DISCOVERY COUNSELING CENTER

Adult Intake Form

Contact Information

Name: _____ **DOB**: _____
(First) (MI) (Last)

Address: _____
(Street) (City) (State) (Zip)

Home Phone: (___) _____ **Cell Phone:** (___) _____ **Email**: _____

May the therapist leave voice & text messages? Yes No **If necessary mail may be sent to my address?** Yes No

Sex: M F Other **Marital Status:** Single Married Divorced Separated Widowed Living Together

In Case of Emergency Notify

Name: _____ **Phone:** _____ **Relationship:** _____

Current Life Issues / Problems

What concerns have brought you to Discovery Counseling Center? _____

_____

Any current or past issues surrounding:

- ☐ Appetite/Food Related
- ☐ Sleep or Nightmares
- ☐ Concentration or Memory
- ☐ Relationships
- ☐ School or Employment Stress
- ☐ Safety Concerns
- ☐ Behavioral Concerns
- ☐ Substance Use
- ☐ Self-Harm or Suicidality

Is there any personal or family history of:

- ☐ Alcoholism
- ☐ Substance Abuse
- ☐ Mental or Emotional Illness
- ☐ Prolonged Physical Illness
- ☐ Psychiatric Hospitalization
- ☐ Suicidal Thoughts or Attempts
- ☐ Trauma or Abuse
- ☐ Other: _____

Level of education: _____ **If current student, school:** _____ **Grade**: _____

Occupation/Employer: _____ **How Long:** ____

Children or others living in the home:

_____ **DOB:** _____ **At Home?** Yes No

_____ **DOB**: _____ **At Home?** Yes No

_____ **DOB**: _____ **At Home?** Yes No

Cultural / Historical Background Information

Language(s) spoken/written fluently: _____ **Ethnic Group(s) you most identify with:** _____

Any Religious Affiliation(s): _____ **How often do you participate:** _____

Any previous therapy dates: _____ **Therapist(s)**: _____

Are you currently under the care of another therapist? Yes No **If so, whom?** _____

Are you currently having Legal or Financial problems: (if so, please specify) _____

Health Information

Any illnesses, injuries, impairments/limitations, allergies: _____

Primary Care Physician: _____ **Date Last Physical Exam:** _____

Prescription or Over the Counter Medication(s): _____ **Dosage(s):** _____

Describe the quantity and frequency of your use of the following:

- ☐ Alcohol _____
- ☐ Drugs _____
- ☐ Marijuana _____
- ☐ Cigarettes _____
- ☐ Vaping _____
- ☐ Caffeine _____

Signature: _____ **Date:** _____

Discovery Counseling Center Consent for Treatment (ADULT)

Patient's Name: _____ **Date:** _____

Therapist's Name: _____ # _____

☐ Fully Licensed Therapist ☐ Registered Associate Therapist* ☐ Intern/Trainee Therapist*

*Works under the supervision of Discovery Counseling Center's certified licensed Supervisors with whom cases are discussed.

CONFIDENTIALITY STATEMENT:

The therapist-client relationship and any information shared in therapy is confidential. I understand information will only be released with my written permission (which may be revoked in writing). According to California law, therapists are mandated reporters and must breach confidentiality under the following circumstances when there is a reasonable suspicion of:

A. An incident of **child abuse**, past or present
B. An incident of **elder abuse or dependent adult abuse**
C. Serious **threat of harm to oneself or to others** or to property
D. Certain other legal situations, such as a **court order** or a court-ordered evaluation

FINANCIAL AGREEMENT**:** ☐ Fee set by Insurance Company ☐ Private Pay Fee $_____

I understand that while Discovery Counseling Center will submit claims to help me receive the maximum benefits allowed through my insurance I ultimately remain responsible for payment of all therapeutic services. I accept this responsibility and agree to the following:

1. **I am responsible for paying all co-payments or private pay fees at the time of service** via cash, check, or credit card (I understand there will be a $50 co-pay for sessions prior to confirmation of insurance coverage for which any resulting credit will be reimbursed and any resulting debt will be my responsibility).
2. **Appointments must be cancelled at least 24 hours in advance to avoid incurring a charge** and in order to keep my scheduled appointment slot.
3. Fee for late cancellations is equal to half the charge for a full session. Since insurance will not cover missed appointments, the missed appointment charge includes half of what insurance normally pays for session.
4. Due to the number of individuals seeking therapy, after 3 late cancellations or no-shows, Discovery therapists reserve the right to move my appointment to another slot or offer to transfer me to another counseling agency.
5. I am responsible for any returned check fees ($25) or any charges incurred if legal or collections services are required for delinquent accounts.
6. I agree to provide information about changes to my insurance coverage as soon as possible. If coverage terminates for any reason, **I understand I am responsible for all fees not covered by my insurance**.
7. I understand that periodically, therapist fee rates are subject to change. In this event, I will be given a month's notice of any fee increases.
8. Administrative staff may handle office and billing transactions as needed in order for insurance claims to be submitted.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**:**

_____ I acknowledge being offered the *HIPAA Notice of Privacy Practices*, which provides information about how my protected health information may be used or disclosed. The DCC *HIPAA Notice of Privacy Practices* is subject to change. If the notice is changed, you may obtain a copy of the revised notice by contacting 408-778-5120 or from the DCC web site.

THERAPUTIC RISKS, BENEFITS, AND EMERGENCIES

All services are performed in the DCC offices and are conducted as 45-minute individual, couple, or family sessions unless otherwise stated.

I understand there is a possibility that stated goals may change during the therapeutic process and I understand that this agreement does not guarantee that I will attain desired outcomes. Our participation in therapy is voluntary and I may withdraw at any time.

In case of urgent situations between sessions, I have been told to call you and specify that it is urgent and you will call us back as soon as possible. I have also been told that if it is an emergency to call 9-1-1 or the Emergency Psychiatric Services at 408-885-6100 or go to the nearest hospital emergency room.

I have read the above information and understand that I am liable for all costs of treatment. I give consent to receive psychotherapy treatment.

Print _____Sign _____Date _____

DISCOVERY
COUNSELING CENTER

Client Credit Card Pre-Authorization

PAYMENT INFORMATION

Client Name: _____

Client Billing Address: _____

_____

Type of Card: ☐ VISA ☐ MasterCard ☐ American Express ☐ Discover

Card Number: _____

Expiration Date: _____ Security Code: _____
(last three digits on card, last four on AMEX)

The undersigned guarantees performance of the financial provisions of this agreement.

Card Holder Name: _____

Signature of Card Holder: _____ Date: _____

CHARGE POLICY

_____ (initial) Being the authorized cardholder, by signing above I understand and agree to the terms set forth in this agreement, agree to pay, and specifically authorize Discovery Counseling Center to charge my credit card for the services provided. I further agree that in the event my credit card becomes invalid, I will provide a new valid credit card upon request, to be charged for the payment of any outstanding balances owed.

_____ (initial) Charges made for actual services performed by Discovery Counseling Center are non-refundable. In the event of pre-payment any unused funds will be refunded within 30 days.