Intake Form – Rebecca Bloom, LMHC

Please provide the following information for your records. ***Leave blank any questions you would rather not answer in print.*** *Information you provide here is held to the same standards of confidentiality as in your counseling sessions.*

Name:_____
(Last) *(First)* *(Middle Initial)*

Name: _____
(Parent/guardian name if client is a minor)

Local Address: _____
(Street)

_____
(City) (State) (Zip Code)

Birth Date: _____/_____/_____ Age: _____

☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Number of Children: ____ Ages: _____

Message Phone: _____
(Okay to leave a message?)

Email: _____

Referred by: _____

Emergency Contact: _____

Insurance Type and Member Number_____

Chief Concerns
What are your three biggest stressors right now?
1. _____

2. _____

3. _____

What are your goals for treatment?

Do you have a history of mental health issues? Yes No
If so, please complete the following:
Diagnosis Dates Treated By Whom
_____
_____
_____
_____
Have you ever been hospitalized for psychiatric reasons? Yes No
Please describe: _____

Do you have any concerns about your health that you would like to discuss? Yes No
Primary care provider:
_____
Phone: _____ Date and place of last physical exam _____

List all biologically related family who have been diagnosed or treated with the following conditions:
Anger: _____ Violence: _____
ADHD/ADD: _____ Alcohol abuse: _____
Eating disorder: _____ Drug abuse: _____
Bipolar (manic depressive) _____ Schizophrenia: _____
To your knowledge, has any family member attempted suicide? Yes No
If yes, whom?
_____

Trauma History:
Do you have a history of trauma? Check all that apply.
Childhood abuse Military combat Workplace trauma Domestic violence
Sexual abuse/ rape Medical trauma Accidents/ injuries Other: _____
Substance Use:
In the past three months, what is the largest amount of alcohol you have consumed in one day? _____
Have you used any street drugs in the last three months? Yes No
If yes, which ones? _____
Do you think you have a problem with alcohol or drug use? Yes No

CONSENT TO TREATMENT

I,_____ with full knowledge of the benefits and consequences of counseling consent to be treated by Rebecca Bloom on a voluntary basis.

I also agree to take financial responsibility for my sessions at the rate of $_____ per 50 min. hour. I will pay for services at the time they are rendered or in advance. I realize that failure to pay for any given session will require me to send payment by mail before the next session or it will not be conducted. Payment may be made by cash or check, however, if a check is returned by the back, you will be charged a $20 fee and denied the right to write checks as payment for your sessions.

Please be aware that you must give 24 hour notice for cancellation or be charged full fee. Excessive cancellations or requests for appointment time changes are disruptive to the therapeutic process, as well as the therapists schedule. Should this become a concern, the therapist reserves the right to terminate treatment or assess a $25.00 re-scheduling fee.

If you plan to use your health insurance benefits, please be aware that it is your responsibility to inquire about mental health coverage and applicable deductions. All sessions must be paid for at the beginning of the session. You will be responsible for filling the claim and the insurance company will reimburse you. The therapist will provide you will necessary information. It is illegal to bill the insurance company for missed sessions, please be informed that you are responsible for paying the therapist directly if this occurs.

Please make checks payable to Rebecca Bloom or Bloom Counseling. Also, <u>please write your check prior to your session.</u>

Signature of Client Date

If minor, parent or guardian

Rebecca Bloom, LMHC, ATR-BC

Client Rights and Responsibilities

Under state law and the American Counselor Association Code of Ethics, you have the right to confidentiality of information you share with me and in the course of our work together. Information will be given to others only at your, or your legal representative's request except in unusual circumstances in which not to do so would pose a clear danger to yourself or another. You have the right to participate in your treatment planning, to ask questions until you understand the goals and methods of our work together and to discontinue treatment if you wish. You have the responsibility for choosing both the person and the treatment modality which best suits your needs. Even though I share office space with others, we are all independent practitioners and do not share professional responsibility for each other's work.

Education and Training

I received my training in clinical art therapy at Pratt Institute in Brooklyn, New York, graduating with a Masters Degree in Art Therapy and Creativity Development. I am a Registered Art Therapist and Washington Licensed Mental Health Counselor. Furthermore, I have participated in numerous clinical trainings since receiving my degree and still continue to attend such training's on an ongoing basis as required by state law to stay licensed.

Philosophy of Care

The focus of my work is to help people address life issues through the creative arts. To find the helpful and knowing artists that lives within all of us. By a blending of creativity, education, encouragement, support, guidance, and accountability, I hope to help clients feel grounded in their lives. The goal of counseling is to create a forward moving momentum in your life that allows you to live according to your own hopes and dreams.

Through an open exploration of your life as it has unfolded over the years, I hope to help you identify repeating patterns of behavior and ineffective beliefs that may have misinformed some of your choices. Once we identify your ineffective beliefs and ineffective behaviors, we are able to literally design new patterns, beliefs and choices that support the life you want to live. The only catch is that you truly must want these changes.

Appointments

The sessions are 50 minutes for adults and 45 minutes for children and teens. An agreed upon hour of time will be reserved for your use on a regular basis. This is important to preserve the consistency of our work together and provides the best opportunity for growth. If you arrive late, the session cannot be extended.

I ask that you let me know at least 24 hrs before a scheduled appointment is cancelled to avoid losing your reserved time. If I do not receive 24 hour notice, you will be charged for the session. If missing or canceling appointments becomes a pattern you will be given the option to pay to hold that reserved time (whether or not you come) or to forfeit that time slot. You will not be charged for a rescheduled appointment in the same week. I will provide you with advanced notice of my expected times away from the office and there will be no charge whenever I am away.

Patient Rights:

You as a patient may question or refuse treatment at any time. All services are strictly confidential, however, in such cases where your life, or the life of another person is in danger, I am required by law to break confidence and pursue an intervention. I am also required to report any suspected child or elder abuse or neglect. Your medical records are kept in a locked and secure file. I reserve the right to destroy all records after seven years.

Fees and Payment

The fee for each session is due at the end of each session. If your insurance will pay a portion, the co-payment is due at the time of the session. For private pay, your canceled check will be your receipt. You are responsible for your account, regardless of whether or not your insurance plan eventually pays a portion of the charges. A rebilling fee is assessed monthly on continuing client balances. If a check is returned from the bank, a $25 fee will be added and no future checks will be accepted. I use Square for Credit Cards.

In Conclusion…

I am aware that your decision to enter therapy may have been a difficult one, and I am pleased that you have placed your trust in me. Should you have any additional questions, feel free to ask them at any time.

By signing this form I give permission to the provider to bill my insurance for reimbursement and share information as needed.

Your signature or initial below indicates that you have read and agree to the above.

Printed Name:___________________________ Signature:___________________