Intake Form for Christopher Galton, LPC

Please fill that information which is pertinent to you

Name: Last: _____ First: _____ Date: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone #: Home: (___) _____ Cell: (___) _____ Work/Other: (_____): (___) _____
E-Mail Address: _____@_____ If using Insurance, Social Security: _____-____-_____

Please indicate if you do not wish to be contacted at the above address, phone, or e-mail.

Date of Birth: ____/_____/_____ Age: _____ Gender: M____F____ O____ Race/Ethnic: _____
Marital: Single: __ Engaged:__ Married:__ Separated:__ Divorced:__ Widow/er :__ Cohabiting:__ Spouse's name:_____
Ages of: children living at home: _____ # of children living away from home: _____
Who to call should you have an emergency? _____ Relation? _____ Phone #: (___) _____
Employment Info: Where: _____ Full__ Part-time__ Unemployed__ Disabled__ Retired___
What kind of work do you do, now or in past? _____
What is your highest level of education? _____ What would you like to be doing? _____

What are your goals for therapy? What do you want different when we are finished?

_____
_____
_____

Briefly: What problem brought you here today? (Problems, symptoms, issues, length of duration, stressors)

_____
_____
_____

What do you think are the causes? Why do you think you have the symptoms? Is there anything in your family history that might relate to the problem you have now? (Childhood issues, family mental health, current family problems, separations, alcohol/drug problems, Employment situations, feelings of worthlessness, hurt, anxiety, anger)

_____
_____
_____

What have you done to try to resolve these problems?
(Things you have done, people or organizations you have attempted to get help from?)

_____
_____
_____

Here are typical feelings that people have. Which ones have you felt? Indicate which 2 you feel most by a double check.
Sad___ Lack of energy___ Irritable___ Depressed___ Worthless___ Anxious___ Panicky___ Angry___

Here are typical behaviors that people do. Do you find yourself doing any of the following?
Retreating___ not speaking up___ yelling___ being violent_____
Not sleeping well____ sleeping more than I feel I should_____ eating more____ or eating less_____
Using alcohol _____ using other drugs _____ to help you deal with things.

Have you …..
Hurt someone you love: physically____ emotionally____
Hurt yourself (risky behaviors, self-mutilation or attempting to kill self) _____
Have legal problems? _____ Your lawyer's name_____

Have you been in counseling, or been in a treatment facility? If so, whom did you see, when and where?

_____

How is your current health? _____
How long ago did you see a doctor? _____ List what **major** medications you take:

Medication Name	Purpose	Dosage	Frequency	When started	Physician

Agreements:

By signing on next page you agree to the following:

Fees:

It is customary and expected to pay for professional services at the time they are rendered.
The hourly fee for individual, couple, and family therapy is $90 for the first hour and $80 for each subsequent hour.
If you have a hardship and do not have insurance, Christopher Galton LPC may adjust payment as noted here: $_____ / session.
I usually give you an hour and a half of therapy but only charge for one hour.
You will be billed up to $50 if you do not cancel 24 hours before appointment time. If repeated, you may be required to put down a deposit (half of the next appointment's fee).

Insurance:

I authorize **Christopher Galton, LPC** to provide a summary of care and assessment information regarding treatment for the purpose of processing claims for Insurance/EAP benefits.
I authorize payments of insurance claims to be paid directly to **Christopher Galton, LPC**. I understand that he is making an the attempt on my behalf. I understand I am responsible for all co-payments and deductibles associated with the insurance.
If he is unable to collect, **it is ultimately my responsibility to pay for the agreed cost of the sessions.**
You will only be required to pay the co-pay for your therapy. If you do not know whether your deductible has been met, you will be charged full fee. Your fee minus the co-pay will be refunded if your deductible has been met.
You are responsible for any fees due to Christopher Galton LPC that your insurance company does not pay.

If using Insurance: **Provide a card --** ***or*** **-- fill out the following:**

Name of the client/insured (as Insurance has it): _____
If the client is not the primary employee: Relationship of the client to the employee: _____
Name of the employee: ___Employee's ID or S.S. number: _____Birthdate: _____
Address of employee: _____ Phone: _____
Address of employer: _____
Insurance Company: _____ Address: _____
Telephone: _____Fax: _____ Insured employer (if group policy): _____Group #_____
Another insurance plan you might be covered under? _____

Confidentiality: What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your or your legal guardian's written consent. While I may listen to anyone who wishes to provide me with information about you, I may not divulge info about you.
The information you share in psychotherapy is protected health information and is generally considered confidential by both South Carolina statute law and federal regulations. The following is a list of exceptions:

- Your therapy file can be subpoenaed in South Carolina through a court order (signed only by a judge) but is considered privileged in the federal court system.
- Duty to Warn and Protect: If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.
- Abuse of Children and Vulnerable Adults: If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.
- Prenatal Exposure to Controlled Substances: Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.
- Minors/Guardianship: Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records. If you are under 18 years old, both your parents have a right to receive general information on the progress of the treatment.
- Insurance Providers: Insurance companies and other third-party payers are given information that they request regarding services to the clients.

Electronic Devices: At times I may use a cellular phone to contact you or return your calls if the information you are discussing requires a more secure level of confidentiality, please let me know so other arrangements can be made.
I discourage sharing personal information on e-mails due to e-mail not being a confidential mode of communication.
I use a Fax machine in communications with other agencies that includes a confidentiality statement. However, I cannot ensure that the Fax is received in the proper place or handled in a confidential matter once it is received. You may pick up and hand-carry documents to agencies if you wish. I will also mail documents on special request.
I can do all of these things if you have signed a general written consent form. Once you sign this general written consent form, it will be in effect indefinitely until you revoke your general written consent. You may revoke your general written consent at any time, except to the extent that I have already relied upon it. To revoke your general written consent, please write to us above.

Cancellation Policy

If you are unable to attend an appointment, we request that you provide at least 24 hours advanced notice to our office. Since we are unable to use this time for another client, please note that you may be billed up to the entire cost of your scheduled appointment if it is not canceled in a timely manner, unless such cancellation is due to illness or an emergency. We appreciate your help in keeping the office schedule running timely and efficiently.

Fees

It is ultimately my responsibility to pay for the agreed cost of the sessions (should insurance not pay**).**

Consent for Treatment and Limits of Liability and Responsibility of Payment :

By signing below, my signature (and those who attend with me) confirms that I: have received, understand, and accept the information and agreements contained in, agreed to the above assumption of risk and limits of confidentiality and understand their meaning consent to the use and disclosure of my health information as agreed upon, and am ultimately responsible to pay for the agreed cost of the sessions.

I

_____ _____

Signature of Client **(Client's Parent/Guardian if under 18)** **Date**

……..

_____ _____

Signature of Client #2 Signature of Client #3

I am in possession of the following pages:

1. Welcoming page with information about therapy
2. Professional Disclosure Statement
3. Health Insurance Portability and Accountability Act of 1996 (HIPAA) Client's Right
4. Client Intake Form
5. Agreement for: Fees, and Confidentiality
6. Signature page -- Consent for Treatment

(Release of Information when needed)

Authorization for Use or Disclosure of Protected Health Information