CONSENT FOR PSYCHOTHERAPY AND/OR EVALUATION

The following policies and expectations pertain to the counseling services at this office. Please read the following information and if you have any questions, please feel free to ask me.

Services: The counseling services I provide include diagnostic evaluation, individual psychotherapy, family therapy, couples therapy, and consultation with other professionals (teachers, physicians, etc.) when needed and with your consent.

Psychotherapy is consultation with a licensed counselor to meet specific emotional or behavioral goals. In order for therapy to be most successful, you will have to be open and honest with your therapist during sessions, and work on the things you and your therapist talk about outside of sessions, at home and in the community. In order to get the most out of a session, please arrive on time, as I cannot extend a session past the scheduled time. Most sessions last 40-60 minutes.

Counseling evaluation services include administration of scientifically validated instruments and questionnaires. They also include interviews with you, and any individuals you feel should have input on the evaluation. The purpose of the counseling evaluation is to provide a diagnosis and detailed information about your psychological functioning. It is not intended to treat or cure any psychological condition. No guarantee of outcome can be made in advance.

Confidentiality: The clinician-client relationship is confidential. Your presence and what you discuss is held in strict confidence and will not be shared with any other individual without your express written consent, except as required by law, as follows:

I. If I have reasonable cause to suspect that a child is being abused or neglected, I must report this to the county's Child Protective Services or police.

II. If I have reasonable cause to suspect that an elder or dependent adult is being abused or neglected, I must report this to the appropriate county agency.

III. If I have reason to believe that you may cause serious harm to yourself or to another person, I will take protective actions. These may include contacting family members, seeking hospitalization, notifying any potential victims of violence, and/or notifying the police.

Payment: Clients are expected to pay for services, including copays, at the time services are rendered unless other arrangements have been made. Please notify your therapist if any problem arises during the course of treatment regarding your ability to make timely payments. There will be a $35.00 charge for all returned checks due to fines imposed by the bank.

Insurance: In the case that your plan denies services, you will be billed directly for services, at the rate negotiated by your plan. If you are not covered under one of the therapist credentialed insurance plans, you will be directly responsible for paying for services at the rate of $100 per hour for therapy, $160 for evaluations. Upon request, your therapist can provide you with a receipt that you may submit to your insurance company for reimbursement.

Cancellation: 24 hours notice is required for rescheduling or canceling an appointment. Missed appointments without 24 hours cancellation will be billed $60.

Out-of-Session Services Brief (10 minutes or less) conversations will not be charged. However, time devoted to treatment and assessment other than office visits is charged on a prorated bases according to the regular fee schedule. This includes school visits, lengthy consultations in person and by phone with other professionals, lengthy telephone conversations with the client or parent or guardian of the client, extensive collection and preparation of data, and the preparation and writing of letters and reports. Please note that these services may not be covered by your insurance and you may have additional costs for out of session services.

I understand and agree with the above information wish to engage in
< Therapy and/or < Evaluation services with Donna Mizwa, MA, LPC, CAADC.

_____

Name of Client

_____

Signature of Client **Date**

_____Please initial that you have received a copy of my Privacy Practices

Insurance Information: (required only if using one of the above insurance plans)

Insurance provider:_____ Policy Number: _____
Group Number: _____
Insured's Name:_____ Phone: ( ) _____
Client relationship to insured: ☐Self ☐Spouse ☐Child ☐Other: _____
Insured's Address:_____
Insured's Date of Birth: / /_____ Insured's SSN: _____
Insured's Employer:_____ Insured's Gender: ☐Male ☐Female

Is there another health benefit plan? (Y/N) If so, please answer below:
Insurance provider:_____ Policy Number: _____
Group Number: _____
Insured's Name:_____ Phone: ( ) _____
Client relationship to insured: ☐Self ☐Spouse ☐Child ☐Other: _____
Insured's Address:_____
Insured's Date of Birth: / /_____ Insured's SSN: _____
Insured's Employer:_____ Insured's Gender: ☐Male ☐Female

I authorize the release of any medical or other information necessary to process any claims resulting from this agreement with the insurers above. I authorize payment of medical benefits to Donna Mizwa for the services described in this agreement.

_____

Signature of Client **Date**

INTAKE QUESTIONNAIRE – ADULT HISTORY FORM

Please fill out all the information to the best of your ability and if you have any questions, please feel free to ask us.

Identifying Information:

Name:_____ Date of Birth: _____

Address:_____

Phone – Home:_____ Work:_____ Cell: _____

Occupation:_____ Employer:_____

Ethnicity:_____ Marital status: ___ Living Situation: Living Alone / With Friends / With Spouse or Partner / With Parents / __ Emergency contact: _____

_____

Reason for Evaluation/Treatment:

Please describe briefly why you are seeking treatment/evaluation at this time: _____

_____

_____

_____

How long have you noticed these concerns?_____

What have you tried so far to manage these concerns? _____

_____

_____

_____

Please mark the difficulties you have now, or have had in the past:

Behavior	Now	Past	Behavior	Now	Past	Behavior	Now	Past
Trouble paying attention			Feeling anxious, tense, or worried			Trouble falling asleep		
Hyperactive			Panic attacks			Waking early and cannot sleep		
Disorganized			Phobias or unusual fears			Cannot wake up in morning		
Problems with work/school			Feeling tired or fatigued			Fall asleep during day		
Making careless errors			Feeling sad or upset			Frequent headaches		
Loses things / Forgetful			Indecisive			Frequent stomach aches/nausea		
Accident prone			Have frequent mood swings			Frequent body aches/pains		
Losing temper			Withdrawn / avoid friends			Lost/Gained weight unintentionally		
Irritable / Easily annoyed			Low self-esteem			Hearing voices / Seeing things		
Sensitive / Feelings easily hurt			Tearfulness/crying spells			Drinking excessively		
Feeling dangerous or out-of-control			Thoughts of death/suicide			Use of illegal drugs		

Medical History:

Do you have any current illnesses? _____

Any chronic health problems? (asthma, heart conditions, diabetes)_____

Are you taking any medications? Yes / No. If yes, please list medication and dosage:

_____

_____

Are you allergic to any medications (Y/N), food (Y/N) or other (Y/N)? If so please list:_____

_____

_____

Have you ever been in the hospital? When and why? _____

Have you ever had a head injury or seizure? When? _____

How often each week do you use alcohol?_____When did you last drink? _____

How often each week do you use cigarettes?_____When did you last smoke?_____

How often each week do you use marijuana?_____When did you last smoke? _____

How often each week do you use other drugs?_____When did you last use?_____

Mental Health History:

Have you seen a therapist or psychologist before? Yes / No. If yes:

When and where? _____

For what concerns? _____

Was treatment helpful? _____

Have you been evaluated for learning difficulties before? Yes / No. If yes, state date and results:

_____

Have you ever been hospitalized for psychological reasons? _____

Have you been physically, emotionally or sexually abused? _____

Does anyone in your extended family (parents, siblings, aunts, uncles, cousins, grandparents) suffer (now or in the past) from the following difficulties? If so state whom.

Depression:_____Bipolar Disorder: _____

Anxiety:_____Schizophrenia: _____

Learning Disabilities:_____ADHD/ADD: _____

Alcohol abuse/addiction:_____Drug abuse/addiction: _____

Has any relative been hospitalized for psychological reasons? _____

_____