CONFIDENTIAL CLIENT INTAKE

GENERAL INFORMATION

Name:____ Date:_____/_____/______

Social Security #: _______-_______-__________ Date of Birth:_____/_____/______

Address: ____

City: ____________________________________ State: ______ Zip: _____________

Phone: (home)______________________________ (cell)_____________________________

Email: ___________________________________

May we call you at home? ❑ Yes ❑ No Okay to leave a message at home? ❑ Yes ❑ No

May we call your cell? ❑ Yes ❑ No Okay to leave a message on cell? ❑ Yes ❑ No

May we text your cell? ❑ Yes ❑ No Please list cell service provider (to text): _____________

May we email you? ❑ Yes ❑ No

Person to notify in the event of an emergency: ______________________________________

Emergency contact's relationship to you: _______________ Contact's phone: _________________

Whom may we thank for referring you? ____

EDUCATION & VOCATIONAL INFORMATION

Highest grade completed and/or degree(s) obtained: __________________________________

Current Occupation:_____________________________ Employer: ___________________________

Household annual income: ____

FAMILY INFORMATION

Present Relationship Status (check all that apply):

❑ Married/Partnered (yrs:___ mos:___)
❑ Single (yrs:___ mos:___)
❑ In a new relationship (6 mos or less)
❑ Dating: ❑ one person ❑ several persons
❑ Widow/Widower (yrs:___ mos:___)
❑ Other: _____________________

If married, partnered or in a primary relationship, do you live with your significant other? ❑ Yes ❑ No

Others living in your household:

Name	Relationship	Age

MEDICAL INFORMATION

Medical Doctor:_____________________________________ Phone: ___________________________

Date of last physical exam (approx) _____/_____/______

How would you rate your physical health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Psychiatrist:____ Phone: ___________________________

Other Specialist:____________________________________ Phone: ___________________________

List any medications you are currently taking (including non-prescription or herbal remedies): _______
____
____

Describe any current physical problems or concerns that you have: ____________________________
____
____

List any history of significant physical problems (e.g, broken bones, head injury, surgery): __________
____
____

CONSENT FOR TREATMENT AND OFFICE POLICY

This consent is to certify that you (client) give permission to the clinical staff at the Center for Healthy Sex to provide psychotherapy treatment. This includes but is not limited to all clinical and administrative staff members of the Center for Healthy Sex. You have a right to terminate the therapeutic relationship at any time without fault.

CHS ORGANIZATION

The clinical staff at CHS work as a treatment team and consult together regarding cases and you authorize the exchange of information between clinicians in order to provide the most effective treatment.

CONFIDENTIALITY

Under most circumstances, all communication between you and your therapist is confidential, unless permission is given by you to convey information to a third party outside of CHS. There are certain exceptions to this:

- When there is a reasonable suspicion of child abuse, dependent-adult or elder abuse.
- When a client threatens violence to an identifiable victim.

The law also allows the therapist to break confidence:

- When a client presents a danger of violence to others.
- When a client is likely to harm him/herself unless protective measures are taken.

Disclosure may also be required in certain legal proceedings. *If you have concerns about the content of our sessions and any legal proceedings in which you are involved or expect to be involved (e.g., child custody cases), please let your therapist know.*

Before such disclosure is made, every reasonable effort will be made to appropriately resolve these issues or to notify the client.

CONTACTING THERAPISTS

You may email your therapist at any time. Please be aware that therapists may not retrieve messages until their regular office hours. **If you have a life-threatening emergency, dial 911.**

APPOINTMENTS

Sessions are 50 minutes in length and begin at the scheduled appointment time. If you arrive late, your session will be shorter; if your therapist arrives late, your session will be extended to make up the time. If you must cancel a session, please let your therapist know at least 24 hours in advance. **You will be responsible for the full fee of any session canceled with less than 24 hours notice.** Appointments must be canceled via voice mail or email. All appointments with CHS therapists are to occur at the CHS offices at 9911 W. Pico Blvd., Suite 700, Los Angeles. For psychotherapy to be most effective, clients must not be under the influence of intoxicating substances. If your therapist feels it necessary, you may be asked to reschedule your appointment for another time; this will be considered a late cancellation.

FEES, BILLING & PAYMENTS

All services are billed at the standard rate. Sliding-scale fees may be established based on ability to pay. Clients pay for services at the beginning of each session, unless other arrangements have been made. Please notify your therapist if any problems arise that affect your ability to make timely payments. All payments for services are to be made payable directly to CHS, never to the name of the individual therapist.

If document preparation is required (e.g. legal proceedings, insurance appeals), clinicians reserve the right to bill for services at 100% of full fee.

In order to prevent any misunderstandings about payment for services, please be advised of the following:

(1) All services provided are billed directly to the client unless other arrangements have been made;
(2) Clients are personally responsible for payment at time of service via cash, credit card, check or money order;
(3) Statements can be provided for you to submit for insurance reimbursement;
(4) You are responsible for submitting all claims to your insurance provider;
(5) If payment is not received when services are rendered, payment plus a 4% fee may be applied to the credit/debit card on file if no other payment arrangements have been made.
(6) If your credit card is invalid and you have made no other payment arrangements, your past due balance may be sent to an agency for collection.

If you commit to group therapy, the weekly fee for group sessions is due even if you do not attend.

Payment Guarantee: You are individually responsible for all incurred charges, even if you direct us to bill another person. If you direct charges to be billed to another person, you represent that you are authorized to give you such direction. If you have directed charges to be billed to another person who fails to make payment, you will promptly pay on demand.

REGISTERED MFT INTERNS

If your therapist is an intern, s/he is an unlicensed counselor who will be consulting regularly regarding your case with their supervisor, the licensed Marriage and Family Therapist under whose license your intern is practicing.

MINOR CLIENTS

In the event that client is a minor (under age 18), signature of parent/guardian indicates permission to treat.

I have read, understand and agree to the information, guidelines and office policies stated above.

______________________________ _______________
Signature Date

____
Printed Name

PAYMENT INFORMATION

Credit Card Authorization: I,____(printed name) authorize the maintenance of valid credit card information to guarantee my chosen payment option. Charges will appear on your credit card statement as "AK, Inc."

Cardholder Name:______________________________________

Circle Card Type: Visa MC Discover AmEx

Billing Address:_________________________ City: ______________________Zip: ____________

Credit Card #____3 digit CVV code: ____________

Expiration date ____/_____/_____

Email Address: ____

Cardholder/Client Signature: _____________________________________Date:_____/_____/_____

Therapist Name:____

Please check your payment preference:

_____ 1. Cash / Check. Pay when services are rendered.
If payment is not made for two consecutive sessions, then your credit card on file will be charged in the amount of the outstanding balance plus a 4% processing fee.

______ 2. Credit Card. Automatic billing (session fee + 4% processing fee).

NOTE: Monthly statements will be provided upon request via email. Clients are responsible for submitting all claims to their insurance provider.

Payment Guarantee: I understand that I am individually responsible for all incurred charges, even if I direct you to bill another person. If I direct charges to be billed to another person, I represent that I am authorized to give you such direction. If I have directed you to bill charges to another person who fails to make payment promptly when due, I will promptly pay on demand. I understand that if I commit to joining a weekly therapy group, I am responsible for paying for the month of sessions in advance on the first day of the month, regardless of the number of group sessions I attend. I understand that all payments for services are to be made payable directly to CHS, never to the name of the individual therapist.

I understand there is a 24-hour cancellation policy and that I will be charged without providing 24 hours advance notice to cancel a session.

I have read, understand and agree to the information, authorization and guarantee stated above.

____ _______________
Signature Date

____
Printed Name