Filitti Counseling Services, LLC

2728 Asbury Rd. Suite 950

Dubuque, IA 52001

The following questions will help me understand your history and reasons you are seeking counseling. This will help me meet your treatment needs. Please complete this intake as thoroughly as possible and let me know if you have any questions.

CONTACT INFORMATION

Client Name: _____ Birth Date: _____

E-mail Address: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Marital Status: ☐Married ☐Single ☐Separated ☐Divorced ☐Widowed Student Status: ☐Not a Student ☐Full Time ☐Part Time

Employment Status: ☐Not Working ☐Full Time ☐Part Time Referred by: _____

The following section will give me the demographic information necessary to begin treatment:

PARENT/GUARDIAN INFORMATION ☐ Not applicable

Note: The guardian who brings the child to treatment will be responsible for payments.

Mother's Name: _____ E-mail Address: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Please check the ways I can communicate with you: ☐Mail ☐Home Phone ☐Cell Phone ☐Text Message ☐Email

Father's Name: _____ E-mail Address: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Please check the ways I can communicate with you: ☐Mail ☐Home Phone ☐Cell Phone ☐Text Message ☐Email

I use an online system through Kasa Solutions (kasa-solutions.com) to schedule and bill insurance. Kasa will also allow you to schedule your own appointments and pay your account balance. If you are interested I can sign you up with your email address. You can also receive reminders through e-mail or text message. Please select the options below:

Would you like to be signed up to schedule and pay online thru Kasa's MyTherapyPortal.com? ☐Yes ☐No

E-mail Appointment Reminders: ☐Yes ☐No E-mail Address _____

Text Appointment Reminders: ☐Yes ☐No Cell Phone _____

COLLATERAL INFORMATION

Primary Care M.D.: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone:_____

ASSESSMENT INFORMATION

Please describe your reason(s) for seeking treatment at this time.

_____

_____

Family Constellation

Mother Information:
Biological: ☐Yes ☐No Education:_____ Occupation:_____ Age:_____

Father Information:
Biological: ☐Yes ☐No Education:_____ Occupation:_____ Age:_____

Parents Married: ☐Yes ☐No Year:_____ If not married, living together? ☐Yes ☐No

Parents Divorced: ☐Yes ☐No Year:_____

Step Mother Information (if applicable):
Education:_____ Occupation:_____ Age:_____

Step Father Information (if applicable):
Education:_____ Occupation:_____ Age:_____

Sibling Information (if applicable):

Name	Age	Relation	Residency

Family History

Substance Abuse: ☐Yes ☐No Notes:_____

Mental Illness: ☐Yes ☐No Notes:_____

Suicide: ☐Yes ☐No Notes:_____

Violence: ☐Yes ☐No Notes:_____

Mental Health History ☐Not Applicable

Provider:_____ Date Range:_____ Outcome: ☐Successful ☐No Change

Provider:_____ Date Range:_____ Outcome: ☐Successful ☐No Change

Provider:_____ Date Range:_____ Outcome: ☐Successful ☐No Change

Current Medications ☐Not Applicable

Medication:_____ Doctor:_____ Date Started:_____

Medication:_____ Doctor:_____ Date Started:_____

Medication:_____ Doctor:_____ Date Started:_____

Medical History

Loss of Consciousness: ☐Yes ☐No Notes:_____

Brain Injury: ☐Yes ☐No Notes:_____

Surgeries: ☐Yes ☐No Notes:_____

Other:_____

Abuse History

Victim of Emotional Abuse: ☐Yes ☐No Notes:_____

Victim of Physical Abuse: ☐Yes ☐No Notes:_____

Victim of Sexual Abuse: ☐Yes ☐No Notes:_____

If YES to any of the above, was it reported? ☐Yes ☐No ☐Not Applicable

Witness to Violence History

Witness of Emotional Abuse: ☐Yes ☐No Notes:_____

Witness of Physical Abuse: ☐Yes ☐No Notes:_____

Witness of Sexual Abuse: ☐Yes ☐No Notes:_____

If YES to any of the above, was it reported? ☐Yes ☐No ☐Not Applicable

Substance Abuse History

Nicotine: ☐Yes ☐No Last Use:_____ Pattern of Use:_____

Alcohol: ☐Yes ☐No Last Use:_____ Pattern & Kind:_____ Treatment: ☐Yes ☐No

Drugs: ☐Yes ☐No Last Use:_____ Pattern & Kind:_____ Treatment: ☐Yes ☐No

Criminal Background

Arrests: ☐Yes ☐No Notes:_____

Charges: ☐Yes ☐No Notes:_____

Convictions: ☐Yes ☐No Notes:_____

Probation: ☐Yes ☐No Notes:_____

Parole: ☐Yes ☐No Notes:_____

Academics ☐Not Applicable

School:_____ Grade:_____ Counselor:_____

Performance:_____ Regular Education: ☐Yes ☐No

Occupational ☐Not Applicable

Employer:_____ Dates:_____ Position:_____

Satisfaction:_____

Risks

Suicide: ☐Yes ☐No Notes:_____

Violence: ☐Yes ☐No Notes:_____

Psychosis: ☐Yes ☐No Notes:_____

HIV: ☐Yes ☐No Notes:_____

Strengths

Please take a moment to list out your strengths and tell me when you feel the most happiness:_____

_____

_____

_____

_____

Nutrition, exercise and sleep are three crucial components to mental health and overall well being. While I am not a medical doctor and will not be treating any physical illnesses, it is important for me to be aware of your daily living habits.

Nutritional Health (Please circle as many statements as pertain to you)

	Circle
I have an illness or condition that made me change the kind and/or amount of food I eat.	2
I eat fewer than 2 meals per day.	3
I eat few fruits and vegetables.	2
I have 3 or more drinks of beer, liquor or wine almost every day.	2
I have tooth or mouth problems that makes it difficult for me to eat.	2
I don't always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take 3 or more different prescribed or over-the-counter medications a day.	1
Without wanting to I have lost or gained 10 pounds in the last 6 months.	2
I am not always physically able to shop, cook and/or feed myself.	2
Total:	_____

Exercise ☐None

Type of Exercise:_____ Duration:_____ Days per week:_____

Type of Exercise:_____ Duration:_____ Days per week:_____

Type of Exercise:_____ Duration:_____ Days per week:_____

Sleep

Normal Bed Time:_____ Normal Wake Time:_____ Estimated Average Hours of Sleep/Night:_____

On an average day, do you feel fatigued? ☐Almost Never ☐Seldom ☐Sometimes ☐Often ☐Almost Always

INSURANCE & MEDICAL INFORMATION

*** Please indicate If you have a Health Savings Account (HSA)*

Primary Insurance Information	Secondary Insurance Information
Insurance Company:	Insurance Company:
Subscriber' Name:	Subscriber' Name:
Subscribers DOB:	Subscribers DOB:
Insurance Address:	Insurance Address:
Insurance Phone:	Insurance Phone:
Employer:	Employer:
Employer Phone #:	Employer Phone #:
Subscriber ID:	Subscriber ID:
Policy #:	Policy #:
Group #:	Group #:
Subscriber's Relationship to Client: □ Parent □ Spouse □ Other:	Subscriber's Relationship to Client: □ Parent □ Spouse □ Other:

TREATMENT PHILOSOPHY

We believe in providing goal-directed treatment. This means that a treatment goal or several goals are established after a thorough assessment. All treatment is then planned with the goal in mind and progress is made toward accomplishment of that goal in a time-efficient manner.

CONFIDENTIALITY

All information between provider and client is held strictly confidential unless:

- The client authorizes release of information with his/her signature, or parent/guardian signature.
- The client presents a physical danger to self.
- The client presents a danger to others.
- Child or Adult abuse/neglect is suspected.

We are required by law to inform potential victims and legal authorities of potential dangers.

FINANCIAL TERMS

Upon verification of health plan/insurance coverage and policy limits, your insurance carrier will be billed for you and we will be paid directly by the carrier. You will be responsible for any applicable deductibles and co-payments. Co-payments must be paid at the beginning of each session for services rendered. If you are not eligible at the time services are rendered, you are responsible for full payment.

CANCELLED/MISSED APPOINTMENTS

A scheduled appointment means that time is reserved only for you. If an appointment is missed or cancelled with less than twenty-four (24) hours notice, you may be billed $45 for the missed appointment.

EMERGENCY PROCEDURES

If you have a mental health emergency, please call (563) 223-8566 to contact Jon Filitti and leave a message stating your name, contact

information, and a description of the emergency. If you have a medical or life threatening emergency, please dial 911.

RELEASE OF INFORMATION

By signing below, you authorize the release of information regarding your care to your health plan for the payment of claims, certifications/ case management decisions, and other purposes related to the administration of benefits for your health plan while being seen at the Filitti Counseling Services, LLC.

CLIENT RIGHTS AND RESPONSIBILITIES

No list of client rights can ensure the respect of those rights. It is the intent of Filitti Counseling Services, LLC to make sure that all aspects of treatment and service reflect concern and respect for client's rights as well as high ethical standards.

- Each client has the right to considerate care with the client's safety and personal dignity being of prime importance.
- Each client shall have reasonable access to care, regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability.
- Each client has the right to have his or her cultural, psychological, spiritual and personal values, beliefs, and preferences respected.
- Each minor client has the right to include his or her parent/family member/guardian in treatment.
- Each client has the right to privacy, confidentiality, and security, in accordance with agency, state and federal regulations governing the confidentiality of information. Client confidentiality will be maintained during case consultations, clinical supervision and all internal or external audits of clinical records. All records reviewed by auditors, external entities and business associations, will be noted on the accounting summary form for HIPAA purposes.
- Treatment services are provided regardless of whether authorization for release of information is signed.
- Each client and when appropriate the family, has the right to complete information about treatment including, but not limited to: Limits of confidentiality, Treatment planning, Risks of Treatment, Alternatives to Treatment, Cost of Service and/or any changes in treatment recommendations (including changes in clinical staff).
- Each client has the right to access, request amendment to, and receive an accounting of disclosures regarding his or her own clinical/service information as permitted under applicable law. (Please see Notice of Privacy Practices)
- Each client who seeks services voluntarily has the right to refuse and/or terminate care, treatment or services at any time.

CONSENT FOR TREATMENT

Please read the following statement and sign below:

> I authorize and request that the professional staff at the Filitti Counseling Services, LLC carry out mental health examinations, therapy, counseling, evaluations, treatments, and/or diagnostic procedures, which now or during the course of my care are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable. I hereby acknowledge that I am willing and without coercion, taking part in these mental health related procedures.

By signing below, I understand and agree to the above information as described on pages 6 and 7 of this intake packet.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature (if applicable) Date

FILITTI COUNSELING SERVICES, LLC

PRIVACY NOTICE ACKNOWLEDGEMENT

Filitti Counseling Services, LLC
2728 Asbury Rd
Suite 950
Dubuque, IA 52001

I hereby acknowledge that Filitti Counseling Services, LLC has provided the Privacy Notice as required by the Health Insurance Portability and Accountability Act of 1996.

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature Date

_____ _____

*Staff Signature Date

* If client refuses to acknowledge receipt of the Privacy Notice

Filitti Counseling Services, LLC
2728 Asbury Rd. Suite 950
Dubuque, IA 52001

CREDIT CARD AUTHORIZATION FORM

Client Name:_____ DOB:_____

Credit Card Information (HSA or Flex accounts accepted)

Card Holders Name (as it appears on the card): _____

Card Number: _____

Expiration Date: _____ Card Code: _____

Street Address (associated with card): _____

City: _____ State: _____ Zip Code: _____ Phone:_____

Credit Card Authorization

I, _____, the undersigned, authorize Filitti Counseling Services, LLC to charge the credit card listed above under the following terms:

- **Payment Authorization:** I authorize charges for services rendered if there is a remaining balance due from copays, coinsurance, or deductible amounts.
- **Billing Schedule:** My card will be charged on the 15th of each month if there is an outstanding balance. Your balance can be viewed online at any time. If the 15th is a weekend or holiday, your card will be charged the following business day.
- **Responsibility for Payment Review:** I understand that it is my responsibility to review my Explanation of Benefits (EOB) statements, as they will indicate the amount owed per session.
- **Secure Payment Processing:** I give permission for my payment information to be securely stored and processed through Authorize.net.
- **Being Informed:** If you would like more information regarding how we bill for services, please ask for a copy of the *Credit Card Billing Explanation* form.

By signing below, I acknowledge and agree to the terms outlined in this authorization.

_____ _____ _____
Card Holder Name (Print) Signature Date