Jennifer Walrod, MSW, MPA, LCSW

Psychotherapy for Adults, Couples and Families

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PATIENT INTAKE QUESTIONNAIRE

General Information:

Patient Name_____Birthdate_____Social Security #_____

Street Address_____

City_____State____ Zip_____ Home phone_____Cell phone_____

If we are trying to return your call or need to reschedule an appointment, when is the best time to reach you? _____At what number(s)?_____

May a voice mail message or text message be left at the above number?_____
(Please indicate voice and/or text)

Responsible Party for Patient (if different than above):

Name_____Relationship to the patient:_____

Street Address_____City_____State_____Zip_____

Home Phone Number_____Cell Phone Number_____

Emergency Contact :

Person to contact in emergency_____Phone(s)_____

Address_____Relationship to you_____

Relationship and Employment Information:

List the persons with whom you are now living and their relationship to you (include ages of children)

_____

_____

List the names, ages and location of children who do not reside with you at this time? _____

_____

Relationship Status _____Married _____Single _____Divorced _____Widowed _____Other

Occupation_____Education level_____

Employer_____Work phone_____

Address_____

Length of employment at above_____

Were/are you a member of the armed services? _____ If so, when? _____What branch? _____

If you are you actively involved in a community of faith/church please indicate which one?

_____

Who referred you to Jennifer's practice? _____

Medical Information:

Describe any physical problems you have that require medication or physical care:_____

_____

_____

Are you currently under a physician's care? ____ No ____ Yes

Name of physician:_____ Date of last physical examination:_____

Are you currently under psychiatric care?____ No _____ Yes Name of psychiatrist:_____

Please list any medications you are currently using?_____

_____

Do you have a past history of substance abuse or addiction? _____ No _____ Yes

If yes, please describe any past treatment, length of sobriety and any current concerns with substance use? _____

Therapeutic History:

Have you had any prior counseling?_____ How helpful was your previous counseling?_____

_____

Current stressors:

(In the fields below please note areas of stress and rate the intensity on a scale of 1-10, 1 being barely noticeable and 10 being extremely distressing):

Marriage and home_____

Children/parents_____

Work/school_____

Financial_____

Social_____

Spiritual_____

Sexual_____

Other_____

Major present

stressors_____

List any current or past legal history or current legal problems (trouble with the law)? _____

_____

Please explain any childhood history of abuse (physical, sexual, emotional or spiritual)?

_____

_____

In your own words, briefly describe the main problem that prompted you to seek therapy?

_____

_____

How can therapy be most helpful to you?_____

_____

What would you like to change about your situation? (e.g., goals)_____

_____

_____

What have you done so far to find solutions to the problem? Has anything been helpful?

_____

_____

Is there anything else that you believe might be important for your therapist to know at this time? _____

_____

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

Insurance Information (If you have a copy of your insurance card you may disregard this section.)

PRIMARY INSURANCE:_____Group No.:_____

Policy Holder:_____Ins. I.D. Number:_____

Relationship to Patient:_____Birthdate:_____Effective Date:_____

Employer:_____City & State:_____

SECONDARY INSURANCE:_____ Group No.:_____

Policy Holder:_____Ins. I.D. Number:_____

Relationship to Patient:_____Birthdate:_____Effective Date:_____

Employer:_____City & State:_____

Please see the next page for consent and assignment of benefits.

Information and Consent to Treatment

Thank you for entrusting your therapeutic care to Jennifer Walrod, LCSW. Jennifer provides client-centered, confidential, psychotherapeutic counseling to individuals, couples and families. She will help individuals look at many aspects of their life; physical, emotional, mental, relational and spiritual using professional clinical training. Jennifer promotes inner healing and wholeness according to the needs of each person, and believes in the dignity, value and worth of each individual life. She believe there is hope even in the most challenging life circumstances.

I acknowledge that I have received, have read (or have had read to me), and understand the privacy policy and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in behavioral health treatment with Jennifer Walrod, LCSW.

- I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest.
- I agree to play an active role in this process
- I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.
- I understand that the intake diagnostic fee is $180 with subsequent session fees at $145/per clinical hour. If insurance is billed, you are responsible for co-pay amounts at the time of services. If you are paying "out of pocket" a 15% deduction will be applied. These fees also apply to the preparation of assessment reports, court appearances, consultations, or meetings you have authorized as part of your therapeutic process. If payment for the services I receive is not made, Jennifer, though reluctantly, may stop my treatment.
- I have the right and responsibility to choose a therapist and treatment modality that best suits my needs and purposes.
- Once sessions begin, the duration and termination of therapy is something that should be a joint decision. Thoughts and feelings around wanting to stop therapy are important and encourage you to raise these concerns in counseling sessions.
- I am aware that I may stop my treatment with Jennifer Walrod, LCSW at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered).
- I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel and do not show up, I will be charged $75 for that appointment.
- Records maintained by Jennifer Walrod, LCSW are considered medical records and protected health information. She places a high value on confidentiality and will make every effort to ensure

your privacy. Consultation with individuals or organizations regarding your treatment will require your written consent. There are, however, some exceptions and limitations to confidentiality as required by law. These specific situations are:

1. Any known or reasonably suspected cases of ***child abuse or neglect.***
2. Any known or suspected ***intentions of harming oneself (suicide****).*
3. Any known or suspected ***intentions of harming others.***
4. When written ***consent is given by the client*** to release information.
5. When charges are brought against a counselor in response to a ***subpoena from a court of law or administrative agency.***

Privacy Policy and Assignment of Benefits

The **HIPPA Notice of Privacy Practices and Authorization to Disclose Limited Mental Health Information** provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I acknowledge receipt of this document and my signature below indicates that I understand and consent to treatment under these conditions.

I acknowledge and authorize Jennifer Walrod, LCSW, PLLC to use and disclose my individual identifiable health information for the purpose of providing treatment to me, receiving payment from responsible parties for behavioral health care services rendered and / or engaging in behavioral health care operations. My signature below allows Jennifer Walrod, LCSW, PLLC to receive all benefits which are or shall become payable from any third party payer. I authorize and direct all third party payers to pay all benefits directly to Jennifer Walrod, LCSW, PLLC.

I understand that I have the right to request a restriction on the use or disclosure on my Health information. I further understand that I have the right to revoke this consent, in writing. I acknowledge that I have received a copy of the HIPPA Notice of Privacy Practices from Jennifer Walrod, LCSW, PLLC which provides a description of the uses and disclosures of protected health information.

With my signature I acknowledge I have read and understand the nature of counseling services, my rights, responsibilities, HIPPA Notice of Privacy Practices and hereby consent to treatment with Jennifer Walrod, LCSW.

_____ _____

Signature of patient (or authorized representative) Date

_____ _____

Printed name Relationship to client

PLEASE SUBMIT PAYMENT AT TIME OF SERVICE