the initial amount. I further understand that I will subsequently be asked to pay my fees in cash or with a money order.

I,_____ hereby, authorize Vicky Kijanski, LCSW to disclose any or all of the following: dates of service, diagnosis code(s), treatment plan or summary, relative to the treatment of:*(Client Name)*_____ to *(Insurance Name)*_____ as required by the plan to obtain coverage of the services provided by Vicky Kijanski, LCSW.

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

CONFIDENTIALITY STATEMENT

This office maintains a strict policy of confidentiality. The staff protects the privacy of clients by not disclosing their names or diagnoses to anyone outside of the treatment setting. Information relating to the diagnoses and treatment will be released to appropriate parties only if the client signs a content form authorizing the staff to do so.

All inquires about the clients, whether in writing, telephone, or in person, will be responded to with a statement similar to this, "We cannot confirm or deny any information unless we have a client's prior written consent."

There are rare occasions when we are required by law to suspend our policy of confidentiality:

- When we have good reason to believe that a client may be involved in the abuse or neglect of a child, elderly or disabled person;
- When we have good reason to believe that a client may be in danger to self or others;
- When emergency personnel in an emergency situation are requesting information necessary to treat the individual.

I have read and understand the above statement of confidentiality.

_____ _____

Print Name Date

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

Medical History Questionnaire

What is your goal in seeking treatment?_____

Who suggested that you come? _____

Have you ever had suicidal thoughts? Yes/No Have you ever attempted suicide? **Yes/No**

As a child, did you suffer from learning disabilities, hyperactivity or disciplinary problems? **Yes/No**

Do you have any children? **Yes/No** Names,ages:_____

List any allergies:_____

List the medications that you have been prescribed to you or you take over the counter:_____

Do you have, or have you had any medical problems? **Yes/No** Please explain below.

Current	**Past**	
☐	☐	Head injury w/LOC:_____
☐	☐	Asthma/bronchitis, respiratory problems:_____
☐	☐	Bowel/stomach problems/ulcers:_____
☐	☐	Heart Disease/chest pain:_____
☐	☐	Chronic cough:_____
☐	☐	Hypertension:_____
☐	☐	Kidney/bladder/prostate problems:_____
☐	☐	Thyroid problems/diabetes:_____
☐	☐	Recent surgery:_____
☐	☐	Female/gynecological problems:_____
☐	☐	Other medical problems:_____

Have you received mental health treatment in the past? **Yes/No**

Was it helpful? **Yes/No**

Please describe the treatment received._____

_____

Client Signature Date

_____ _____

Witness Date