

Angela T. Williams, LCSW, Inc.
Licensed Clinical Social Worker (LCS 24723)
3711 Long Beach Blvd., Suite 1016D
Long Beach, CA 90807
(562) 439-5117 phone (562) 394-9211 fax

CLIENT INTAKE FORM

Today's Date _____ Referred by _____

CLIENT INFORMATION

Last Name _____ First Name _____

Address _____
Number Street (Apt. #) City State Zip Code

Home phone _____ Work/Cell phone _____

Date of Birth _____ Social Security No. _____

Occupation _____
Marital Status: Single Married Domestic Partner
 Coupled Separated Divorced
 Widowed

MEDICAL INFORMATION

Health care providers: Please list any physicians, psychiatrists, therapists, healers, naturopaths, herbalists, etc. whose services you currently use. (They will not be contacted without permission.)

<u>Name</u>	<u>Title</u>	<u>Phone number</u>	<u>Fax number</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medications/Remedies: Please list any medications (alternative or traditional) that are prescribed and/or taken at this time.

<u>Medication Name</u>	<u>Condition Prescribed for</u>	<u>Date Began</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies _____

INSURANCE/PAYOR INFORMATION

Insured Name _____ DOB _____ SSN _____

Insurance Carrier _____ Policy or ID # _____
Medical and/or Behavioral Healthcare Organization

Insurance Telephone # _____ Group # _____

Insurance Address _____ Other Contact Info _____
Effective Date _____

EMERGENCY CONTACT

This person will only be contacted in the case of a medical/health emergency while receiving services or with your permission.

Name/Relationship _____ Phone _____

Address _____

INFORMED CONSENT

The following is a disclosure statement about the individual and/or group therapy relationship, the factors involved, and clarification of the rights and responsibilities of the therapist and client. A clearly defined structure for therapy creates the safety and support needed to take risks and feel empowered and healthy. Please read these guidelines carefully, we will go over them verbally, and you may ask questions for clarification before signing your consent to start therapy.

My Philosophy of Therapy:

I utilize a strengths-based perspective where therapy is directed at supporting coping behavior, change and growth, and emphasizes new possibilities and options. I believe that you are the expert on your own experiences and see therapy as one tool that can be used to heal from past experiences and grow in new directions. I will focus on your strengths and facilitate a safe space to work on mutually agreed upon goals based on the issues that led you to seek assistance. My approach to therapy draws on several theoretical orientations, and the techniques I utilize are determined by the needs of the client. I might suggest that you consult with a physician or health care provider, if I feel that your symptoms might benefit from other treatments. In most cases, I will work concurrently with other resources that you find helpful including support groups, body work, psychiatric medication, alternative/holistic remedies, hypnosis, etc.

Treatment Risks:

There are risks and benefits of seeking psychotherapy. Sometimes painful feelings and issues emerge as we work together—it seems to get worse, before it gets better. Approaching thoughts or feelings you have tried not to acknowledge may be very difficult. In some cases, psychotherapy uncovers such profoundly intense emotions, that temporary disability or hospitalization may occur. Sometimes in psychotherapy, clients choose to make major life decisions including decisions about family, relationships, employment, and lifestyles. Decisions made during the psychotherapy process may result from calling into question old beliefs and values that may bring about changes not originally intended. There are no guarantees that our work together will provide you with the outcomes you desire.

Confidentiality:

With certain specific exceptions, you have the right to confidentiality. I will not share what you have told me with anyone else, or even let someone know you are in therapy without your prior written permission except in certain situations. There are cases, where I am legally mandated or ethically allowed to break confidentiality:

- ❖ If you threaten to harm someone else
- ❖ If you threaten to harm yourself
- ❖ Where there is any suspected incidence(s) of child abuse, neglect, or molestation
- ❖ Where there is any suspected incidence(s) of abuse of an elderly or dependent adult
- ❖ By subpoena, deposition, or order of the court
- ❖ As required by the Patriot Act (if the FBI determines that records are relevant to an authorized investigation to protect against international terrorism or clandestine intelligence activities)

I will consult with other licensed professionals regarding our work together in order to obtain feedback about clinical issues and concerns; your name and identifying information will not be disclosed in these consultations however.

Records of our therapy sessions are kept in locked files, in a secure location, where they cannot be accessed by anyone other than me. Following the termination of our work together, your records will be kept for seven years after our last session in locked files, in a secure location, where they cannot be accessed by anyone other than me before they are destroyed. I am the only person in my office with access to client information as I have no other

employees. In the event of my own emergency, severe illness, or death, I have designated another mental health care professional (also bound by confidentiality) to access my files and contact clients.

Boundaries and Arrangements:

I do not engage in relationships other than the therapy relationship with clients. The therapy relationship, while somewhat intense, is unlike a friendship. Specific boundaries are set for your protection, to provide a safe space for the work of therapy to be done without my personal feelings/life choices/advice disrupting the process. I never have sexual or intimate relationships, friendships, business partnerships, etc. with current or former clients. Psychotherapy is never value-free and I will happily explain the value/interpretation behind my philosophy of counseling, any techniques I employ, or any reading materials suggested. I reserve the right to refuse to answer personal questions, unrelated to my training or competence to serve as your therapist.

Fees:

My regular fee for therapy is \$100 for a 50-minute session of individual therapy. Group rates are set at the time of the group-screening interview. The fee is to be paid at the beginning of each session by cash or check. I do not accept barter for therapy. There is a \$25 fee for checks not paid due to non-sufficient funds.

If you are using insurance coverage to pay for your therapy, you may still have a copayment or coinsurance charge due. I can bill your insurance directly provided you authorize the insurance payment be made directly to Angela T. Williams, LCSW, Inc. You are responsible to know the limits and specifics, including copayment amounts and deductibles, of your insurance coverage.

Regardless of your insurance coverage, you are solely responsible for any charges incurred. With most insurance companies, there are procedures you can use to appeal denied charges. If your insurance company denies payment for services, you are responsible for the charges incurred.

I reserve a percentage of my appointments for sliding scale clients, living on SSI, Disability, Social Security, or other fixed incomes. I will let you know, upon request, if any of these spaces are available.

Appointments and cancellation policies:

Services are by appointment only. The length of an appointment is 50 minutes. Please give me at least 24-hours notice for any appointments you need to cancel. Because each appointment is reserved specifically for you, it is necessary to charge a late cancellation fee of \$50 for appointments that are cancelled with less than 24-hours notice. The same fee applies if you fail to show for a scheduled appointment without calling to cancel. I cannot bill your insurance for a missed appointment or late cancellation. You are responsible for missed appointment and late cancellation fees.

Messages and emergency procedures:

In the case of a life-threatening emergency, please call 9-1-1. If you have a psychiatric emergency, please get to the nearest hospital emergency room and ask for the psychiatrist on duty. If you have a primary care physician, he/she may also be contacted to facilitate emergency psychiatric care. If you need to reach me, you can telephone me at (562) 439-5117; leave me a confidential message. I will normally respond to voicemail messages by the end of the next business day. I will make every effort to return your call quickly.

I will give you notice of my absences in advance. I will provide you with the number of another therapist(s) who could assist you in my absence.

Termination:

Termination is usually mutually agreed upon by the client and the therapist. As we meet the goals we set, we will enter a process of ending our therapy relationship. You have the right to end therapy at any time, for any reason. If it is foreseeable that our work together will become outside of my area of competence and training to help you, I may refer you to other professionals that I believe might meet your needs. I cannot however guarantee that they will accept you for therapy. If you commit violence, threaten violence, verbally or physically, or harass myself, my family or other professionals in the office, I reserve the right to terminate our therapy relationship immediately.

Your rights:

You may questions and/or refuse therapeutic or diagnostic procedures or methods or request additional information regarding procedures at any time. If you are dissatisfied with your services with me, I hope that you will provide me with that feedback so that we may try to remedy the problem, or find referrals more suitable to your needs. I take your feedback seriously, and treat it with respect and concern.

Concerns may also be brought to the attention of the California Board of Behavioral Sciences (www.bbs.ca.gov).

In working toward a common goal, you and I will form a unique partnership based on trust, clear boundaries, and confidentiality. It is my hope that this will prove to be empowering and beneficial to you.

Agreement:

I consent to participate in psychotherapy services with Angela T. Williams, LCSW, Inc. and agree to the policies as detailed in the above paragraphs. I have had the opportunity to ask questions and clarify my understanding of these policies and there are no misunderstandings or disagreements. I have read, understand, and agree to the “Notice of Privacy Practices” and have received a copy for my records.

Signature_____ Date_____

I authorize my insurance carrier to pay benefits associated with my care directly to Angela T. Williams, LCSW, Inc. and authorize the release of information necessary to coordinate benefits, treatment, and payment (including quality improvement efforts where applicable).

Signature_____ Date_____

Therapist:

I have reviewed the above policies and informed consent with the patient.

Signature_____ Date_____

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APPOINTMENT AND CANCELLATION POLICIES

Psychotherapy services are by appointment only. The length of the appointment is 50 minutes. Please give me 24 hours notice for any appointment you will need to cancel (leaving a voice mail message notification is acceptable).

Because each appointment time is reserved specifically for you, it is necessary to charge a **late cancellation fee of \$50 for appointments that are cancelled with less than 24 hours notice. The same fee will apply if you fail to show for a scheduled appointment without calling to cancel.** If you are using insurance to pay for your psychotherapy services, please be aware that your insurance will not pay for a missed appointment or late cancellation fee.

Understanding of Appointment and Cancellation Policies

I have read the above statement and understand that if I fail to notify Angela T. Williams within 24 hours that I will be canceling my scheduled appointment, or fail to show for an appointment, I will be personally responsible for the \$50 late cancellation or no-show fee.

Signature _____

Date _____