(Consultation with:____________________________)

Westport Family Counseling *

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Name of client ____ Date of birth __________________________

Please check box if client is a minor ☐ If client is a minor, please fill out this section with parent information

How did you hear about us? ____

Home address____

If client is a minor with divorced/separated parents, please list secondary address if applicable:

____

Home Phone ____________________________________ Mobile Phone ____

Email Address ____

How would you like to be contacted? ☐ Home Phone ☐ Mobile Phone ☐ Email ☐ Postal Mail ☐ Texting

Do we have your permission to identify ourselves, and/or ask for you by name? ☐ Yes ☐ No

Please list your primary care physician and their phone number. No one will be contacted without your written permission, or only in an emergency.

____

Please list an emergency contact, their relationship to you, and their phone number.

____

Have you had prior experience with psychotherapy? If so, please give the approximate time in your life, as well as some information about why you chose to have counseling at that time. ___________________________

____

____

Briefly describe your reason for this consultation. ____

____

____

Please indicate any family history of mental illness or addiction:

____

____

How many siblings do you have? ____ Names and ages? ____

____

Is there anything else you think we should know about your family history? __________________________________

____

____

Check the box to indicate the appropriate relationship status: ☐ married ☐ domestic partner ☐ divorced ☐ separated ☐ contemplating separation or divorce ☐ widowed ☐ single

If married, spouse's name and age? ______________________________

If you have children, what are their names and ages? ______________________________

What is your occupation/profession? ______________________________

Please list any health issues, such as allergies, respiratory or heart conditions, or problems with vision or hearing.

____

____

Are you in the care of a psychiatrist, or psychopharmacologist? If so, what is their name and number? No one will be contacted without your written permission, or only in an emergency. ______________________________

____

Please list any supplements and medications you are currently taking, if any.

____

____

Please list any accidents, or trauma that you have had.

____

____

Please check the box to indicate if you have witnessed a trauma. ☐ Yes ☐ No

Please check the box to indicate if you been a victim of domestic violence. ☐ Yes ☐ No

Have you ever miscarried, or aborted a pregnancy? ☐ Yes ☐ No

Did you experience a complicated pregnancy or complications in childbirth? ☐ Yes ☐ No

Do you dream? ☐ Yes ☐ No Do you remember your dreams? ☐ Yes ☐ No

Do you have nightmares? ☐ Yes ☐ No Sleep Apnea? ☐ Yes ☐ No

Restless sleep? ☐ Yes ☐ No Insomnia? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No Do you use illicit drugs (this information is confidential)? ☐ Yes ☐ No

Type of drugs ______________________________

Do you drink? ☐ Yes ☐ No Type: ☐ Cocktails ☐ Wine ☐ Beer ☐ Mixture Average # of drinks ______

When? ☐ Weekdays ☐ Weekends ☐ Before Noon ☐ "Cocktail Hour" ☐ With dinner ☐ Socially ☐ Rarely

Any DUI's or other arrests? If so, please explain ______________________________

Do you have any pending legal issues? If yes, please explain.

____

Have you ever attempted suicide? ☐ Yes ☐ No Have you ever cut yourself? ☐ Yes ☐ No

Please indicate if you have been diagnosed with, or think you might have an eating disorder? ☐ Yes ☐ No

If yes, please explain. ______________________________

Are you adopted? ☐ Yes ☐ No If so, do you have contact with your birth parents? ☐ Yes ☐ No

IF CLIENT IS A MINOR, PLEASE FILL OUT THIS SECTION:

School____ Grade____________________

Mother's name________________________ Mother's phone number_____________________

Father's name________________________ Father's phone number _____________________

If child has mobile phone, please list number ______________________________
If parents are divorced, who has custody? □ Mother □ Father □ Shared What is/are the living/visitation arrangement(s)? ______________________________
Which parent is responsible for payment? □ Mother □ Father

Please note any legal issues regarding the divorce, or affecting the child/children (i.e. restraining order, father not permitted to schedule appointments, not permitted to know/see confidential information, etc.):

____

Is there any other information that may be relevant to the therapy, or specific issues you feel should be addressed? Is there anyone else (such as a teacher) that may be a good source of information or support? We will need a release to communicate with them.

____

Insurance

-We do not accept insurance, but may be able to help in filling out forms or adding the member ID to the invoice. Please list your insurance company, your member ID and date of birth, and the address and phone number connected with the primary member. For couple's counseling, please list partner's insurance information, as well. **If you have your insurance card with you, please present it to your therapist, so that a copy can be made.**

Insurance company: ______________________________________

Member ID: ________________________ Group number: ________________________

Policy holder's name: ______________________________________

Policy holder's date of birth: ______________________________________

Policy holder's phone number: ______________________________________

Policy holder's address: ______________________________________

Policy holder's employer or school: ______________________________________

Please note: Insurance companies ask for information from us that helps them determine the **need** for coverage, **amount** of coverage, and **continuation** of coverage. If you intend to submit claims to your insurance company, your carrier may contact us by phone, fax, or mail for information such as age, date of birth, spelling of names, verification of address and telephone numbers, or treatment compliance. They may also wish to discuss, review, or confirm information such as diagnosis codes, procedure codes, dates of service, and type of therapy (i.e., individual counseling, couples counseling, psychodynamic counseling, etc.) **No confidential descriptive, narrative, or representational information will be discussed without a separate, signed authorization from the client. Corresponding with your insurance company is not an indication that WFC will accept payment for services from your insurance company.** To authorize this type of communication, please sign and date below.

Signature:____Date: ________________

Policies

- Fees must be paid at the time of each appointment. If you would prefer to be billed on a monthly basis, you must submit a credit card that can be billed recurrently; this card may be charged per your instruction, or— in the event of delinquent payment—this credit card may be charged at the discretion of WFC.

-Any charge or fee incurred by Westport Family Counseling as a result of checks drawn on insufficient funds, or because of a credit card dispute that is resolved in our favor, will be applied to the client's balance/account.

-Any damages incurred to the property of Westport Family Counseling by a client or the client's children or guests will be billed to the client.

All information discussed in therapy is confidential, with the following exceptions:

- If you have a signed written release.
- If it is determined that you are suicidal, homicidal, or acting out in such a way that a psychiatrist, medical doctor, or clinical staff feels that your safety or well-being is in jeopardy; or, if another person you speak about is deemed physically threatened by you; in this case, a hospital, your psychiatrist, and/or your "emergency contact" may be, though not necessarily be contacted.
- If your counselor, or doctor deem it necessary to receive confidential supervision, or consultation with WFC clinical staff.
- When a minor discusses information that suggests impaired judgment, or possible harm to self or others; parents or guardians may be notified; however, any information may be restricted to the specific issue of concern. Parents or guardians are not entitled to other information, unless the minor instructs the clinician to discuss this information with them.

Federal and state law mandates healthcare professionals to report violence, threat of homicidality, suicidality, child abuse/neglect, or reckless behavior linked to possible endangerment, *without exception*. This mandate applies to the belief, suspicion, intuition, or evidence of emergent conditions or danger; therefore, regardless of whether information is/has been confirmed, a legitimate report may be based on professional opinion that any of the above conditions presently exist or appear to be imminent. **As healthcare providers, Westport Family Counseling (WFC), and all those employed by, or affiliated with WFC have a duty to warn law enforcement and emergency medical services – as well as any third party – of any possible danger to client, self, or other. All WFC staff and affiliates are mandated reporters.**

-Contact information, or billing information may be viewed, filed, or processed by both clinical and administrative staff. Contact and billing information does not include any information that is discussed between you and your counselor, in confidence.

By signing, printing, and dating below, you acknowledge that you have read, understand, and agree to these terms and policies.

________________________________ ________________

Print name of client (or parent/guardian) Date

________________________________ ________________

Signature of client, (or parent/guardian) Date

Please indicate whether you are aware of HIPAA policies, or if you wish to review the policies.

☐ I am aware of HIPAA regulations.
☐ I would like a written explanation of HIPAA rights.

Summary of Notice of Privacy Practices

The following is a brief summary of your rights and responsibilities as detailed in the Notice of Privacy Practices.

Uses and Disclosures of Your Health Information: We may use the information we develop and collect for treatment by our practice or disclose the information to others to whom we refer you for treatment, for payment for these services and for certain health care "operations" such as improving the competence and quality of our staff and business planning and management. We may disclose your information to our business associates such as medical transcriptionists, billing services, and others who assist in the operations of our practice. We will communicate with the client regarding their treatment at WFC using the selected preferred method and any other instructions given by the client on the intake form. We will adapt to any verbal permission or retraction that you convey in treatment, or on your respective clinician's voicemail box, or the general voicemail box. We are not accountable for any error made due to a client's change of preferences if this change has not been communicated before the time of the error. We may also disclose information to your family about your location or general condition. If you are available and able, we will ask your consent first. Your medical information may be disclosed without your authorization as required by law, for public health purposes, healthcare oversight, including audits and investigations, judicial and administrative proceedings.

Other Uses and Disclosures: Except as described in the Notice, we will not use or disclose your medical information without your written authorization. You can revoke an authorization at any time except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights: You have a number of rights under state and/or federal law, which are subject to the terms and conditions specified in the Notice:

You may request restrictions on certain uses and disclosures of your information.
You may request that you receive your information from us in a certain way.
You may inspect and copy your medical records.
You may request an amendment to any record you believe is inaccurate.
You may request an accounting of disclosures made of your records.

Changes to the Notice: We reserve the right to change the Notice. If we do so, we will post it in our office and provide a copy upon request.

Complaints: You may file a complaint to our Privacy Official whose name is above or with the federal government as detailed in the Notice. You will not be penalized for filing any complaint.

I hereby acknowledge that I have received/reviewed a copy of Westport Family Counseling's Summary of Notices of Privacy Practices and that I may request a copy of the entire Notice at any time. I understand that this Summary is for convenience only and is not a substitute for reading the entire Notice and does not modify the terms of the Notice.

____
Print name of client (or parent/guardian)

____ __________________
Signature of client (or parent/guardian) Date

Westport Family Counseling*
Credit Card Authorization Form

***Herein**, **Westport Family Counseling** refers to all clinical and administrative staff under the auspices of **Westport Family Counseling, LLC**. **Westport Family Counseling** may also be referred to as "**WFC.**"

I, ____________________________, understand that WFC is a private pay therapy group, and that I am responsible for their full fee, regardless of health insurance coverage. If I cannot, or do not attend a session, I must give 24 hours notice. It is clear to me that if I do not give 24 hours notice, I will be charged for the amount of time scheduled. A single session is equal to 45 minutes. Having read, understood, and agreed to these terms, I hereby authorize WFC to charge $_____________ per session:

☐ AMEX ☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ OTHER

Name as it appears on card:____

Card number:____

Expiration date: _____ /_____

Security code: ______________

(For American Express, the security code is the 4-digit number on the front. For all other cards, it is a three-digit number on the back).

Billing address: ____

Billing phone number: ___________________________________

Having read this form and the above WFC policies carefully, I agree to be responsible for all charges, and I fully understand that there are no refunds.

In the case of a dispute, this form, and the corresponding appointment date(s), time(s) and charge(s) will be submitted to any financial or legal institution/person(s) associated with guaranteeing payment to WFC.

My authorization and agreement are indicated by printing my name, dating, and signing below.

____

Print Name

____ ______________________

Sign Date