McDermott Counseling
Adult Intake

Client's name: _____ SSN ___ - ___ - ____ DOB: ___ / ___ / ___ Age: ___

Address: _____ Apt. # ____ City: _____ State: _____ Zip: _____

Phone (primary): _____ (work): _____ (email): _____

How did you hear about our office? _____

Insurance Company Name: _____ ID # : _____ Group # : _____

Answer the following regarding PRIMARY INSURED: Name: _____ DOB: ___ / ___ / ___

Address: _____

SSN: ___ - ___ - ____ Telephone # ( ) ___ - ____ Employer: _____

Secondary Insurance Company Name _____ ID#: _____ Group#: _____

Answer the following regarding SECONDARY INSURED: Name: _____ DOB: ___ / ___ / ___

Address: _____

SSN: ___ - ___ - ____ Telephone # ( ) ___ - ____ Employer: _____

INSURANCE DISCLAIMER: Failure to provide **all necessary insurance information** may lead to billing issues. If issues arise because the patient failed to provide McDermott Counseling with any and all insurance information**, fault will be found with the patient and not McDermott Counseling**. It is the patient's responsibility to provide all medical insurance coverage. If the correct information is not provided and claims are denied any outstanding balances will be the patients responsibility to pay.

X _____

PLEASE ACKNOWLEDGE YOU HAVE READ THE ABOVE INSURANCE DISCLAIMER

Person to contact in case of Emergency: _____

Relationship: _____ Phone (home): _____ (cell): _____

Primary reason(s) for seeking services: _____

FAMILY INFORMATION

			Living		Living with you		Your Relationship?		
Relationship	Name	Age	Yes	No	Yes	No	Good	Fair	Poor
Mother			☐	☐	☐	☐	☐	☐	☐
Father			☐	☐	☐	☐	☐	☐	☐
Spouse / S.O.			☐	☐	☐	☐	☐	☐	☐
Children			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐
(Other):			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐

What compelled you to seek treatment at this time? _____

_____

Where do you work/ attend school?_____

_____

Symptoms

Please check all symptoms you may have felt in the last few months:

□ Aggression □ Anger □ Irritability □ Worrying □ Fear □ Anxiety □ Panic Attacks □ Social Anxiety

□ Depression □ Loneliness □ Withdrawing □ Hopelessness □ Worthlessness □ Fatigue □ Isolating

□ Lack of Motivation □ Distractible □ Lack of Focus □ impulsivity □ Easily Lose Things

□ Excessive Talking □ Fidgety □Defiance □Concrete Thinking □ Drugs □ Alcohol Use/Abuse □ Vaping

□ Gambling □ Eating Disorder □ Hallucinations □ Paranoia □ Voices □ Elevated Mood □ Mood Shifts

□Risky Behavior □ Judgment Errors □ Phobias □ Repetitive Actions □ Recurring Thoughts

□ Body Image Concerns □ Suicidal Thoughts □ Thoughts Hurting Others □ Self-Harming □ Sick Often

□ Sexual Difficulties □ Sexual Addiction □ Sleeping Problems □ Relationship Problems

Please list any other symptoms not stated above:

_____

_____

How do symptoms impair your functioning?_____

_____

How long have you been dealing with these symptoms?_____

Is there a history of mental health issues in your family? No __ Yes__,

If yes please explain:_____

What is your goal with therapy?_____

What are your strengths?_____

What are your hobbies?_____

What are your coping skills?_____

Any questions for your therapist?_____

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Intimate Partner ☐ Cohabiting ☐ Separated How Long? _____

PARENTAL INFORMATION: ☐ Parents still married and together ☐ Parents Separated ☐ Parents Divorced

☐ Father remarried _____number or times ☐ Mother remarried _____number or times

Have either of your parents or anyone in your family ever suffered from a mental illness (i.e. depression, anxiety, schizophrenia)?

☐ Yes ☐ No If yes, please describe:_____

_____

DEVELOPMENTAL HISTORY

Are there special, unusual, or traumatic circumstances that affected your development? ☐ Yes ☐ No Describe:_____

_____

Has there been history of child abuse? ☐ Yes ☐ No If Yes, which type(s)? ☐ Sexual ☐ Physical ☐Verbal / Emotional

Describe:_____

Other childhood issues: _____

TRAUMA HISTORY

The following are examples of trauma. Please check all that you have personally experienced or witnessed.

Domestic Violence ____ Witnessed Violence ____ Natural Disasters ____ Vicarious Trauma ____

Medical Trauma ____ Sexual Abuse ____ Physical Assault ____ Car Accident:____ Other:_____

If you checked any, please explain (ages, others involved, outcome):

_____

_____

_____

SOCIAL RELATIONSHIPS

Check how you generally get along with other people: (check all that apply) ☐ Affectionate ☐ Angry ☐ Aggressive ☐ Shy

☐ Withdrawn ☐ Outgoing ☐Passive ☐ Friendly ☐ Other (specify): _____

Sexual orientation: _____ Sexual dysfunctions? ☐ Yes ☐ No If yes describe:_____

CULTURAL/ETHNIC

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? ☐ Yes ☐ No If yes describe:_____

_____

SPIRITUAL/RELIGIOUS

How important to you are spiritual matters? ☐ Not at all ☐ Little ☐ Moderate ☐ Very Much ☐ Not Currently Practicing

Are you affiliated with a spiritual or religious group? ☐ Yes ☐ No Name and Type:_____

Were you raised within a spiritual or religious group? ☐ Yes ☐ No Name and Type:_____

LEGAL

Are you involved in any active cases (traffic, civil, criminal)? ☐ Yes ☐ No If yes describe:_____

Have you ever been arrested (i.e. DUI) ? ☐ Yes ☐ No If yes describe:_____

EDUCATION & EMPLOYMENT

Years of Education: _____ Current Occupation: _____ Employer: _____

MEDICAL

List any health concerns: _____

List any surgeries (including cosmetic procedures): _____

List all medications presently taking (Rx and over-the-counter): _____

_____

CHEMICAL USE HISTORY

	Age of First use	Age of last use	amount used	Used in past (circle) 30 days		48 hours	
Alcohol				Yes	No	Yes	No
Amphetamines				Yes	No	Yes	No
Cocaine/Crack				Yes	No	Yes	No
Opiates				Yes	No	Yes	No
Marijuana				Yes	No	Yes	No
Caffeine				Yes	No	Yes	No
Nicotine				Yes	No	Yes	No
Prescription drugs				Yes	No	Yes	No

Does/Has someone in your family present/past have/had a problem with drugs or alcohol? ☐ Yes ☐ No If Yes, describe: _____

_____

Have you ever received treatment for substance abuse issues? ☐ Yes ☐ No If yes, where:_____

COUNSELING/PRIOR TREATMENT HISTORY

Have you ever been to counseling / therapy / or seen a psychiatrist for any reason? ☐ Yes ☐ No If Yes, Name of Provider and dates of service: _____

Have you ever had suicidal thoughts/attempts? ☐ Yes ☐ No If Yes, When:_____

Have you ever been Hospitalized? ☐ Yes ☐ No If Yes, Where & When:_____

Please Explain_____

_____

_____

CONSENT FOR TREATMENT & PATIENT AGREEMENT

Welcome to McDermott Counseling. Your therapy is an important joint venture in which you and your therapist will work together to understand the problems that you are having and to explore your options and obstacles in resolving those problems. This document contains information about our professional services and business policies. Should you have any questions about these at any time, we will be happy to answer them.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on many factors, including the personalities of the patient and therapist, your early experiences, your life stage, and your goals. There are several different approaches that can be used. Psychotherapy requires an active effort on your part and a working relationship with your therapist in which you work together to identify the issues you would like to resolve.

Psychotherapy can have both benefits and risks. Since therapy often involves discussing difficult aspects of your life, you may experience uncomfortable feelings and changes in your behaviors/thoughts. This is a normal part of the therapeutic process. It is important that you consider carefully whether these risks are worth the benefits to you of changing. Most people who take these risks find that therapy is helpful. It often leads to a significant reduction of feelings of distress, better relationships, and resolutions of specific problems.

Your first sessions will involve an evaluation of your needs. By the end of the evaluation, your therapist will be able to offer you some first impressions of what our work will include and a treatment plan/goals if you decide to continue.

You have the right to stop treatment at any time. The process of termination is generally one of the most important times in therapy. It is highly recommended that you spend at least three to four sessions to work through this process of termination.

CONFIDENTIALITY

With certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. We cannot and will not tell anyone else what you have told us, or even that you are in therapy with us, without your prior written permission. The following are legal exceptions to your right to confidentiality. Should one of these situations occur, we will make every effort to discuss it with you fully before taking any action.

- If we reasonably suspect that a person under 18 or over 65, or a disabled person, is being abused or has been abused, we must file a report with the appropriate state agency.

- If a patient threatens to harm him/herself, we may be obligated to seek hospitalization for the patient, or to contact family members or others who can help provide protection.

- If a patient communicates a serious threat of physical violence against an identifiable victim, we must take protective actions, including notifying the potential victim and contacting the police. We may also seek hospitalization of the patient or contact others who can assist in protecting the victim.

- We may find it helpful to consult with professional colleagues about our work from time to time. In these consultations, we make every effort to avoid revealing the identity of our patient. The consultant is also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together.

- If you are involved in a court proceeding and a request is made for information about the services that we have provided you and/or the records of them, such information is protected by therapist-patient privilege law. We cannot provide any information without your written authorization, a court order, or compulsory process (a subpoena) or discovery request from another party to the court proceeding where we do not have grounds for objecting under state law (or you have instructed us

not to object). If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

APPOINTMENTS

Psychotherapy appointments are usually scheduled for 45 or 60 minute sessions. We agree to meet here and to be on time. **Sessions are scheduled on the hour and end 15 minutes before the next hour, or on the hour**. If we are ever unable to start on time, we ask for your understanding, and we assure you that you will receive the full time agreed to. If you are late, we will probably be unable to meet for the full time

CANCELLATION POLICY

Because the scheduling of an appointment involves the reservation of a large amount of time set aside specifically for you, a minimum of ***24 hours notice is required for rescheduling or canceling an appointment***. **Insurance companies do not pay for missed appointments; therefore, your credit card will be charged $115 if you do not show up for your appointment or do not cancel within the 24 hour timeframe.**

PROFESSIONAL FEES

Your first session will be an initial assessment. and the fee is **$250**. The fee per 38- 45 minute session is **$150**. The fee for a 53-60 minute session is **$185**. **Fees are to be paid at the time of each visit.** We charge this amount for other professional services you may need, though we will break down the hourly cost if we work for periods of less than one hour. Other services include report writing, telephone conversations (lasting longer than 5 minutes), attending meetings or consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of us. When fees are not paid for services rendered, a collection agency may be used and given appropriate billing and financial information, (non-clinical information). A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

INSURANCE BENEFITS

You the patient are responsible for knowing and understanding your own insurance policy and benefits. McDermott Counseling is an out of network provider, therefore is not held to the limitations of your plans usual and customary rate schedule. Should your insurance company not consider the entire fee, you will be responsible for the remaining balance. McDermott Counseling is not responsible for misquoted benefits. It is always advisable for you to contact your insurance plan and confirm your benefits and obtain a reference number for the call.

CONTACTING US

We are often not immediately available by telephone. When we are unavailable, our telephones are answered by voicemail, which we monitor during normal business hours. We will make every effort to return your call on the same day you make it, with the exception of calls on weekends and holidays. If you are unable to reach us and feel that you cannot wait for us to return your call, you can contact the Mental Health Info line at (800)321-1616, National Crisis Hotline (800)784-2433, Tulare County Crisis Line (559) 733-6877, or 911

I have read the above information and have had an opportunity to ask questions which clarify the conditions under which I consent to treatment. I give McDermott Counseling permission to provide evaluation and psychotherapy. I am aware that Esmerelda Alvarez AMFT is a Marriage and Family Associate Supervised by Dr. Hoehing (Lic#21474); and Haley Gee AMFT, Regina Nieto AMFT and Isabella Mausser AMFT are supervised by Rachel McDermott (Lic# MFC 39944).

Signature of patient _____ Date _____

Credit Card/HSA Authorization Agreement

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.

I, _____, authorize McDermott Counseling, to use the credit card information below to charge my card in the following events:

SESSIONS: Session fees will be charged on the day of (or after) a scheduled session.
MISSED SESSIONS: I understand that when I schedule an appointment, that time is held for me, and that insurance will not pay for missed sessions. Therefore, I understand if I cancel a session without 24 hours' notice or if I do not show for the appointment, I authorize McDermott Counseling to charge my credit card for the missed session. I understand I will be charged the full session fee (not just my insurance copayment, if using insurance).
FORGOTTEN PAYMENTS: I understand that if I do not have my payment when I come to a session, the expected payment will be charged.
RETURNED CHECKS: If a check is returned unpaid, the amount of the check will be charged to the credit card, plus any returned check fees.
HEALTH SAVINGS ACCOUNT (HSA) CARDS: If I have a HSA credit card, I authorize McDermott Counseling to charge the card for all services at the time of the session or afterward. I understand that missed sessions cannot be billed to HSA credit cards.

I will not dispute charges ("charge back") with the credit card company for sessions I have received or appointments I have missed according to the above policy.
I understand that my card will automatically be charged $**115**, in the event of cancellations in less than 24 hours. I understand that failure to attend will also result in a charge of $**115**.

X_____

PLEASE SIGN HERE CONFORMING YOU ARE AWARE OF OUR 24-HOUR CANCELLATION POLICY

My credit card information: VISA MC AMEX

Name as it appears on card:_____

Credit card number:_____

Expiration date:_____

Security code: (3 digits on back of card, 4 digits on front of AmEx):_____

Zip code:_____

"I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied."

Signature:_____

Client Written Name:_____

Date:_____/_____/_____