reCONNECT
INTEGRATIVE TRAUMA TREATMENT CENTER

Confidential Client Intake Form

Date: _____

Name: _____ Date of Birth: _____ ☐ Male ☐ Female
Month/Day/Year

Address: _____
Street *City* *State/Country* *Zip Code/Postal Code*

Home Phone: _____ May we leave a message at home? ☐ Yes ☐ No

Cell Phone: _____ May we leave a message on cell phone? ☐ Yes ☐ No

Email address: _____ May we email you? ☐ Yes ☐ No

Person to notify in case of emergency: _____ Phone number: _____

Relationship Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Dating ☐ Domestic partnership

Referred by: _____

GENERAL MEDICAL INFORMATION

Primary physician: _____ Phone number: _____

How would you rate your current physical health? ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

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

How would you rate your current sleeping habits? ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

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

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

Do you exercise? ☐ Yes ☐ No If yes, what type and how many times per week? _____

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

Have you (*currently or in the past*) been prescribed psychotropic medication? ☐ Yes ☐ No
If yes, the name of medication: Current dose:

Are you currently being treated by a psychiatrist? ☐ Yes ☐ No
If yes, name of the treating psychiatrist:

Are you taking any other prescribed medication? ☐ Yes ☐ No
If yes, name of medication:

Have you (*currently or in the past*) used any recreational drugs? ☐ Yes ☐ No
If yes, how often? Date of last use:

Do you drink alcohol? ☐ Yes ☐ No If yes, how many times per week?

Do you smoke cigarettes? ☐ Yes ☐ No

Have you ever been hospitalized? ☐ Yes ☐ No If yes, please describe the reason:

Have you ever had a surgery? ☐ Yes ☐ No

Have you had chemotherapy? ☐ Yes ☐ No

Have you ever had head concussion? ☐ Yes ☐ No

GENERAL MENTAL HEALTH INFORMATION

What is the main reason that you are seeking treatment today?

Have you ever attempted suicide? ☐ Yes ☐ No

Do you meditate? ☐ Yes ☐ No

Have you ever had a near death experience? ☐ Yes ☐ No

Have you recently lost a loved one? ☐ Yes ☐ No

(*For women*) Have you given birth that was stressful beyond the ordinary? ☐ Yes ☐ No

CONSENT FOR TREATMENT AND OFFICE POLICY

This consent is to certify that you (client) give permission to the clinical staff at Reconnect to provide psychotherapy treatment. This includes but not limited to all clinical and administrative staff members of Reconnect. You have a right to terminate the therapeutic relationship at any time without fault.

The clinical staff at Reconnect work as a treatment team and consult together regarding cases and you authorize the exchange of information between clinicians in order to provide the most effective treatment.

If your therapist is an intern, s/he is an unlicensed counselor who will be consulting regularly regarding your case with their supervisor, Dr. Karol Darsa, Psy 19847, under whose license your intern is practicing.

Limits of Confidentiality

Under most circumstances, all communication between you and your therapist is confidential, unless permission is given by you to convey information to a third party outside of Reconnect. There are certain exceptions to this:

- When there is a reasonable suspicion of child abuse, dependent-adult or elder abuse.
- When a client threatens violence to an identifiable victim.
- When a client is likely to harm him/herself unless protective measures are taken.
- If a client admits prenatal exposure to controlled substances that are potentially harmful.
- Insurance companies (when applicable) and other third-party payers are given information that they request regarding services to clients.
- When CARF (Commission on Accreditation for Rehabilitation Facilities) needs to review clients' files in order to insure the quality of care.

Disclosure may also be required in certain legal proceedings. If you have concerns about the content of our session and any legal proceedings in which you are involved or expect to be involved, please let your therapist know.

Contacting Therapists

For life threatening emergency, you may call 911. For other times, you may call your therapist during business hours or you may email your therapist at any time.

Appointments

Sessions are 50 minutes in length (unless scheduled for longer sessions) and begin at the scheduled appointment time. If you arrive late, your session will be shorter. If you must cancel your session, please let your therapist know at least 48 business hours (Monday 8:30am – Friday 4:00 pm) in advance. You will be responsible for the full fee of any session canceled with less than 48 business hours (Monday 8:30am – Friday 4:00 pm) notice.

For treatment to be most effective, clients must not be under the influence of intoxicating substances. If your therapist feels it necessary, you may be asked to reschedule your appointment for another time; this will be considered a late cancellation.

In case you seek any type of treatment outside of Reconnect while you are seeing a practitioner in our center, please advice your therapist about such treatment.

Fees; Billing & Payments

All services are biled at the standard rate. Weekly psychotherapy clients pay for services at the beginning of each session. You can pay cash, check or credit card. If you signed up for one of our longer treatment packages, payment has to be made at least 48 hours in advance. All payments for services are to be made directly to Reconnect and never to the name of the individual therapist.

If document preparation is required (e.g. legal proceedings, insurance appeals), clinicians reserve the right to bill for services at 100% of full fee.

Reconnect is not in network with any insurance, however we accept PPO and will be ale to bill you only a portion of the treatment. For detailed insurance information, please talk to your therapist since it depends on the health plan you are on.

If payment is not received when services are rendered, payment plus a 4% fee may be applied to the credit/debit card on file if no other payment arrangements have been made.

I have read, understood, and agree to the information, authorization and guarantee stated above, and I have received a copy.

Printed Name *Signature* *Date*

TREATMENT PLAN

I understand, and agree to the above treatment plan.

Printed Name *Signature* *Date*