ELIZABETH MOFFETT, L.M.H.C.
Virtual Psychotherapy
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CLIENT INTAKE FORM

*****Please provide a copy of your drivers license and insurance card.

The following intake form is to be filled out by all new clients. You are welcome to print the paper version of this form and bring it with you to your intake appointment. The answers you provide will become part of your confidential mental health records. If you have any questions, feel free to discuss it with Elizabeth Moffett, LMHC.

Date: ___/___/___

First Name _____ Middle Name_____ Last Name _____
Address _____ Apt # _____
City _____ State _____ Zip _____ + _____
Primary Phone _____ Cell Phone _____ Email Address _____
Soc. Sec. #_____ Date of Birth_____ Age _____
Drivers LIcense Number_____ State_____

Spouse Name _____ Middle Name_____ Last Name _____
Soc. Sec. #_____ Date of Birth_____ Age _____

Name and ages of all children: _____

_____

Employer _____ Address_____
Employer Phone Number_____ Name of Supervisor_____

Insurance Company_____ Phone #_____
Member #_____Group #_____ Co-Pay_____
Deductible_____ Insured Name_____ Number of allowed visits:_____
Primary Care Physician_____ Phone Number_____
Address_____

Treating Psychiatrist_____ Phone Number_____
Address_____
Diagnosis_____
Last time you were treated by your psychiatrist?_____

Who may we contact in case of an emergency?_____ Phone #_____

Address_____ Relationship to you_____

Who referred you to this office?_____

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Please list any prescription medications you are currently taking:

_____
_____
_____

Please list any over the counter medications, vitamins, or herbal supplements you are currently taking:

_____
_____
_____

Briefly describe your reason for seeking counseling today:_____
_____
_____
_____

CLIENT CONTRACT/ RIGHTS & RESPONSIBILITIES:

Counseling and psychotherapy occur within a human relationship which is close and intimate, and yet which also needs to be professional in order to be therapeutic. I have found that keeping professional boundaries clear will help to facilitate your therapy. To optimize the therapeutic relationship I have developed the following guidelines for all of my patients.

APPOINTMENTS

- Should YOU CANCEL YOUR APPOINTMENT WITHOUT A FOURTY-EIGHT (48) HOUR NOTIFICATION, YOU WILL BE CHARGED THE FULL FEE. This is inclusive of all circumstances. The fee for cancelled appointments is payable at your next scheduled appointment. Additionally, ONLY ONE CANCELLED APPOINTMENT FOR AN EMERGENCY WILL BE ACCEPTED. ALL OTHER CANCELLED APPOINTMENTS AFTER THAT WILL BE BILLED THE NEXT SESSION. THE CLIENT IS RESPONSIBLE FOR THE ENTIRE AMOUNT OF THE FEE AS THE INSURANCE COMPANIES DO NOT PAY FOR MISSED APPOINTMENTS.
- I expect you to be responsible for making and keeping your appointments. Your appointment begins and ends at a specific time. Being tardy to your session will shorten your session accordingly. If late by more than 15 minutes, the client will be charged for the session and have to cancel till the next week.
- Individual, couple and family sessions are within a given amount of time, depending on the length of your session. Many clients have the tendency to avoid bringing up serious and complex problems until their sessions are almost over. You will do better for yourself if you bring up such problems at the beginning of the hour, not just before its end. Your sessions will end at the appointed time unless I am late in starting in which case you will have your full time allotment.
- Should you require additional sessions other than your normally scheduled ones, please ask me. I will do my best to schedule the extra appointment for you.
- Completion of homework assignments and other tasks as discussed and decided in session are an important part of treatment and you are required to comply with them for services to be effective. This also applies for additional referrals made as deemed necessary (such as individual, family, couple, or group, therapy,

psychiatric, substance abuse detox and/or inpatient/outpatient treatment, etc.).

- Upon completion of the Bio-psychosocial, this counselor will discuss a Master Problem List and your diagnosis as well as work with you on your Treatment Plan in the second session, or the session following completion of the Bio-psychosocial.
- Honesty, openness, active participation, and willingness to change are required for the services to be effective.
- In the event of an emergency, please call 911 or proceed to an emergency room for immediate intervention. You may give the attendant your providers contact information and also advise your provider of the situation by the next business day.

I have read and understand the policy on canceling appointments and giving 48 hour notice:

FEES

In this day and economy, money is a tremendous issue for all people. The therapeutic relationship is an important place to learn how to deal with financial obligations responsibly and successfully. I believe that the following guidelines will facilitate that goal.

The full fee (or the co-pay, depending on the agreed upon amount) is expected at the beginning of the counseling session. You may pay with either cash or check. Receipts are provided at the time of payment.

A service charge of $35.00 will be assessed for all returned checks.

The charge for each counseling session is $250.00 which is requested at the time of your appointment. Also, insurance is accepted and will be confirmed prior to your first counseling session of which all deductibles should be met or you are responsible for the allowable amount per session by the insurance company. All co-pays are due before each counseling session as well.

INSURANCE

The Health Insurance Portability and Accountability Act (HIPAA) outlines specific rights that you have as a patient. The following are your rights as a patient under HIPPA

1. Right to inspect you own health information and obtain a copy (excluding psychotherapy progress notes).
2. Right to request an amendment to health information ((excluding psychotherapy progress notes.)
3. Right to receive an accounting of disclosures for purposes other than treatment, payment and healthcare operations.
4. Right to request that uses and disclosures of health information is restricted, unless prohibited by court order or mandated abuse reporting.
5. Right to file a privacy complaint with your provider and to have that complaint reviewed by an objective reviewer.

As your provider, I am legally required, under Federal Law and HIPAA, to protect your health data and to release only the minimum necessary information for the purpose of treatment, payment, or healthcare operations, unless otherwise specifically authorized by you.

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I have read and understand my privacy rights as a patient:

CONFIDENTIALITY

You understand that I am a Licensed Mental Health Counselor in the State of Florida. You understand that whatever transpires between you and your therapist is confidential. Professional guidelines require all information given in individual and/or conjoint therapy sessions will be held in confidence and not discussed or written about outside of sessions.

When there is a couple being treated, confidentiality takes on another problem. Any information given in the individual sessions will not be held in confidence from the partner; that is, information in individual sessions needs to be openly discussed in couples sessions, unless otherwise specified and reasons made clear. This remains at the discretion of the therapist and will be discussed with all participants.

For several reasons, it is better to have the individual sessions fully confidential. Anything that the therapist says in an individual session cannot be talked about or paraphrased outside of that session without the expressed permission of the therapist. No information will be released unless you authorize such a release.

The therapist is understood to have the right to inform the proper persons and/or authorities if, in his judgment, you intend to harm yourself or another person(s), or if you are gravely disabled. Strict confidentiality is maintained except in instances involving child abuse, elder abuse, dependent abuse, and homicidal and/or suicidal communications. Please feel free to discuss with me any concerns you have regarding the confidentiality of these three highly sensitive issues. Information discussed in the therapy setting is held confidential and will not be disclosed without written permission except under the following conditions:

- The client threatens suicide.
- The client threatens to bring harm to another person(s), including murder, assault, or other physical harm.
- The client reports suspected child abuse, including but not limited to physical beatings and sexual abuse.
- The client reports suspected abuse or exploitation of an aged person or disabled adult.
- Records are requested through court order and signed by a judge.

Florida State law mandates that mental health professionals must report these situations to the appropriate persons and/or agencies. Communications between the clinician and client will otherwise be deemed confidential as stated under the laws of the State of Florida. I have read and have had the above fully explained to me and I consent and authorize that psychotherapeutic services be rendered to me as may be deemed necessary.

Therapist: Date:

_____

Client: Date:

_____

Spouse/Minor Child: Date:

_____

Client Initials _____