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
3469 Fortuna Drive
Akron, Ohio 44312
Phone (330) 644-3469
Fax (330) 644-8519
www.akronfamilyinstitute.com

TELEMENTALHEALTH INFORMED CONSENT

You will need access to certain technological services and tools to engage in telemental health-based services with your provider. Telemental health has both benefits and risks, which you and your provider will be monitoring as you proceed with your work. It is possible that receiving services by telemental health will turn out to be inappropriate for you, and that you and your provider may have to cease work by telemental health. You can stop work by telemental health at any time without prejudice. You will need to participate in creating an appropriate space for your telemental health sessions. You will need to participate in making a plan for managing technology failures, mental health crises, and medical emergencies. Your provider follows security best practices and legal standards in order to protect your health care information, but you will also need to participate in maintaining your own security and privacy.

What is Telemental Health

"Telemental health" means, in short, the provision of mental health services with the provider and recipient of services being in separate locations and the services being delivered over electronic media.

Services delivered via telemental health rely on a number of electronic, often Internet-based, technology tools. These tools can include videoconferencing software, email, text messaging, virtual environments, specialized mobile health ("mHealth") apps, and others.

Akron Family Institute provides telemental health services using Doxy.Me. You will need access to Internet service and technological tools needed to use the above-listed tools in order to engage in telemental health work with your provider. If you have any questions or concerns about the above tools, please address them directly to your therapist so you can discuss their risks, benefits, and specific application to your treatment.

Benefits and Risks of Telemental Health

Receiving services via telemental health allows you to: Receive services at times or in places where the service may not otherwise be available. Receive services in a fashion that may be more convenient and less prone to delays than in-person meetings. Receive services when you are unable to travel to the service provider's office. The unique characteristics of telemental health media may also help some people make improved progress on health goals that may not have been otherwise achievable without telemental health.

Receiving services via telemental health has the following risks: Telemental health services can be impacted by technical failures, may introduce risks to your privacy, and may reduce your therapist's ability to directly intervene in crises or emergencies. Here is a non-exhaustive list of examples: Internet connections and cloud services could cease working or become too unstable to use Cloud-based service personnel, IT assistants, and malicious actors ("hackers") may have the ability to access your private information that is transmitted or stored in the process of telemental health-based service delivery. Computer or smartphone hardware can have sudden failures or run out of power, or local power services can go out. Interruptions may disrupt services at important moments, and your provider may be unable to reach you quickly or using the most effective tools. Your provider may also be unable to help you in-person.

There may be additional benefits and risks to telemental health services that arise from the lack of in-person contact or presence, the distance between you and your provider at the time of service, and the technological tools used to deliver services. Your therapist will assess these potential benefits and risks, sometimes in collaboration with you, as your relationship progresses.

Although it is well validated by research, service delivery via telemental health is not a good fit for every person. Your provider will continuously assess if working via telemental health is appropriate for your case. If it is not appropriate, your provider will help you find in-person providers with whom to continue services. Please talk to your therapist if you find the telemental health media so difficult to use that it distracts from the services being provided, if the medium causes trouble focusing on your services, or if there are any other reasons why the telemental health medium seems to be causing problems in receiving services. Raising your questions or concerns will not, by itself, result in termination of services. Bringing your concerns to your therapist is often a part of the process. You also have a right to stop receiving services by telemental health at any time without prejudice and use telephone therapy or continue with in-person therapy when it becomes available.

Your Telemental Health Environment
You will be responsible for creating a safe and confidential space during sessions. You should use a space that is free of other people. It should also be difficult or impossible for people outside the space to see or hear your interactions with your provider during the session. If you are unsure of how to do this, please ask your provider for assistance.

Our Communication Plan
At your first session, your therapist will develop a plan for backup communications in case of technology failures and a plan for responding to emergencies and mental health crises. You may contact your therapist by contacting 330-644-3469. Please note that your provider may not respond at all on weekends or holidays. Your provider may also respond sooner than stated in this policy. That does not mean they will always respond that quickly.

Please note that all textual messages you exchange with your provider, e.g. emails and text messages, will become a part of your health record. Your provider may coordinate care with one or more of your other providers. Your provider will use reasonable care to ensure that those communications are secure and that they safeguard your privacy.

Our Safety and Emergency Plan
As a recipient of telemental health-based services, you will need to participate in ensuring your safety during mental health crises, medical emergencies, and sessions that you have with your provider. Your therapist will require you to designate an emergency contact. You will need to provide permission for your provider to communicate with this person about your care during emergencies. Your provider will also develop with you a plan for what to do during mental health crises and emergencies, and a plan for how to keep your space safe during sessions. It is important that you engage with your provider in the creation of these plans and that you follow them when you need to.

Your Security and Privacy
Except where otherwise noted, your provider employs software and hardware tools that adhere to security best practices and applicable legal standards for the purposes of protecting your privacy and ensuring that records of your health care services are not lost or damaged. As with all things in telemental health, however, you also have a role to play in maintaining your security. Please use reasonable security protocols to protect the privacy of your own health care information. For example: when communicating with your provider, use devices and service accounts that are protected by unique passwords that only you know. Also, use the secure tools that your provider has supplied for communications.

Recordings
Please do not record video or audio sessions without your provider's consent. Making recordings can quickly and easily compromise your privacy and should be done so with great care. Your therapist will not record video or audio sessions.

The effective date of this notice is 3/19/2020.

Having been informed of the potential benefits and risks of telementalhealth therapy, I consent to treatment for myself and/or my child(ren).

X _____ _____
Signature of person authorized to consent Date

X _____ _____
Signature of person authorized to consent Date

_____ _____
Signature of minor Date

_____ _____
Signature of therapist Date

AKRON FAMILY INSTITUTE, INC.
3469 Fortuna Drive
Akron, Ohio 44312
Phone: 330-644-3469 Fax: 330-644-8519

FINANCIAL RESPONSIBILITY FORM

(To be completed by the responsible party 18 years old or older)

FULL PAYMENT OR INSURANCE COPAY IS DUE AT THE TIME OF THE SESSION!

Client's Name: _____

Client's Insurance ID #: _____

Policy Holder's Name: _____

Policy Holder's DOB: _____

***Policy Holder's Home Address*:** _____

Therapist Name: _____

APPOINTMENTS CANCELLED OR MISSED WITH LESS THAN 24 HOURS NOTICE WILL BE CHARGED TO YOU AT THE FULL FEE AND CANNOT BE BILLED TO YOUR INSURANCE COMPANY.

With the proper information, we will prepare and file your insurance claims as a service to you free of charge. You will need to file your own claims to your secondary insurance. We will assist you by providing you with an itemized statement that you can attach to your form and submit.

Your insurance policy is a contract between you and your insurance company. It is important that you understand its provisions. We **cannot** guarantee payment of your claims, and our office will **not** accept responsibility for negotiating claims with your insurance companies or other persons. The **client** is responsible for payment of his/her care, regardless of the status of the claim. If your insurance company pays only a portion of your bill or rejects the claim, any contact or explanation should be made by you, the policyholder. **Reduction or rejection of your claim by your insurance company does not relieve your financial obligation that you have incurred with our office.** If necessary, we will lend assistance when needed to help process your rejected claims.

In all cases, we will accept cash, check, MasterCard, Visa, and Discover.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT COVERED BY INSURANCE. 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.

AKRON FAMILY INSTITUTE, INC.
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Phone: 330-644-3469 Fax: 330-644-8519

CONSENT FOR TREATMENT

Client Name: _____

Client ID: _____

Name of Therapist: _____

Name of Supervisor: _____

Your therapist will work to develop a treatment plan that will address your specific needs and problems. This plan will generally consist of a number of counseling sessions. Your therapist may recommend that you participate in one or more of the following: individual counseling, group counseling, family or couples counseling, referral to other professionals, such as a physician, participation in other counseling programs, seminars and support groups, psychological or personality assessments or other tests.

Therapy has many potential benefits. These include, but are not limited to, greater awareness and understanding of self and others, positive change in behavior, and insight into personal issues. There are potential risks as well. These include, but are not limited to, an increased level of distressing feelings, changes which may be perceived as negative and changes in relationships.

I have been given a Client Information Form, read the form and understand its contents and I have had my questions about the therapy process answered. The Client Information Form explains office and billing procedures and cost of service. I understand and agree that release of Personal Health Information (PHI) to a staff therapist at AFI, other than my immediate therapist, might be necessary to ensure 24-hour coverage in case of emergencies.

I have read about confidentiality and I understand the limits of confidentiality including suspected child abuse, court ordered treatment and/or concerns that the client may be in danger to self or others.

Having been informed of the potential benefits and risks of therapy, I consent to treatment for myself and/or my child(ren).

X _____ _____
Signature of person authorized to consent — Date

X _____ _____
Signature of person authorized to consent — Date

_____ _____
Signature of minor — Date

_____ _____
Signature of therapist — Date

_____ _____
Signature of supervisor — Date

X _____ _____
I have received a copy of the NOTICE OF PRIVACY PRACTICES - BRIEF VERSION. I have read & understand information described in it. — **Date**