Sarasota Therapy, LLC
New Client Intake Sheet

Date: _____

Client Name: _____
(Please print) Last, First Middle Nickname
If minor, Parent/guardian name(s): _____

Emergency Contact:_____Cell:_____Relationship_____

Email address: _____

Sex: _____ Age: _____ SS#_____/_____/_____ Birth date: _____/_____/_____

Address_____

City; _____State:_____Zip:_____

Phone: Home_____ Work: _____ Cell: _____

# of Children_____ Marital Status (Please circle): Married Divorced Separated Widowed Single

Education (Please Circle): Grade School Some High School High School/GED
Some College College Graduate Master's Degree Doctoral Degree
Race (Please Circle): Caucasian Black Asian Native American Other_____
Ethnicity: _____
IF YOU HAVE YOUR CARD, PLEASE PRESENT AND ONLY COMPLETE INSURED'S NAME AND DOB.
Insurance Company: _____ **Insured's Name:** _____ID#_____

Claims Address: _____ **Insured's DOB**_____

Phone#_____ Ins Plan Name or Program: _____

Insured's Policy Group: _____ AUTHORIZATION #_____
_____
Referred by: _____ Previous Counseling? _____

If yes, When? _____ Where? _____ How long?_____

Why? _____

Current Reason for seeking counseling:
_____

Permissions:

I would like to receive text reminders of my appointments YES NO

Cell Number _____

Best way to contact (circle) : TEXT EMAIL TELEPHONE____Can a message be left? YES NO

Signature_____

Sarasota Therapy, LLC
Information and Consent

Qualifications/Experience:

This document is designed to inform you about my background and insure you understand our professional relationship.

I earned a Master of Social Work degree and a Bachelor of Arts degree in Psychology from Rutgers's University in New Jersey. I have worked in the human service and counseling field since my Freshman year in college with a variety of populations (individuals with developmental disabilities and/or severe and persistent mental illness, homeless individuals and families, teens and teen mothers in foster care, people with a myriad of addictions and everyday people who just want to work out an issue affecting them; all ranging in age from 5-92) and in a variety of settings (group homes, medical centers, independent living programs, homeless shelters, school and in people's homes). I became a Licensed Clinical Social Worker (LCSW) in Florida in 2006, established my private practice in 2008 and have been practicing full-time since 2014. In addition to being an LCSW, I also hold the following credentials, Substance Abuse Professional (SAP), Certified Master's Addiction Professional (MCAP), Certified Electronic Therapist (CET) and Master Addiction Counselor (MAC). Always feel free to ask me any questions regarding my experience, training or about any of my pets!

Fees, Cancellations and Insurance Reimbursement:

The fee for each session will be due and must be paid at the end of each session. Cash or personal checks are acceptable as payment. In the event you will be unable to keep an appointment, you must notify me 24 hours in advance. Because this time is reserved especially for you, I must charge for unused/cancelled appointments. **Your insurance company cannot and will not be billed for this fee.** You will also be charged for any fees (20% of outstanding balance) incurred for the collection of your account, if it is necessary.

Diagnostic Interview (First session):	160.00
Individual/Family/Couple Therapy Sessions (45-50 minutes):	190.00
Letters (extensive will be additional)	35.00
Mental Health/Substance Abuse Evaluation	200.00
Preparation of Client Report	200.00
Court/Expert Testimony	200.00
No Show/Late Cancel Fee	70.00
DUI Fees will be discussed at intake	Varied

(Fees are calculated on an hourly basis for all services. Billable clinical hours include evaluation services, travel time, telephone conference, preparation time with client/attorney and direct testimony.)

Please note sessions are based on a 45-minute hour. Your time begins at the time scheduled, if you are late for your appointment, time will not be added at the end, as it interferes with others' scheduled appointment times. If you are more than 15 minutes late for a scheduled appointment *without calling/texting to notify clinician* it will be considered a 'no show' and you will be responsible for payment in full of session.
Some health insurance companies will pay for counseling services and some will not. In addition, most require that I provide a diagnosis before they will pay for services. Some reasons people seek counseling do not qualify for reimbursement. If a qualifying diagnosis is appropriate in your case, I will inform you of the diagnosis I plan to render before I submit it to your insurance company. Any diagnosis will become part of your permanent insurance records.

If you wish to seek payment for my services from an insurance company, I will be happy, as a courtesy, to submit for reimbursement from any insurance company with which I am credentialed. Please note, I WILL SUBMIT ONE TIME per session, my office is not responsible nor required to submit charges to your insurance company. Please remember, however, that you, not an insurance company are responsible for all fees, bills and amounts due this office. Please assign all payments to Sarasota Therapy, LLC/Amy Thatcher, LCSW. It is your responsibility to obtain authorization if necessary from your insurance provider.

Records and Confidentiality:
All our communication becomes part of your clinical record. I will keep confidential anything you say to me, with the following exceptions:

1. You direct me, in writing, to tell someone else.
2. I determine you are a danger to yourself or others.
3. I become aware of child or elder abuse.
4. I am ordered by a court to disclose specific information.

Authorizations:
By signing below, you request and authorize payment of any medical benefits, including major medical benefits to which you are entitled, to be paid directly to Sarasota Therapy, LLC/Amy Thatcher, LCSW. You also authorize the release of any medical information necessary to process claims made by Sarasota Therapy, LLC/Amy Thatcher, LCSW. In addition, you consent to the treatment of yourself and/or your child by Sarasota Therapy, LLC/Amy Thatcher, LCSW.

By signing below, you agree that you are solely responsible for all fees incurred through you and/or your child's treatment by Sarasota Therapy, LLC/Amy Thatcher, LCSW. This includes, but is not limited to session fees, co-payments, no shows/late cancellation fees, and collection/legal fees.

By signing below, you are indicating that you have read and understood this two-page document, and/or that any questions you had about this document have been answered to your satisfaction. You are also indicating that you have had the opportunity to read Sarasota Therapy, LLC/Amy Thatcher, LCSW's HIPAA document and you have no questions about the information contained in it.

Client/guardian Name (Print):_____

Signature (Client/guardian):_____

Date: _____

Sarasota Therapy, LLC
Physical Health History

_____ _____ _____
Client Name (last, first) Age Date of Birth

General Health (Circle One) Excellent Good Fair Poor

Sleep Problems (Circle One) None Occasional Frequent
Describe:_____

Appetite: (Circle One) Excellent Good Fair Poor
Recent Gain or Weight Loss?
_____

Please check below if you currently have any of these symptoms?

__Severe Headaches __Nausea/Vomiting __Nose Bleeds
__High/Low Blood Pressure __Numbness/Tingling __Severe Injury
__Shortness of Breath __Vision Pounding __Back Injury
__Asthma/Chronic Cough __Heart Pounding __Hearing Trouble
__Difficulty Concentrating __Dizziness/fainting __Loss of Memory
__Abdominal Pain/Indigestion __Chest Pain/Pressure

If checked, please explain current conditions:
_____
_____

Personal or Family History Of:
__Cancer __Diabetes __Thyroid Problems __Heart Disease __TB __Other
_____

Major Surgeries or Injuries/year:
_____
_____

Head Injuries: Yes/No
_____
_____

Who is your primary care physician? _____Ph#_____

Date last seen by physician: _____

Current medications:
Name of medication Dosage
_____
_____

Please check below for any that apply to you:
Smoke_____ # Packs per day_____ For how long?_____
Alcohol____ Amount per week_____ For how long?_____
Coffee____ # Cups per day_____ For how long?_____
Exercise____ Describe_____

Have you ever been addicted/dependent on alcohol or drugs? ____Yes ____No
Are you currently using drugs or alcohol? ____ Yes ____No

If "yes" list all substances
_____

If this use was in the past, when did you stop?_____

Have you ever received mental health services before? ____Yes ____No

In-Patient
When?_____
Where?_____

Out-Patient
When?_____
Where?_____

Have you ever been a victim of emotional, physical, or sexual abuse? ____Yes ____No
_____
_____

FAMILY HISTORY: Please tell us if anyone in your family has ever had:

Mental Health History
_____
_____
_____

Substance Abuse History
_____
_____
_____

This information is correct to the best of my knowledge.

_____ _____
Client Signature Date

Sarasota Therapy, LLC
Consent to Treatment and Recipient's Rights

I, _____, hereby attest that I have Voluntarily entered treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at Sarasota Therapy, LLC/Amy Thatcher, LCSW, hereby referred to as the Practice. Further, I consent to have treatment provided by a psychologist, social worker, counselor, or intern in collaboration with his/her supervisor. The rights, risks, and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. The practice encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

Recipient's Rights: I certify that I have received the Recipient's Rights pamphlet and certify that I have read and understand its content. I understand that as a recipient of services, I may get more information from the Recipient's Rights Advisor.

Involuntarily Discharge from Treatment: A client may be terminated from the Practice involuntarily. if: (A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the practice, and/or (B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the involuntary discharge by letter. The client may appeal this decision with the Practice Director or request to reapply for services later.

Client Notice of Confidentiality: The confidentiality of patient records maintained by the Practice is protected by federal and/or state law and regulations. Generally, the Practice may not say to a person outside the Practice that a patient attends the program or disclose any information identifying a patient as an alcohol or drug abuser unless: (1) the patient consents in writing, (2) the disclosure is allowed by a court order, or (3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Violation of federal and/or state law and regulations by a treatment provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or state law and regulations do not protect any information about a crime committed by a patient either at the Practice, against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under federal and/or state law to appropriate state or local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the Practice's duty to warn any potential victim when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about the client, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

I consent to treatment and agree to abide by the above-stated policies and agreements with Sarasota Therapy, LLC/Amy Thatcher, LCSW.

_____ _____
Signature of Client/Legal Guardian Date

_____ _____
Witness Date

Sarasota Therapy, LLC
Financial Policy

The staff at Sarasota Therapy, LLC/Amy Thatcher, LCSW (hereafter referred to as the Practice) are committed to providing caring and professional mental health care to all our clients. As part of the delivery of mental health services, we have established a financial policy that provides payment policies and options to all consumers. The financial policy of the practice is designed to clarify the payment policies as determined by the management of the practice.

The Person Responsible for Payment of Account is required to sign the form Payment Contract for Services, which explains the fees and collection policies of the practice. Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance company.

As a service to you, the practice will bill insurance companies and other third-party payers but cannot guarantee such benefits or the amounts covered and is not responsible for the collection of such payments. In some cases, insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases the Person Responsible for Payment of Account is responsible for payment of these services. We charge our clients the usual and customary rates for the area. Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

The Person Responsible for Payment (as noted in the Payment Contract for Services) will be financially responsible for payment of such services. The Person Responsible for Payment of Account is financially responsible for paying funds not paid by insurance companies or third-party payers after 60 days. Payments not received after 120 days are subject to collections (25% surcharge). A 1% per month interest rate is charged for accounts over 60 days.

Insurance deductibles and co-payments are due at the time of service. Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g., if there were previous visits to another mental health provider since January of the current year that were prior to the first session at the practice), this amount will be collected by the practice until the deductible payment is verified to the practice by the insurance company or third-party provider.

All insurance benefits will be assigned to this practice (by insurance company or third-party provider) unless the Person Responsible for Payment of Account pays the entire balance each session.

Clients are responsible for payments at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. Unaccompanied minors will be denied nonemergency service unless charges have been preauthorized to an approved credit plan, charge card, or payment at the time of service.

Missed appointments or cancellations less than 24 hours prior to the appointment are charged at a rate noted in the Payment Contract for Services. In the event a client has two or more missed and/or late cancel appointments, payment for subsequent appointments will be required in advance.

Payment methods include check, money order or cash. Please speak with your therapist of the office manager regarding acceptance of credit/debit cards for payment. This office utilizes a third party to process credit/debit cards. There is a 3.5% fee charged by the third party which the client will be responsible for if opting to pay with a credit/debit card. Clients using charge cards may either use their card at each session or sign a document allowing the practice to automatically submit charges to the charge card after each session.

Questions regarding the financial policies can be answered by the Office Manager.

I (we) have read, understand, and agree with the provisions of the Financial Policy.

Person responsible for account (Print): _____

Signature: _____ Date:_____/_____/_____