Rhea Fugal Counseling

Licensed Clinical Social Worker, Registered Play Therapist
(619) 741-3324, www.RheaFugal.com, info@rheafugal.com
5480 Baltimore Dr. Suite 201, La Mesa, CA 91942
Individual, Family, & Child Therapy

INTAKE FORM (ADULT)

Name: _____ **Sex**: _____ **Age**: _____

Birth-date: _____ **Place of Birth**: _____

Address: _____

City: _____ CA, **ZIP** _____

Home phone: _____ **Other phone**: _____

For Confidential /Private Messages: Phone: _____

Occupation or School attending: _____

Highest Grade Completed/Degree: _____ **Type of Degree**: _____

Social Security #: _____

Marital Status: S M D Widow/er Separated

Spouse/Partner's name (if applicable) _____

Presenting Problem (when did it start, how does it affect you…): _____

_____

_____

Estimate the severity of above problem: Mild-Moderate-Severe-Very severe

_____

_____

INSURANCE INFORMATION

Insurance: _____

Name of Insured: _____ **DOB:** _____

Social Security number of insured member: _____

Employer: _____

ID/Plan Name/Number: _____ **Group Number:** _____ **Co-payment:** _____

MEDICAL INFORMATION

Primary Care Physician: _____ **Phone:** _____

Past/Present Medical Issues (if applicable):

_____

_____

Current Medications: _____

_____

Medication allergies or other serious allergies? _____

RISK HISTORY

Drug/Alcohol Use/Abuse: _____

Suicide Attempt/s or **Violent Behavior:** (describe: ages, reasons, circumstances, how, etc)**:**

_____

Abuse Victim? _____ **Domestic Violence Victim/Witness?** _____

OTHER MEMBERS OF THE HOUSEHOLD

Name	**Relationship**	**Age**

EMERGENCY CONTACT INFORMATION

Who may I contact in event of an emergency?

Name: _____

Address: _____

Phone: _____ **Relationship:** _____

Name: _____

Address: _____

Phone: _____ **Relationship:** _____

Referral Source: _____

_____

Signature of Client or Representative Date

_____

Signature of Client or Representative Date

ASSIGNMENT OF BENEFITS

Please sign this section if insurance benefits are to be paid to the provider rather than to the client.

I hereby authorize payment, directly to Rhea Fugal, LCSW, of the benefits otherwise payable to me under the terms and conditions of my health insurance. I understand that I am financially responsible to the above provider for the charges not covered by my insurance.

_____

Signature of Client or Representative Date

RELEASE OF INFORMATION

I authorize the release of any medical or other information necessary to process insurance claims or obtain additional/continued authorization for services. I understand that this release includes billing and clerical personnel who are also under legal obligation to maintain confidentiality.

_____

Signature of Client or Representative Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* that I have provided for you in paper or electronic form. My *Notice of Privacy Practices* provides information about how I may use and disclose your protected health information. Please read it in full.

The *Notice of Privacy Practices* is subject to change. You may obtain a copy of the updated notice upon revision or request. If you have any questions about my *Notice of Privacy Practices*, please contact me at 760-815-5826.

_____

Signature of Client or Representative Date

AGREEMENT FOR SERVICES/INFORMED CONSENT

Welcome to my practice. There follows some essential information about psychotherapy. Please read and sign at the bottom to indicate that you have reviewed this information.

Length and frequency of treatment: Psychotherapy typically involves regular sessions that are 50 minutes in length. Duration and frequency vary depending on the nature of your problem and your individual needs.

Confidentiality: Information that you share with me will be kept strictly confidential and will not be disclosed without your written consent. By law, however, confidentiality is not guaranteed in life-threatening situations involving yourself or others, or in situations in which children are put at risk (such as by sexual or physical abuse or neglect).

Regular professional consultation is an important element in psychotherapy practice. Please be aware that I may participate in clinical, ethical, and legal consultation with appropriate professionals. If I need to discuss your treatment with a colleague, I will make sure to conceal identifying information, including using a pseudonym.

Please be aware that e-mail, faxes, and cell phone communication can be easily accessed by unauthorized persons and hence, the privacy and confidentiality of such communication can be compromised. If you communicate confidential information through such means, I will assume that you have made an informed decision and view it as your agreement to take the risk that such communication may be intercepted, and I will honor your desire to communicate on such matter via e-mail, fax, or cell-phone. **Please do not use e-mail or faxes for emergencies.**

Disclosure of confidential information may be required by your health insurance carrier in order to process the claims. Only the minimum necessary information will be communicated by Therapist to the insurance carrier for reimbursement purposes. Please be aware that submitting a mental health invoice for reimbursement carries a small amount of risk to confidentiality, privacy or to future capacity to obtain health or life insurance or even a job.

Policies: If you need to cancel an appointment, please notify me at least 24 hours in advance; otherwise, I may charge you for the missed session. Please be aware that insurance carriers will not cover cancellation charges.

If you carry mental health insurance coverage, I will bill your carrier and assist with insurance reimbursement. In many circumstances, the insurance carrier limits the fee charged for the session. You will not be charged for the difference between my ordinary fee and the cap placed by insurance. Any copayment necessary should be made at the time of the office visit.

Phone and emergency contact:
If you need to contact me by phone, do not hesitate to call me. When I am not available, my confidential answering system will take a message. I do my best to return all calls within the next business day. You will not be charged for phone calls unless we have a scheduled conversation of an information-exchanging or problem-solving nature that lasts more than 15 minutes. Phone sessions will be indicated on such receipts and are not generally reimbursed by insurance. If you cannot reach me in an emergency, please contact the Access and Crisis Line at 1-800-724-7240 or go to the nearest emergency room.

Patient Litigation:
I will not voluntarily participate in any litigation or custody dispute in which Client, and another individual or entity, are parties. I maintain a policy of not communicating with you, the client's, attorney and generally will not write or sign letters, reports, declarations, or affidavits to be used in legal matters. I will generally not provide records or testimony unless compelled to do so. Should I be subpoenaed, or ordered by a court of law, to appear as witness in an action involving you, you agree to reimburse me for any time spent for preparation, travel, or other time in which I have made myself available for such an appearance at my usual and customary hourly rate.

Physician contact:
Physical and psychological symptoms often interact. I encourage you to seek medical consultation if warranted. In addition, medication may sometimes be helpful for psychological problems. When appropriate, I will arrange a referral for medication evaluation.

Termination of Therapy:
You have the right to end therapy at any time. If you wish, I will give you the names of other qualified psychotherapists.

I also reserve the right to terminate therapy at my discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, or if your needs are outside my scope of practice.

Informed consent:
I have read and understood the preceding statements. I have had an opportunity to ask questions about them, and I agree to participate in psychotherapy with Rhea Fugal, LCSW. Moreover, I agree to hold Rhea Fugal, LCSW free and harmless for any claims, demands, or suits for damages from an injury or complications whatsoever, save negligence, that may result from such treatment.

_____

Patient Name (please print)

_____

Patient signature (or authorized representative) Date