Date of Intake: _____

Chart Number: _____

Therapist Name: _____

Referral Source: _____

DSM-V Code: _____

Client Intake Form

Client Name: (Last, First, Middle) _____

Birth/Maiden Name: _____ **Preferred Name**: _____

Social Security Number: _____ **DOB:** _____ **Age:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Email:** _____

Race: □ Caucasian/White □ African American/Black □ Asian/Pacific Islander □ Latina/Latino/Latinx

□ Native American/Alaskan Native/Indigenous person □ Multi-Racial/Multi-Ethnic □ Other _____

Gender: □ Female □ Male □ Trans Male □ Trans Female □ Genderqueer □ Nonbinary □ Other _____

Preferred Pronouns: _____

Spiritual/Religious Affiliations: _____ **Active/Past Military:** _____

SIGNIFICANT OTHER/SPOUSE INFORMATION

Spouse/Significant Other's Name: (Last, First, Middle) _____

Social Security Number: _____ **DOB:** _____ **Age:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Email:** _____

Gender: □ Female □ Male □ Trans Male □ Trans Female □ Genderqueer □ Nonbinary □ Other _____

Preferred Pronouns: _____ **Preferred Name:** _____

PARENT/GUARDIAN INFORMATION (IF CLIENT IS UNDER 18):

Parent/Guardian Name: _____ **Phone:** _____

Social Security Number: _____ **(needed for insurance/billing purposes)**

Address: _____

DOB: _____ **Occupation:** _____ **Email:** _____

Parent/Guardian Name: _____ **Phone:** _____

Social Security Number: _____ **(needed for insurance/billing purposes)**

Address: _____

DOB: _____ **Occupation:** _____ **Email:** _____

Person Completing Form: _____ **Relationship to Child:** _____

EMERGENCY CONTACT

Emergency Contact: _____ **Relationship to Client:** _____

Address: _____

Phone: _____ **Email:** _____

EDUCATION/OCCUPATION STATUS

Status:

□ Full-Time Job □ Part-Time Job □ Unemployed □ Student □ Disabled □ Retired

Education Completed:

□ Less Than High School □ High School / GED □ Associate degree

□ Some College □ Bachelor's Degree □ Post Graduate Degree

Employer / School: _____ **Occupation / Year in School:** _____

Longest Place of Employment: _____ **Date Employed:** _____

FAMILY HISTORY

Describe your current living situation:

_____

_____

List all adults and children currently living in the home:

Name	Date of Birth	Relationship to Client

Please list family members/significant other not living in the home:

Name	Date of Birth	Relationship to Client

Parents' Relationship Status (Check all that apply):

□ Still Married □ Never Married □ Divorced at age: _____ □ Mother remarried □ Father remarried

□ Father deceased at age: _____ □ Mother deceased at age: _____ □ Raised By Relatives □ Raised by Foster Parent

Home Environment Growing Up:

□ Normal / Good □ Chaotic □ Witnessed Abuse □ Experienced Abuse

Please elaborate on or describe any special circumstances during your childhood:

Relationship Status:

□ Single □ In a relationship _____ years □ Engaged _____ years

□ Married _____ years □ Divorced _____ years □ Widowed _____ years

Relationship / Relationship Status Satisfaction:

□ Very Satisfied □ Satisfied □ Neutral □ Dissatisfied □ Very Dissatisfied

Please describe any relationship concerns:

LEGAL HISTORY

Check off any current or past legal concerns:

□ Driving Offenses □ Financial □ Spousal / Custody □ Violence □ Immigration □ Substance Use

Have you previously been imprisoned? □ Yes □ No

If yes, please explain:

Are you currently involved in a court case or legal matter? □ Yes □ No

If yes, please explain:

MEDICAL HISTORY

Primary Care Physician: _____ **Phone Number:** _____

Psychiatrist: _____ **Phone Number:** _____

Serious Medical Illnesses / Accidents (identify and give dates):

Are you currently on any medications? □ Yes □ No

If yes, please list dosage and condition it is treating:

Have you previously been hospitalized? □ Yes □ No

If yes, please describe:

Have you previously been treated by a counselor? □ Yes □ No

If yes, please list name of counselor, dates of treatment, and diagnosis:

_____

_____

Have you been the victim of physical or sexual abuse?	□ Yes	□ No
Do you or have you had suicidal thoughts?	□ Yes	□ No
Have you ever attempted suicide?	□ Yes	□ No
Do you or have you had an eating disorder?	□ Yes	□ No
Have you been previously treated for substance abuse?	□ Yes	□ No

If you answered 'yes' to any of the above questions, please describe below:

_____

_____

Please check all the items below that are of concern to you:

□ Alcohol / Drug Problem	□ Anger	□ Anxiety, Nervousness
□ Depression	□ Eating / Appetite Problem	□ Family Conflict
□ Friendship Conflict	□ Health Problem	□ Loneliness
□ Money / Financial Problem	□ Parent - Child Problem	□ Procrastination / Motivation
□ Relationship / Couple Problem	□ Self-Control	□ Self-Esteem
□ Sexual Concerns	□ Shyness	□ Sleep Problem
□ Spiritual / Existential Problem	□ Stress	□ Suicidal Thoughts / Behaviors
□ Traumatic Experience	□ Work / Career Concerns	□ Other: _____

Describe the main concern that brings you here:

_____

_____

_____

What are your main therapeutic goals?

Is there anything else you would like to share?

AKRON FAMILY INSTITUTE

INFORMED CONSENT

THERAPIST-CLIENT SERVICE AGREEMENT

Welcome to Akron Family Institute. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights regarding the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

THERAPY SERVICES

Therapy is a professional relationship between a client and a therapist that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who actively participate in it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress, and resolutions to specific problems. However, there are no guarantees about the outcomes of therapy. In order to be most successful, you will need to be very active in the therapy process, including working on things we discuss outside of sessions.

The first few sessions will involve a comprehensive evaluation of your needs and setting goals, as well as a discussion of an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you connect with another mental health professional.

APPOINTMENTS

Appointments or sessions will ordinarily be 45-50 minutes in duration. The frequency of sessions varies greatly and is based on several factors, such as the intensity of your symptoms and degree of functional impairment. The time scheduled for your appointment is assigned to you and you alone. Should you need to cancel or reschedule a session, I ask that you provide me with 24 hours' notice. If you miss a session without canceling or cancel with less than 24-hour notice, my policy is to collect $80 [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for missed or canceled sessions; thus, you will be responsible for the portion of the fee as described above. If it is possible, I will try to find another time to reschedule

the appointment. In addition, you are responsible for coming to your session on time; if you are late, your session will still need to end on time.

PROFESSIONAL FEES

In addition to appointments or sessions, it is my practice to charge on a prorated basis (I will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.

PROFESSIONAL RECORDS

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. Except in unusual circumstances that involve danger to yourself, you have the right to request a copy of those notes and/or that they are sent to another mental health professional. Because these are professional records, they contain complex information that may be difficult to accurately interpret and/or comprehend and could be upsetting to untrained readers. Thus, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other healthcare provider via the completion of a release of information (ROI) form.

CONFIDENTIALITY

My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document. Please remember that you may reopen the conversation anytime during our work together.

CONTACTING ME

I am rarely immediately available by telephone due to the nature and privacy of therapy. You may leave a message on my confidential voicemail, and your call will be returned as soon as possible. Please note that it may take a day or two for me to respond to non-urgent matters. I also do NOT check messages in the evenings when I am not working or on any weekends. I will attempt to inform you in advance of planned absences and provide you with the name of the colleague covering in my absence.

Should a more urgent issue arise, and you feel you cannot wait for a return call or are unable to keep yourself safe, you should: call 911, go to your local Hospital Emergency Room, call the National Suicide and Crisis Line (dial 988), or utilize the Crisis Text Line (text HOME to 741741).

OTHER RIGHTS

If you are dissatisfied with any aspect of our professional relationship and/or therapy, I encourage you to bring these concerns to my attention so that we may discuss and address them.

Your input is vital to our working relationship and the progress of therapy and will be addressed with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe, and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

TELEMENTAL HEALTH

Should you elect to participate in therapy via teletherapy, there are some important pieces of information for you to consider outlined below. You will need access to a telephone or a computer-like device (with cellular or internet access) in order to engage in teletherapy. Teletherapy has benefits and risks, which you and I will monitor throughout our work. You may decide to utilize teletherapy only or a combination of teletherapy and in-person visits in the office. It is possible that receiving teletherapy services may not be beneficial or appropriate, in which case we would shift to only in-person meetings in my office. You may also decide to discontinue teletherapy at any time. It should be noted that phone and/or video teletherapy sessions are never recorded by your therapist.

When utilizing teletherapy, I am responsible for ensuring security, privacy, and confidentiality at the end of teletherapy sessions. This includes implementing best practices and legal standards to protect your health care information. Akron Family Institute provides video teletherapy services using Doxy.Me. You must also create an appropriate space for your teletherapy sessions that affords you privacy and security. We will jointly plan for managing technology failures, mental health crises, and medical emergencies at the onset of teletherapy. * You MUST be in the state of Ohio at the time of your teletherapy session, or the session will be canceled. *

There are several potential benefits associated with teletherapy, including receiving services at times or in places where the service may not otherwise be available, receiving services in a more timely manner which may be less prone to delays than in-person meetings, and the ability to receive services when you are unable to travel to the therapist's office. There are also risks associated with teletherapy, including technical failures, limitations to your privacy, and a possible reduction in your therapist's ability to intervene directly in crises or emergencies.

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

_____ Date: _____

Signature of Patient or Personal Representative

_____ Date: _____

Printed Name of Patient or Personal Representative

_____ Date: _____

Signature of Therapist

FINANCIAL RESPONSIBILITY FORM

Client's Name: _____

Therapist Name: _____

Payment Options

Insurance: Your insurance policy is a contract between your insurance company and yourself; Akron Family Institute (AFI) is not a party to that contract. It is your responsibility to understand whether therapeutic services are covered, including your portion of the financial responsibility for said services. AFI cannot guarantee payment of your claims, and we do not accept responsibility for negotiating claims with your insurance companies or other persons on your behalf. You are responsible for payment of your (or your minor's) services in the event that your insurance company pays only a portion of your bill or rejects the claim(s). Thus, any portion of your bill not covered by your insurance is to be paid by you, and the balance is expected to be paid in full**.** We will provide supporting documentation at your request to assist you in appealing your rejected claims.

If you wish to utilize your insurance policy to pay for your services, you are required to provide insurance information prior to your initial appointment. AFI will subsequently bill your insurance for services rendered. Please note that you are responsible for providing updated insurance information to AFI yearly and/or in the event that you make any changes to your policy and/or plan. If an insurance claim is denied due to AFI having inaccurate and/or out-of-date insurance information, you are required to pay the balance in full.

Self-Pay: You may elect not to utilize your insurance to pay for services at AFI. In that case, you and your therapist will negotiate an out-of-pocket rate you will pay per session, and your insurance will NOT be billed. You assume responsibility for paying all charges on your account. A separate "Self-Pay" form may be completed with your therapist in order to outline the agreed-upon rate per session.

Regardless of your payment method, you are responsible to **pay co-payments, co-insurance, deductibles, and out-of-pocket (self-pay rate) **at the conclusion of your session**. If receiving teletherapy, you may make a payment through the AFI website or call the office to provide payment information over the phone.

Should you encounter financial hardship, please contact the office to set up a payment plan to remedy your balance. AFI reserves the right to send your account to collections after 90 days of non-payment on your account.

No Show & Late Cancellation Policy

It is AFI's policy to charge $80 for any appointments missed and/or canceled within less than 24 hours notice. These fees cannot be billed to your insurance, and you are responsible to pay them.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER COVERED BY INSURANCE OR NOT. I AUTHORIZE THE THERAPIST AND AFI STAFF ON BEHALF OF THE THERAPIST TO RELEASE ALL MEDICAL INFORMATION NECESSARY FOR TREATMENT, TO SECURE PAYMENT OR HEALTH CARE OPERATIONS.

Print Name of Person Responsible for Account: _____

X _____ _____

Signature of Person Responsible for Account Date

I AUTHORIZE THE ASSIGNMENT OF INSURANCE BENEFITS TO AKRON FAMILY INSTITUTE, INC.

X _____ _____

Signature of Person Responsible for Account Date

A $25.00 FEE IS CHARGED ON ALL RETURNED CHECKS.