Client Intake Form

Client Name _____**Preferred Name & Pronoun**_____

How did you hear about us? _____ **DOB** _____ **Age:** ___ **Today's Date** _____

Social Security Number ____-__-_____ *(for insurance purposes)* **Relationship Status:** _____

Contact # _____ **(**h/w/cell**) Alt # (optional)** _____**Email:** _____

Address _____

How did you hear about us? Online Search____ Physician _____ PT _____ Counselor _____

Present Partner's Name _____ **Number of months/years together** _____

Emergency Contact: Name _____ **Phone #** _____**Relation:** _____

Do you have any children? __Yes __ No If yes, please list their names, ages, and where they live.

_____

_____

Client's Employer: _____ **Address:** _____

Position: _____ **Years Employed:** _____

Client's Education – years of schooling _____ **College or University:** _____

Areas of Study: _____ **Degree(s):** _____

If Client is a Minor:

Father's Name: _____ **SSN:** _____ **DOB:**_____

Mother's Name: _____ **SSN:** _____ **DOB:**_____

Father's work phone: _____ **Mother's work phone:** _____

Primary Insurance: _____ **ID#**_____ **Group#**_____

Primary Insurance Phone #:_____

Secondary Insurance:_____ **ID#**_____ **Group#**_____

Secondary Insurance Phone #:_____

Self Pay: ___Yes ____ No

Presenting Concern: Briefly state the problem for which you want help

_____

_____

Brief History of Presenting Concern (How long have you had this concern?)

_____

_____

Current Medical Problems

_____

Medications, Drugs, Vitamins, Supplements, & Integrative Medicines you currently take, and reason for taking:_____

Have you ever experienced an addiction or dependence of a substance? Yes _____ No ____

If yes, which substance? _____

Have your close relatives (parents, grandparents, uncles, aunts, siblings) ever experienced an addiction or dependence of a substance? Yes _____ No ____. If yes, what relatives? _____

Have you ever experienced episodes of epilepsy or seizure?_____

Have you ever seen a counselor, psychologist, or psychiatrist before? _____

If yes, when and for what reasons? _____

_____

Did you find it helpful? Why or why not? _____

_____

Have you, in the past year, ever considered suicide? _____

Have you ever attempted suicide? _____

Do you have a spiritual/religious affiliation? If yes, please describe:_____

_____

Legal History

Presently, are you involved in any legal problems? _____ Have you had legal problems in the past? _____

If yes to either, please explain _____

_____

Name some of the top 5-10 things you love and/or enjoy doing

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

Transmission of Privileged Client Information

It is my policy not to release financial or personal information by answering machine, home, work, or cell phone unless specifically instructed by you, the client. In order to leave specific information, I require permission from you. Indicate below how I may release sensitive information about you. You may change this at any time by signing a new release of Privileged Client Information Form.

Home Phone ____ Yes ____ No Answering Machine ____ Yes ____ No Email ____ Yes ____ No

Work Phone ____ Yes ____ No Voice Mail ____ Yes ____ No *Email Address: _____

Cell Phone ____ Yes ____ No Fax Records ____ Yes ____ No _____

☐ ***Please check this box if you wish to be added to our email list where we send updates and announcements about trainings, support groups, and special events for clients.**

Release of Privileged Information

Information can only be released to the client, their guardian, the holder of their power of attorney or those specifically authorized by the client. Please list the names of those authorized to receive privileged information about you.

_____ _____ _____

Print Client's Name:_____

Client's or Guardian Signature: _____ Date: _____

Credit Card Information for Pre-Authorized Healthcare:

Your completion of this authorization form helps us to protect you from credit card fraud. All information entered on this form will be kept strictly confidential and within PCI Compliance.

Name on Card:_____

Billing Address: _____

Card Type: ___Visa ___ Mastercard

Card #:_____ Expiration Date: _____ CVC#:_____

I authorize 4Directions Counseling, LLC to keep my signature on file and to charge my Visa, MasterCard, or Discover as indicated in the policy. I understand the policy regarding paying for counseling services, copays, and/or missed appointments as described above. I agree to be bound by the policies, terms and conditions for counseling services. I understand this form is valid unless I cancel this authorization by written notice. If I choose to cancel this form, I assume full responsibility for paying my charges in full at the time of service or making alternative arrangements for paying. **I authorize my credit card to be charged 50% or 100% of my therapist's fee for sessions that are missed per the policy outlined in the Office Policies.**

Cardholder Signature (Required): _____

Attach a photocopy of the front and back of the signed credit card.

I hereby state that all information on this form is true to the best of my knowledge.

_____ _____

Client Signature **Date**

Acknowledgement of Receipt of the OFFICE POLICIES and Review of the HIPAA Notice of Privacy Practices

By signing this form, I acknowledge that:

- **I have received a copy of OFFICE POLICIES;**
- **I have seen the HIPAA notice of privacy practices;**
- **I have been offered an opportunity to review both of these documents and ask all of the questions I had about these policies and procedures; and,**
- **I am in agreement with the stated terms and conditions.**

_____ _____

Client- Signature Date

Social Media Policy Acknowledgment

By signing below, I acknowledge that I have read, understood, and retained a copy of the Social Media Policy which outlines office policies related to use of Social Media. I understand that if I have questions about this policy, I can bring them up when I meet with my therapist. I understand there may be times when this policy may need to be updated. I understand I will be notified in writing of any policy changes and will be provided with a copy of the updated policy.

_____

Client- Print Name

_____ _____

Client- Signature Date

_____ _____

Witness Signature Date

4Directions Counseling
Mind. Body. Heart. Spirit.

Consent to Professional Services

I, _____(client), hereby authorize Alexandra Milspaw, Ph.D. to provide professional services to myself/my child. I understand that Alexandra Milspaw is a Licensed Professional Counselor (License #PC006739) in the state of Pennsylvania. As such, I understand that Dr. Milspaw is only able to provide education, hypnosis, neuro-linguistic programming, and training in mindfulness-based stress reduction to clients living outside of Pennsylvania. I understand that Dr. Milspaw may recommend referral to another professional service provider if that is deemed to be in my best interest.

I consent to treatment and professional clinical practices with Dr. Milspaw freely of my own will if I am 14 years of age or older. I may grant authorization for a child of mine under the age of 14 to receive professional services. In matters of a child's treatment when that child's parents are separated or divorced and custody matters are at issue, I understand that both parents' rights will be respected, that the child will be considered the client, and that Dr. Milspaw shall treat the child from a stance of neutrality over the parents and in the best interest of the child. I understand that I may contact my managed care or insurance provider to obtain the names of other qualified professionals who may provide services to me.

_____ _____

Client's Signature **Date**

_____ _____

Client's Parent/Guardian Signature (under 14) **Date**

_____ _____

Client's Parent/Guardian Signature (under 14) **Date**

_____ _____

Counselor (witness) **Date**

ONLINE CONFIDENTIALITY NOTICE

By choosing to use the convenience of ONLINE (Email, Skype, FaceTime, Zoom, Signal, Doxy) communication with me, you understand and agree to the following:

The use of online communication may pose risks to the confidentiality of your health information. The internet is an open network and provides no inherent protection for confidential information. While my internet, email (Google Business Suite – HIPAA secure), and computer are protected by passwords and Sonicwall Firewall software, *I can not guarantee 100% protection*. You accept these risks. You must contact me by telephone or in person about critical or time-sensitive issues. There will be times when I will not have access to email. Be sure to contact me by telephone (484-894-1246) when necessary.

Please review your HIPAA Privacy Practice Notice for more information on HIPAA compliance. This is located in the Office Policies document on my website: www.4dcounseling.com.

By signing this form you are agreeing to the risks of online communication.

_____

Printed Name

_____ _____

Signature Today's Date