Acorn Center For Wellness LLC

270 Farmington Avenue
Farmington, CT 06032
Suite 365

www.acorncw.com
860-709-9942

Client Intake Form

Please answer the following questions to the best of your ability. This form is for **Acorn Center For Wellness LLC** records and to assist me in providing you with the best possible service. All of the information you provide here is strictly confidential. Please print out this form and bring it to your first session or allow yourself 20 minutes prior to your session to fill it out at the office.

Today's Date: _____

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

Please describe the problem(s) that bring you in today:

_____
_____
_____

Are you currently involved with other providers for the same problem(s) listed above?
Yes / No If Yes, please describe the services you are involved in:

_____
_____
_____

What do you consider your and/or your family's strengths?

_____
_____
_____

Please List All of the Members of Your Household:

Name	Relationship	Age

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Health:

Please list any other health issues you are currently experiencing:

_____

_____

Please list any medications, vitamins, or supplements you are currently taking or have taken in the past, related to your presenting problem:

Medication Name	Present or Past?	When Did You Start/Stop Taking It?	Effects?

Employment:

Are you currently employed? (Circle One) Yes / No

If Yes, Name of Employer _____
Job Title: _____
How long have you worked there? _____

Family Mental Health History:

In the section below, identify if there is a family history of any of the following. If yes, indicate that family member's relationship to you (example: mother, spouse, child, etc.)

	Please Circle List	Family Member
Alcohol/Substance Abuse	Yes / No	_____
Anxiety	Yes / No	_____
Depression	Yes / No	_____
Domestic Violence	Yes / No	_____
Eating Disorders	Yes / No	_____
Impulsivity/Attention Problems	Yes / No	_____
Schizophrenia	Yes / No	_____
Sexual Problems	Yes / No	_____
Suicide Attempts	Yes / No	_____

Is your spirituality important to you? (Circle One) Yes / No

If yes, please describe:

_____

_____

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Briefly, what are your goals for therapy?

1._____
2. _____
3. _____

Is there anything else that is important for me to know about you and/or your family?

_____
_____
_____

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Client Information Form

Name:_____

Home Address:_____

Date of Birth: _____

Gender:_____ Relationship Status: _____

Occupation: _____

Home Phone: _____ Mobile Phone: _____

Email Address: _____
*Note: e-mail correspondence is not considered to be a confidential form of communication. Best way to reach you to discuss appointments? (Circle) Home # Mobile# Email Is it okay to leave a voicemail? (Circle) Yes No

Emergency Contact:_____

Phone Number: _____ Relationship to you: _____

Primary Care Provider: _____
City & State: _____ Phone: _____

Insurance: _____
Insurance Member ID #: _____

How did you hear about our therapeutic services? _____
If you were referred by someone, can I thank them for the referral? (Circle One) Yes / No If yes, please leave their contact information:

Name: _____
Phone Number: _____
Address: _____ _____

Client Signature: _____ Date: _____

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CLIENT-THERAPIST AGREEMENT

You have chosen to enter into a therapeutic relationship with me. This two-paged agreement consists of a summary of Office Policies, Costs and Cancellation Policies, and a Confidentiality/HIPPA Statement. Kindly review it and sign this agreement to let me know you understand and agree with all of these statements.

OFFICE POLICIES

• I am an outpatient therapist and therefore, I am not available 24 hours a day. In the case of an emergency, please call 911 or 211.

• Email is only used for making or cancelling appointments. Emails are not confidential and therefore will not be used for therapeutic purposes. If you need to speak with me, please call.

• Therapy and life coaching can be done in the office, in a location that we choose, online, or on the phone.

• If you arrive late for an appointment, you are still charged the entire session fee. The usual length of an appointment is 50 minutes. Usually, I will not be able to extend our sessions.

• Payment is expected at the beginning of each session, unless a payment plan is arranged.

• CANCELLATION POLICY: If you are unable to make an appointment, give at least 48 hours' notice by calling or emailing me. The first time a late cancellation or missed appointment occurs, you will be expected to pay 50% of the session fee. After the first late cancellation or missed appointment occurs, you will be expected to pay 100% of the session fee in addition to your next appointment fee.

• In addition to direct treatment, it may be necessary to provide a range of indirect case management services, such as writing letters or reports; extensive phone conversations; traveling to and from meetings, etc. The surcharge for office-based case management is $100/Hour and is prorated for half-hour time periods and any part thereof.

• Twice a year, March 1 and September 1, I have the right to adjust my therapeutic fees. If fees change, you will be notified at your next appointment. Returned checks will be charged $30. Treatment will be ended if you fail to pay any charges accrued. Overdue accounts may be turned over to a collection agency, and you will be responsible for all reasonable associated costs.

• Unless otherwise noted, this process is voluntary. During the course of treatment, please provide me with feedback to ensure that you reach your treatment goals. You may, at any time, withdraw from the process. While I hope to be of help to you, I cannot guarantee treatment outcome. I will make every effort to facilitate your consultation with or transfer to another therapist. I will offer that same referral help in the event that I find it necessary to end my work with you. Acorn Center For Wellness LLC

• I will make every effort to protect your privacy. If I should see you outside the office, I will not approach you unless you let me know that it is okay. Information regarding our therapeutic relationship will be shared only in certain circumstances, with your permission. For a more complete review of the privacy guidelines, refer below to the Confidentiality/HIPPA Statement.

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CONFIDENTIALITY/HIPAA STATEMENT

There are federal and state laws that protect your right to confidentiality with regard to your treatment in my office. Without your written permission, I cannot discuss any information you share with me with another person or agency. I must report the following exceptions:

1. DUTY TO WARN AND PROTECT: If a client reports an intention to harm him/herself or others

2. ABUSE OF CHILDREN AND VULNERABLE ADULTS: If a client reports or suggests that a child or vulnerable adult is being or has recently been abused, or it is suspected he/she may be abused, or is in danger of being abused

3. MINORS/GUARDIANSHIP: If a parent or legal guardian of a client under age 18 requests access to the client's records

4. COURT ORDER: If I am required to provide records or information by a court order

Your signature below indicates that you understand and agree with all the statements in this two paged Client-Therapist Agreement and that you consent to treatment with Acorn Center For Wellness LLC.

In the case that a minor child or teenager (under 18 years old) is receiving treatment, you can consent for them to obtain treatment by signing below.

_____	_____	_____
Print Client Name	Client Signature	Date Signed
_____	_____	_____
Print Client Name	Client Signature	Date Signed
_____	_____	_____
Print Parent/Guardian Name	Parent/Guardian Signature	Date Signed
_____	_____	_____
Print Therapist Name	Therapist Signature	Date Signed

*This is a strictly confidential client medical record. Re-disclosure or transfer is expressly prohibited by law.

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Credit Card Policy & Authorization Form

At Acorn Center For Wellness LLC, our policy is to have a credit card on file for every active client receiving treatment. This is to ensure payment for any missed sessions (with the exception of Husky/Medicaid clients, as we cannot charge our missed session fee for these clients), copays, deductibles, and any non-covered services such as writing letters on behalf of our clients or filing paperwork (I.e., disability). This is an absolute requirement with no exceptions. Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐VISA ☐ Discover ☐ AMEX ☐ Other
Cardholder Name (as shown on card):
Card Number: _____ CVV_____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize _____ to charge my credit card above for agreed upon services. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date