Caldwell-Clark

10951 Sorrento Valley Road, Suite 2G • San Diego, CA 92121 • (858) 876-5113

NEW CLIENT INFORMATION/CONSENT FORM

Client Name(s): _____Today's Date: _____
(To be completed by the Parent/Guardian if client is younger than 18 years)

Date of Birth: _____ Age: _____ Social Security #: _____

Address: _____ Email: _____

Phone (May we call you at): Home? _____ Work?_____ Cell?_____ Text? Y/N

Relationship Status: (Check one) Single ___ Married: Date _____ Separated/Divorced: Date _____ Widowed: Date _____
Living together – Date _____ Partnered – Date _____ Other: _____

People living in home: name/age/relationship to you: _____

_____

_____

Employer/School: _____ Occupation: _____

Person to be contacted in case of emergency:
Name: _____ Relationship: _____

Phone: Home _____ Work _____ Cell _____

Presenting Problem (s): Please describe the reasons you are seeking counseling (include date the problem started):

_____

_____

_____

_____

Medical History: Please list any prescription medications you currently use:

NAME	DOSAGE	FREQUENCY

_____

_____

_____

_____

Please list any past or present conditions that you are of have been treated for:

_____

_____

_____

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Client Name: _____**Today's Date**: _____
(To be completed by the Parent/Guardian if client is younger than 18 years)
When did you last have a physical examination? _____

Who did you see? Name: _____ Phone: _____

Phone (May we call you at): Home? _____ **Work?**_____ **Cell?**_____

Psychiatric History:
Have you ever received psychological or psychiatric treatment of any kind before? [ ] Yes [ ] No
If you answered Yes to the above question, please answer the following:
What type of care did you receive? [ ] Inpatient (hospital) [ ] Outpatient [ ] Both
Dates you were in treatment: _____
Where? _____
How long was your treatment? _____
Who was your therapist or doctor? _____
Were you prescribed medicine at this time? [ ] Yes [ ] No [ ] Not applicable
If Yes, what was prescribed (include dosages if you know): _____

_____

_____

Family History: Please describe any significant emotional, medical, or chemical dependency conditions of your parents and/or other family members: _____

_____

_____

_____

_____

Substance Use History: Have you ever used drugs or alcohol? [ ] Yes [ ] No - If Yes, please describe:

Substance	Amount	Frequency	When? (First and Last use)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever received substance abuse treatment of any kind before? [ ] Yes [ ] No
Do you have a history of blackouts, seizures, or withdrawal symptoms? [ ] Yes [ ] No

Please describe anything else you'd like your clinician to know:

_____

_____

_____

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Client Name: _____**Today's Date**: _____
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Habits:	**Amount Currently Using**	**Most Ever Used**
Coffee (cups/day):	_____	_____
Cigarettes:	_____	_____
Alcohol:	_____	_____

PLEASE INDICATE HOW YOUR PROBLEMS ARE AFFECTING THE FOLLOWING AREAS:

	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	Extreme Effect
Marriage/Relationship	1	2	3	4	5	6
Family	1	2	3	4	5	6
Job/School Performance	1	2	3	4	5	6
Friendships	1	2	3	4	5	6
Hobbies	1	2	3	4	5	6
Financial Situation	1	2	3	4	5	6
Physical Health	1	2	3	4	5	6
Anxiety level/nerves	1	2	3	4	5	6
Mood	1	2	3	4	5	6
Eating Habits	1	2	3	4	5	6

If your eating habits are affected, describe how: _____

_____

Sleeping Habits	1	2	3	4	5	6

If your sleeping habits are affected, describe how: _____

_____

Sexual Functioning	1	2	3	4	5	6
Ability to concentrate	1	2	3	4	5	6
Ability to control temper	1	2	3	4	5	6
Self-confidence	1	2	3	4	5	6

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Client Name: _____**Today's Date**: _____
(To be completed by the Parent/Guardian if client is younger than 18 years)
Please initial each section, indicating you acknowledge the information you have read:

____**Confidentiality:** All information between counselor and client is held strictly confidential, unless:

1. The client authorizes release of information with his/her signature.
2. The client presents a physical danger to self.
3. The client presents a danger to others*.
4. Child/elder abuse/neglect are suspected*.

**We are mandated by law to inform potential victims and legal authorities so that protective measures can be taken.*

____**Financial Terms:** The client is responsible for payment of psychotherapy services. Unless otherwise negotiated with therapist payment of services is due in full at the time of service. Payment arrangements should be made prior to your first visit. **Fee per hourly visit is $85/therapy hour (50 min)**, unless determined otherwise in the amount of ____ /therapy hour. *Therapist reserves the right to increase the fee with reasonable notification (at least 30 days).*

____**Canceled/Missed Appointments:** A scheduled appointment means that time is reserved only for you. If an appointment is missed or canceled with less than 24 hours notice, the client will be billed according to the scheduled fee. A credit card will be placed on file to pay for the missed session.

____**Phone calls:** Phone calls beyond 10 minutes will be subject to charge.

INSURANCE INFORMATION:

Health Plan/Insurance: _____ Policy # _____ Group # _____

Subscriber Name: _____ Employer: _____ Ins. Phone: _____

(If Applicable) Preauthorization/Referral needed? Yes No Auth Code: _____ Physician Name: _____

* **Financial Terms with Health Insurance:** Many clients have insurance coverage for psychotherapy services. As with all health care, the client or designated party is responsible for payment of services. Insurance forms will be prepared on a monthly basis to help collect from insurance carriers when the forms and information required by the insurance company are submitted to this office.

*** Caldwell-Clark and its representatives are Out-of-Network Providers.** The client shall pay fee in full each session. Insurance forms will be prepared on a monthly basis. Caldwell-Clark deems no responsibility for the reimbursement of payment from the client's insurance carrier. **It is the responsibility of the client to send in the forms and receive reimbursement from their insurance carrier, unless otherwise agreed upon.**

____**HIPAA: In accordance with the Health Insurance Portability and Accountability** Act of 1996, Caldwell-Clark, and it's employees, ensures all correspondence and documentation of the client is kept confidential and secure based on the national HIPAA and Board of Behavioral Science standards.

____**VIDEO COUNSELING:** I consent to video counseling. I am aware that, at times, Caldwell-Clark, and it's employees, utilizes HIPAA compliant platforms to conduct counseling.

____**Consent for Treatment:** I further authorize and request that Caldwell-Clark provide psychological treatment and/or diagnostic procedures, which now or during the course of my care as a client are advisable. I understand that the purpose of these procedures will be explained to me upon my request and are 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.

Confirmation of Acceptance to Terms: I agree to all of the above information.

_____	_____	_____
Client (or Parent/Guardian) Print	Client (or Parent/Guardian) Signature	Date
_____	_____	_____
Client (or Parent/Guardian) Print	Client (or Parent/Guardian) Signature	Date