I N T A K E F O R M

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: _____

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated

□ Divorced □ Widowed

Please list any children/age: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?
□ Yes
□ No

Please list: _____

_____

Have you ever been prescribed psychiatric medication?
□ Yes
□ No

Please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in _____

4. Please list any difficulties you experience with your appetite or eating patterns

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
□ No
□ Yes

If yes, please describe _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

FAMILY 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 member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List 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:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation:

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

_____

4. What do you consider to be some of your weakness?

_____

_____

_____

_____

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

_____

_____

_____

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

_____

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

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

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

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

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

_____
Today's Date

CANCELLATION POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment.

Thank you for your consideration regarding this important matter.

_____

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

_____

Today's Date

ANDREA TANG COUNSELING SERVICES, LLC
Taking Next Steps Together

1555 NW St Lucie West Blvd. Suite 201 Port Saint Lucie, FL 34986 O: (772) 999-1438 F: (772) 361-6861 E: info@atangcounseling.com

Teletherapy Informed Consent Form

I _____ (name of client) hereby consent to engaging in teletherapy with Andrea Tang, *LMHC, NCC, CCTP, CCTHP* 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 during the course of my 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 of my questions have been answered to my satisfaction.

_____ _____
Signature of Patient or parent/legal guardian of patient Date

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION/RECORDS

ANDREA TANG COUNSELING SERVICES, LLC
1555 NW St Lucie West Blvd. Suite 201 Port Saint Lucie, FL 34986 O: (772) 999-1438 F: (772) 361-6861 E: info@atangcounseling.com

I,_____, DOB:_____
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:

_____

To/From: First and last name, phone, and address of person(s)

To Be Released: *from Andrea Tang Counseling Services*	To Be Requested: *from Third Parties*
____Treatment Plans	____Treatment Plans
____Process Notes	____Process Notes
____Health/Medical Records (if applicable)	____Health/Medical/Academic Records
____Letter(s) of Progress	____Psychological/Psychiatric Evaluations/Assessments
____Bio Psychosocial Evaluation/Assessment	____Court Documents
____Verbal Communication	____Verbal Communication
____Other (Specify): _____	____Other (Specify): _____

** In the case of notes documenting or analyzing the contents of conversation during a private counseling session (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 or not 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 CFR164.524 (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.

Release:	Request:
_____	_____
Signature Client/Next of Kin/Guardian Date	Signature Client/Next of Kin/Guardian Date
_____	_____
Signature Therapist/ Credentials Date	Signature Therapist/ Credentials 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 or as per my insurance cost-share. I understand that my information will be saved on file for future transactions on my account

_____ _____

Client Signature Date