**Adult Intake Forms**

Client’s Full Name

Client’s Date of Birth

Client’s Address

Phone Number

Can a message be left?

Yes No

Alternate phone Number

 Can a message be left?

Yes No

Email Address

Can you be contacted via email?

Yes No

Emergency Contact Name

Emergency Contact Phone Number

**Health Insurance Information**

Client’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Date of Birth (MM/DD/YY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Address/City/Zip Code (as given to insurance company):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Relationship to the insured: \_\_\_ Self \_\_\_ Spouse \_\_ Child \_\_ Other

**The following information is about who carries the insurance**

Insured’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Address/City/Zip (If different from the client’s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Phone Number (If different from the client’s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Policy Group or FECA Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Date of Birth (MM/DD/YY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client or authorized person’s signature:

I authorize the release of any medical or other information necessary to process this claim. I also request payment of medical benefits to the supplier of services (Amy Pezzotti, MA, LPC, RPT, NCC)

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Notice of Policies and Practices to Protect the Privacy of your Health Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This notice describes how your private health information may be used and disclosed, and how you can gain access to this information. Please review it carefully.

**Private Health Information may be used and disclosed in the following circumstances:**

1. Information that is necessary in order to file insurance claims and successfully complete all billing and collection procedures.
2. When required for public health issues such as workman’s compensation.
3. When required by any state or federal law, including cases of abuse and neglect.
4. When required for an specialized government or military functions, including: active personnel, reservists, veterans, and discharged members of the military service.
5. When used for any clerical purposed and necessary chart audits by managed care companies.

**As a client, you have rights to your Private Health Information, including:**

1. The right to review your records or receive a copy of your records at any time by signing a written release. However, under certain rare circumstances your request can be denied. If needed, interpretation of the records will be provided. Requests for records will be honored within 30-60 days.
2. The right to request information of any party that has requested information pertaining to your protected health information.
3. The right to receive confidential information regarding your protected health information.
4. The right to revoke this consent in writing; however, this will not affect any information already disclosed.

**As a private practitioner, I have the responsibility to:**

1. Make each client aware of the Privacy Notice.
2. At any time, make the necessary changed to the Privacy Notice that are required by law. If you as the clinet feel your privacy has been violated, you have the right to contact The U.S. Department of Health and Human Services Office of Civil Rights at [www.hhs.gov/ocr/hippa/](http://www.hhs.gov/ocr/hippa/). I have reviewed understand this notice.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Personal Representative/Guardian Date

**Disclosure & Confidentiality Agreement**

**Qualifications:**

Amy is a Licensed Professional Counselor, a Registered Play Therapist and a Nationally Certified Counselor. She is licensed to counsel in the state of Texas through the Department of State Health Services. Amy earned her Bachelor’s Degree in Psychology from Texas A&M University. She earned her Master’s Degree in Professional Counseling from the CACREP accredited program at Texas State University. Amy works primarily with children and adolescents with a variety of presenting concerns, including anxiety, behavioral difficulties, trauma and transitions. Amy adheres to the ethical standards of the LPC board and the International Association of Play Therapy.

**Confidentiality:**

With the exception of specific legal and training circumstances described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not disclose to anyone what we discuss in session, without your written permission. Legal situations in which confidentiality must be breeched include:

1. If the client is deemed by the therapist to be a danger to themself or someone else
2. If child abuse/neglect is suspected, I must inform Child Protective Services.
3. If abuse/neglect of another individual within the family is suspected, I must inform Child Protective Services or Adult Protective Services.
4. If a court orders confidential records to be released
5. If the client agrees in writing for the release of information.

Whenever possible, I will inform you before any of these steps are taken.

**Use of Insurance:**

If you choose to use insurance (see my website for updated insurance programs Icurrently accept), please know that insurance companies require me to provide a diagnosis for treatment. This information would be shared and discussed in session.

**Late policy and cancellations:**

Although I will take into consideration personal emergencies and extenuating circumstances, a 24-hour cancellation notice is required, otherwise a fee of $50 will be charged. I also reserve the right to terminate therapy if cancellations or no-shows become excessive and are unable to be dealt with in the therapeutic relationship. I will discuss this with you prior to canceling services.

Please be responsible for coming to your session on time and at the time we have scheduled. Sessions are approximately 45-50 minutes, depending on the nature of the session and the age of the client. Some people need only a few sessions to resolve their concerns, while others may need months to achieve their stated goals. If you are late, we will end on time and not run over into the next person's session.

**Complaints:**

If you have a compliant regarding your treatment or therapist, you may report it to the Texas State Board of Examiners of Professional Counselors at (512) 834-6658 or lpc@dshs.state.tx.us

**Explanation of Fees:**

Session fees are $100 per hour. Group Therapy fees vary depending on the type and duration of the group. Payment is required when services are rendered. Clients (or guardians of minors) will be responsible for any insurance co-payment, deductibles, or unpaid claims. Any outstanding balance not paid within 30 days will be turned over to a collection agency for recovery and a $75 collection fee will be charged to the client’s account. A $50 fee will charged to the client’s account for all returned checks.

**Court:**

If records are requested for personal or for legal matters, the client will be charged a $50 flat administration fee. If there are other costs associated with this service, (i.e. notary, postage), the client will be responsible for that cost, as well. This request must be made in writing via paper or electronically.

Court cases are billed at a flat rate of $1,000 per day, paid in advanced to Amy Pezzotti. This includes but is not limited to testimony or being on ‘stand-by’ for testimony. Any cancellation of Amy’s scheduled appearance will require a 48-hour notice or prepayment will not be refunded. Insurance companies will NOT cover court appearances.

**Email:**

Email may be used for scheduling and informational purposes but not for emergencies. Please call 911 or another emergency service, such as 472-HELP, if you need immediate assistance. Although all considerable measures have been taken to ensure confidentiality of emails sent and received, please be aware of the risks taken when sharing personal or confidential information via email.

**Ending Therapy:**

You have the right to terminate therapy at any time. If you choose to end therapy, a referral can be provided to you. If a client becomes verbally or physically violent towards the therapist, including threats, the therapist reserves the right to immediately discontinue therapy.

I have read the preceding information and understand my rights and responsibilities as a client. My signature below acknowledges this understanding and indicates that I accept the conditions of counseling.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Personal Representative/Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Personal Representative/Guardian Date