ANDREA TANG COUNSELING SERVICES, LLC
Taking Next Steps Together

260 NW Peacock Blvd. Suite 102 Port Saint Lucie, FL 34986 O: (772) 999-1438 F: (772) 361-6861 E: info@atangcounseling.com

CLIENT INTAKE FORM

Please fill in the information below and bring it with you to your first session. Please note: information provided on this form is protected as confidential information.

PERSONAL INFORMATION:

Name: _____ DATE: _____

Parent/Legal Guardian Name: *(if client under 18)*: _____

Address: _____ CITY: _____ ZIP: _____

Home/Cell Phone: _____/_____ May we leave a message? Yes ___ No ___

Email: _____ May we respond by email? Yes ___ No ___

*Please note: Email correspondence is not considered to be a confidential medium of communication.

DOB: _____ Age: _____ Identify as: _____

Marital Status:

Never Married _____ Domestic Partnership _____ Married _____

Separated _____ Divorced _____ Widowed _____

Referred by (if any): _____

HISTORY:

Personal Information

Have you previously received any type of mental health services- counseling, psychotherapy, psychiatric services? Yes ___ No ___

Previous therapist/practitioner: _____ Phone: _____

Current prescription medication: Yes ___ No ___ If yes, please list: _____

_____

Current/past prescribed psychiatric medication: Yes ___ No ___ If yes, please list: _____

_____

General and Mental Health Information

How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing: _____

_____

How would you rate your current sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good

Please list any specific sleep problems you are currently experiencing: _____

_____

How many times per week do you generally exercise? _____ Types of exercise? _____

_____

Please list any difficulties you experience with your appetite or eating problems: _____

_____

Are you currently experiencing overwhelming sadness, grief, or depression? Yes ___ No ___ If yes, please list: _____ How long? _____

Are you currently experiencing anxiety, panic attacks or have any phobias? Yes ___ No ___ If yes, please explain: _____

Are you currently experiencing any chronic pain? Yes ___ No ___

If yes, please describe: _____

Do you drink alcohol more than once a week? Yes ___ No ___ How much weekly? _____

Recreational drug use? Yes ___ No ___

Daily Weekly Monthly Infrequently Never

Are you currently in a romantic relationship? Yes ___ No ___ For how long? _____

How would you rate your relationship (scale of 1-10, 1 being poor and 10 being exceptional?) _____

What significant life changes or stressful events have you experienced recently? _____

_____

FAMILY AND MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following: If yes, please indicate the family members' relationship to you in the space provided (i.e., father, grandmother, uncle, etc.)

CONDITION	YES/NO	FAMILY MEMBER
Alcohol/Substance Abuse	Yes/No	_____
Anxiety	Yes/No	_____
Depression	Yes/No	_____
Domestic Violence	Yes/No	_____
Eating Disorders	Yes/No	_____
Obesity	Yes/No	_____
Obsessive Compulsive Behavior	Yes/No	_____
Schizophrenia	Yes/No	_____
Suicide Attempts	Yes/No	_____

ADDITIONAL INFORMATION:

Are you currently employed? Yes ___ No ___ If yes, what is your current employment? _____

Do you enjoy your work? Yes ___ No ___ Is there anything stressful about your current work? _____

_____

Do you consider yourself to be spiritual or religious? If yes, describe your faith or belief: _____

_____

What do you consider to be some of your strengths? _____

_____

What do you consider to be some of your weaknesses? _____

_____

What would you like to accomplish out of your time in therapy? _____

_____

Consent for Treatment
and Limits of Liability

Limits of Services and Assumption of Risks:

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Limits of Confidentiality:

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect
If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults
If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

Prenatal Exposure to Controlled Substances
Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers
Insurance companies and other third-party payers are given information that they request regarding services to the clients.

The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

Cancellation Policy

If you are unable to attend an appointment, we request that you provide at least 24 hours advanced notice to our office. Since we are unable to use this time for another client, please note that you will be billed for the entire cost of your scheduled appointment if it is not timely cancelled, unless such cancellation is due to illness or an emergency.

For cancellations made with less than 24 hour notice (unless due to illness or an emergency) or a scheduled appointment that is completely missed, you will be mailed a bill directly for the full session fee.

We appreciate your help in keeping the office schedule running timely and efficiently.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

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Assignment of Benefits and Release of Information

I hereby authorize my insurance benefits to be paid directly to Andrea Tang Counseling Services, LLC. I understand that I am financially responsible for all co-pays, deductibles, and non-covered services. I authorize the release of any medical and mental health records necessary to process insurance claims on my behalf.

Client's/Patient's Name

Signature of Client/Patient/Responsible Party **Date**

Acknowledgment of Self-Pay Status

I have health insurance, but I do not want my health insurance billed and have elected to pay out of pocket at the rate set by Andrea Tang Counseling Services, LLC. By signing this, my mental health records and billing information **WILL NOT** be released to my health insurance plan for any reason unless I give written permission to do so. I understand that payment is due at the time of service.

Client's/Patient's Name

Signature of Client/Patient/Responsible Party **Date**

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Credit Card Authorization Form

Please complete all fields so that we may run your card for your teletherapy services. This authorization will remain in effect until services terminate or authorization is revoked by notifying the office. You may cancel this authorization at any time by contacting Andrea Tang Counseling Services at 772-999-1438 or emailing tyoung@atangcounseling.com

Credit Card Information

Cardholder Name (as shown on card): _____

Card Number _____ **CVV** _____

Expiration Date (mm/yy): _____ **Billing Zip Code** _____

I, _____, authorize Andrea Tang Counseling Services, LLC to charge my credit card above for agreed upon session fees. I understand that my information will be saved on file for future transactions on my account.

_____ _____

Client Signature Date

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I, _____ (Name) Date of Birth, _____

hereby give my permission to Andrea Tang Counseling Services, LLC to release or request from a third party, information contained in my medical record. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in federal law.

This information will be Released/Requested upon request to the following: **(client to leave this blank)**

_____

____ Treatment Plans

____ Progress/Process Notes

____ Health / Medical Records (if applicable)

____ Letter(s) of Progress

____ Bio Psychosocial Evaluation / Assessment

____ Other (Specify):

(In the case of notes documenting or analyzing the contents of conversation during a private counseling session i.e., process notes, such records may be protected from disclosure under the HIPAA Privacy Rule).

_____(initial) I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to the authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Andrea Tang Counseling Services, LLC.

_____(initial) I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and Andrea Tang Counseling Services, LLC will not base my treatment or payment whether I provide authorization for the requested use or disclosure. I understand that I may inspect or copy the information to be disclosed, as provided in CFR 164.524 (with reasonable charge).

_____(initial) I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws or Andrea Tang Counseling Services, LLC. Andrea Tang Counseling Services, LLC will not be held liable for information disclosed to another party per the client's request.

_____ (initial) I understand that Andrea Tang Counseling Services, LLC will release only the minimum amount of information necessary to fulfill a request. This authorization shall expire when the client is discharged from the current episode of care (treatment has been completed, the client rejects/ declines/drops out of treatment, is referred elsewhere, moves, or in the case of the client's death). This agreement is subject to revocation in writing at any time.

_____ _____ _____ _____

Signature Client/Next of Kin/Guardian Date Signature Therapist Date

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Teletherapy Informed Consent Form

I _____ (name of client) hereby consent to engaging in teletherapy with Andrea Tang, *EdS, LMHC, NCC, CCTP* as part of my psychotherapy. I understand that "teletherapy" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

I understand that I have the following rights with respect to teletherapy:
(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
(2) The laws that protect the confidentiality of my personal information also apply to teletherapy. As such, I understand that the information disclosed by me while in therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the teletherapy interaction to researchers or other entities shall not occur without my written consent.
(3) I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my personal or therapeutic information could be disrupted or distorted by technical failures; the transmission of my personal or therapeutic information could be interrupted by unauthorized persons; and/or the electronic storage of my personal or therapeutic information could be accessed by unauthorized persons. In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services. I also understand that a variety of alternative methods of care may be available to me (e.g. face-to-face encounters) and that I may choose one or more of these at any time.
(4) Finally, I understand there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve and in some cases may even get worse. I understand that I may benefit from teletherapy but that results cannot be guaranteed or assured.
(5) I understand that I have a right to access my personal or therapeutic information and copies of records in accordance with Florida law. I have read and understand the information provided above. I have discussed it with my psychotherapist, and all my questions have been answered to my satisfaction.

_____ _____

Signature of Patient or parent/legal guardian of patient Date