PATIENT INTAKE FORMS

*All information completed below is to allow for your treatment and is considered private and confidential*

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: Gender: female male

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred phone: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (OK to leave message? Yes No )

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: @ .com

(OK to email? Yes No )

Email communications are not considered secure or private. Please limit email communications to inquiry and scheduling only.

Social Security Number: xxx-xx-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship Status: [ ]  Single [ ]  Married [ ]  Divorced [ ]  Partnered [ ]  Widowed

[ ]  Never partnered

Ethnicity: Who lives with you?

Religious or Spiritual belief or affiliation:

Please help me to understand what your hopes from therapy are at this time and any other information you think would be helpful for me to better know you (use the back side of this sheet if you need more room):

Who can I thank for your referral?

HEALTH INFORMATION

Current health concerns and or medications:

Serious illnesses or hospitalizations, include dates:

Date of most recent physical examination:

Primary Physician’s name:

Primary Physician’s address and phone number:

Prior mental health treatment:[ ] Yes[ ] No

Prior psychiatric treatment:[ ] Yes[ ] No Psychiatric Medications [ ] Yes[ ] No

Reasons you received treatment:

Dates: Name of provider:

Current or prior substance abuse treatment or 12 step Recovery?

Dates and treatment provider length of sobriety:

PERSONAL HEALTH HISTORY

Take your time with the following, your answers may help me to know you better.

ON A SCALE OF 1-10 RATE THE FOLLOWING WITH 1 BEING POOR AND 10 EXCELLENT

Give any additional information you believe would be helpful.

Physical Health: 1 – 2 -3 – 4 – 5 – 6 – 7 -8 – 9 – 10

Sleeping Habits: 1 – 2 -3 – 4 – 5 – 6 – 7 -8 – 9 – 10

Exercise: 1 – 2 -3 – 4 – 5 – 6 – 7 -8 – 9 – 10

Appetite/eating habits: 1 – 2 -3 – 4 – 5 – 6 – 7 -8 – 9 – 10

Sadness, grief, depressive symptoms: 1 – 2 -3 – 4 – 5 – 6 – 7 -8 – 9 – 10

Thoughts of suicide or homicide: 1 – 2 -3 – 4 – 5 – 6 – 7 -8 – 9 – 10

Past suicidal thoughts or attempts: 1 – 2 -3 – 4 – 5 – 6 – 7 -8 – 9 – 10

Anxious feelings, panic or compulsions: 1 – 2 -3 – 4 – 5 – 6 – 7 -8 – 9 – 10

Pain (which interferes with functioning): 1 – 2 -3 – 4 – 5 – 6 – 7 -8 – 9 – 10

Number of drinks weekly: 1 – 2 -3 – 4 – 5 – 6 – 7 -8 – 9 – 10

Recreational drug use: 1 – 2 -3 – 4 – 5 – 6 – 7 -8 – 9 – 10

Recent trauma: 1 – 2 -3 – 4 – 5 – 6 – 7 -8 – 9 – 10

Previous trauma: 1 – 2 -3 – 4 – 5 – 6 – 7 -8 – 9 – 10

FAMILY HEALTH HISTORY

Indicate below information about your close family members and who:

Depression [ ] Yes[ ] No

Anxiety [ ] Yes[ ] No

Trauma [ ] Yes[ ] No

Eating issues [ ] Yes[ ] No

Alcohol/Substance abuse (including prescription medications) [ ] Yes[ ] No

Chronic Pain [ ] Yes[ ] No

Schizophrenia [ ] Yes[ ] No

Suicide attempts or completion [ ] Yes[ ] No

Hospitalizations [ ] Yes[ ] No

INSURANCE INFORMATION

SUBSCRIBER Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to client \_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If different from client information:*

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: XXX-XX-

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance or EAP Company:

EAP Authorization number: Number of sessions:

Phone number:

ID number: Group number:

Does your insurance require pre-authorization? [ ] Yes[ ] No

EMERGENCY CONTACT

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ relationship:

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ASSIGNMENT, FINANCIAL AGREEMENT, and SIGNATURE RELEASE

Please initial each statement and sign at the bottom

I, the undersigned, certify that I (or my dependent) have insurance coverage with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and assign directly to the therapist all insurance benefits, if any, otherwise payable to me for the services rendered.

I understand that the offices of Laara Israhel, LMFT bill my insurance as a courtesy and I am financially responsible for all charges whether or not paid by insurance.

I hereby authorize the offices of Laara Israhel, LMFT or her representative, to release all information necessary by mail, fax or telephone, to secure the payment of benefits.

I understand that the offices of Laara Israhel, LMFT reserves the right to charge the client, or responsible party, 100 % of billable amount, directly for missed appointments or those not cancelled 24 hours in advance.

There is a $30.00 fee for returned checks.

I, understand that I am responsible for late cancellation, missed appointment fees, outstanding co-pays, deductibles, or other fees deemed client responsibility.

I authorize the use of this signature on all insurance submissions.

Patient printed name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature (or Responsible Party) Date

INTRODUCTION

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask your therapist any questions that you may have regarding its contents prior to beginning therapy.

In the beginning, therapy is often difficult, you should also experience a sense of hope with a sense of possibility of improvement within the first few sessions. If this is not happening, please let your therapist know, this is important information.

Laara has a Master’s in Education from Seattle Pacific University and a Bachelor’s degree in Dance Therapy from The Evergreen State College. But she believes that her true education has come from a combination of life and professional experience, education and training and working with clients.

Areas of specialization: Mindfulness, Advanced training in Gottman Method Couple’s Therapy, anxiety, depression, trauma recovery, women’s and men’s issues, grief and loss, life transitions, addiction/ addictive family recovery, 12 step recovery, body-based expression and job/career issues. She works with diverse cultures and populations.

Laara is currently enrolled in a Qi Gong Teacher Certification training program.

THERAPEUTIC CONTRACT

Welcome

Most people enter into a therapeutic relationship because something in their lives is not working and resolving it on their own has not worked and there is the hope of improving their lives. Laara’s goal is to help her clients find ways to identify and voice needs and increase effectiveness in meeting them. Participating in therapy can result in a number of benefits to you, including a better understanding of your personal goals and values, improved interpersonal relationships, and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on you part and may result in your experiencing considerable initial discomfort. Change will sometimes be easy and swift, but more often it will be slow and take practice with new thoughts and behaviors. Remembering and resolving significant life events in therapy can bring on strong feelings of anger, depression, fear, etc. As part of my therapeutic process, I use several techniques including, but not limited to: Mindfulness, Somatic based healing, CBT, Solutions focused and Psychodynamic and psycho-education. I have advanced training in Gottman Method Couples Therapy and use this in couples therapy.

Client's Rights

You have the right to a confidential relationship with your therapist. Within certain legal limits information revealed by you during the course of therapy will be kept completely confidential and will not be revealed to any person without your written permission unless otherwise stated by law.

1. You have the right to know the content of your records at any time and I have the right to provide you with the complete records or a summary of their content. I am required to keep appropriate records for 10 years. I keep brief records noting you were here, your reasons for the visit, the goals and progress made, diagnosis (for insurance purposes).
2. If you ask me, I can release any part of your records on file to any person you specify. I will tell you when you make your request whether or not I think releasing that information to that agency or person might be harmful to you. If you are being seen as a couple, both partners must sign any releases.
3. Under certain legally defined situations, I have the duty to reveal information you tell me during the course of therapy to other persons without your written consent. I am not required to inform you of my actions if this occurs. These legally defined situations include:
4. Revealing to me active child abuse or neglect. If an alleged perpetrator is in contact with minors and there is a reasonable suspicion that he/she may still be abusing minors. Active physical, sexual, financial abuse or abandonment of a dependent adult or an elder is taking place.
5. If you threaten serious harm or death to another person, I am required to warn the intended victim and notify the appropriate law enforcement agencies.
6. If you are in therapy or are being tested by order of the court, the results of the treatment or tests ordered must be revealed to that court. I do not write any court documents or interface with the courts directly. I do not provide documentation in Workman’s Comp cases if you are being seen through your Employee Assistance Program (EAP).
7. If a court of law issues a legitimate subpoena, I am required by law to provide the information specifically described in that subpoena.
8. If you are in a lawsuit claiming emotional harm, the opposing side may subpoena your therapy records.

4. You have the right to ask questions about any of the procedures used in the course of your therapy.

5. Should you choose not to enter therapy with me, I will provide, at your request, a list with names of other qualified professionals whose services you may prefer.

6. You have the right to terminate therapy with me at any time without any financial, legal, or moral obligations other than those you've already incurred. I have the right to terminate therapy with you under the following conditions:

1. When I believe that therapy is no longer beneficial to you.
2. When I believe that another professional will better serve you.
3. When you have not paid for the last two sessions, unless special arrangements have been made with me.
4. When you have failed to show up for your last two therapy sessions without a 24-hour notice.
5. If I determine during the first three sessions that I cannot help you, I will assist you in finding someone qualified. If I have written consent, I will provide that professional with information they request.
6. When you fail to cooperate with the proposed treatment plan.

If any of these situations apply, I will send you a certified letter to your address of record to inform you of my decision and I will give you the names of several therapists for your future counseling needs.

As life can bring unexpected circumstances, should I be unable to continue your therapy, I will contact you to discuss what would be best for you at that time.

Fees and Length of Therapy

It is the policy of this office to request payment at the time services are provided unless other arrangements are made in advance or you are covered through health insurance. Sliding scale may be available upon request.

Payment for Service: Fees will be discussed prior to your first session. In general session rates are: $130.00 per individual hour/session and $150.00 per 90 minute individual session. $150.00 per couples or families hour/session and $175.00 for 90 minute couples or family sessions. Please discuss with your therapist any hardship situation that may interfere with your participation in therapy due to financial demands.

Payment is expected at the time services are rendered unless other arrangements have been made. Please notify me if any problem arises regarding your ability to make timely payment. Your fee may be paid by cash, check, credit card or Paypal. All billing is handled by a HIPAA compliant 3rd party and is done as a courtesy to you. As the client you are responsible for all payments in a timely fashion.

EAP: The benefits and responsibilities of specific EAP’s apply.

When an appointment is made that time is reserved exclusively for you. If you need to cancel or reschedule an appointment, please do so 24 hours prior to the appointment, otherwise a late cancellation fee may be charged.

I agree to pay the standard fee of for each completed session, unless other agreements are made. I will make payment in cash or by check at the time of the therapy appointment, unless other arrangements are made. I understand that the offices of Laara Israhel, LMFT bill my insurance as a courtesy and I am responsible for all therapy costs. I understand that I can leave therapy at any time and that I have no financial, legal, or moral obligation to complete the maximum number of sessions listed in this contract. I am contracting only to pay for completed therapy sessions, or session I miss without providing 24-hour notice.

I have read and understand the above information, agree to the terms and conditions and acknowledge receipt of a copy of this form, upon request.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name: date:

Therapist's Signature: Laara Israhel Date: , 201 .

**Consent for Treatment**

I authorize and request that Laara Israhel, MFT, carry out treatment which now or during the course of my care as a patient are advisable.

I understand that the purpose of any procedure will be explained to me and be subject to my agreement. I have read and fully understand this Consent for Treatment form.

Date Client's Signature

Date Therapist's Signature Laara Israhel

OFFICE POLICIES

Insurance Reimbursement: Your insurance company will be billed as a courtesy. Your personal health information and diagnosis is required for billing. Insurance information will be obtained prior to, or at first session to confirm eligibility and co-payment.

Cancellation: Since an appointment reserves time specifically for you, a minimum of 24-hours’notice is required for rescheduling g or cancellation of an appointment. The full fee will be charged for missed sessions without such notification.

Office Hours: Office hours are by appointment. Laara meets with client’s in her Mission Valley office location Wednesday, Thursday, Friday and Saturday.

Telephone Time: Contact between sessions is available. Calls for longer than 5 minutes will be charged at a pro-rated amount based on the agreed session fee. Telephone and HIPAA Compliant video conferencing appointments are available.

Sessions Greater Than 50 Minutes: Sessions beyond the fifty minutes will be prorated to the nearest quarter hour, unless you have made prior arrangements.

Emergency Procedure: An emergency is an unexpected event that requires immediate attention and can be a threat to your health. If an emergency situation arises, you will may contact San Diego crisis line: 888-724-7240, 9-1-1, or go to a local emergency room. If it is not life threatening, please state this when you leave your message and I will return your call as soon as possible.. If I have not called you back within 60 minutes and the emergency persists, follow the instructions for crisis above.

I have read and understand these office policies.

Name Printed:

Date: Signature:

Date: Signature: Laara IsrahelL

Laara Israhel, LMFT #50309

2831 Camino del Rio, South, suite 112

San Diego, California 92108

“Most people spend their lives fighting against what they don’t want, rather than fighting for what they do want."

Thank you for the privilege of working with you.