KiteString Counseling

Intake Form

PLEASE PRINT CLEARLY Today's Date _____

PERSONAL INFORMATION

CLIENT (S) _____ **RESPONSIBLE PARTY** _____

Date of Birth _____ Gender _____ Relationship to Client _____

Grade _____ School _____

Address _____ Address (if different) _____

_____ _____

City, State _____ Zip _____ City, State _____ Zip _____

Home Phone _____ Home Phone (if different) _____

Cell Phone _____ Cell Phone (if different) _____

Email _____ Email (if different) _____

Please indicate with an * which phone numbers we may leave a message.

Relative or friend in case of emergency _____

Name Phone# Relationship

Reason for referral _____

How did you hear about KiteString Counseling? _____

FINANCIAL

I understand that KiteString Counseling does not accept insurance. I will be given a receipt that I may submit to my insurance for possible reimbursement. As well, I understand that if I cancel within 24 hours or do not show up for an appointment I will be billed the entire amount of the session. I have been given the opportunity to ask questions regarding this statement.

_____ _____ _____

Signature of Responsible Party Printed Name Date

KiteString Counseling

FAMILY INFORMATION

NAME	M/F	AGE	DATE OF BIRTH	RELATIONSHIP TO CLIENT &/or MARITAL STATUS	EDUCATION	OCCUPATION
Client (s)						
1.						
2.						
Parent (s)						
1.						
2.						
Children/Step Children/Siblings						
1.						
2.						
3.						
4.						
5.						
6.						
Others Living in Household						
1.						
2.						
3.						
4.						
5.						
6.						

KiteString Counseling

MEDICAL INFORMATION

1. **Client Name** _____

Has your child ever been treated for emotional difficulties before (When and Where?) _____

_____

Physician: Name/Practice _____ Address_____ Phone _____

Date of last physical exam _____

How is your child's general health now? _____ Medications? _____

Is he/she presently being treated by a physician for any conditions? _____

Has he/she had any serious illness or injury? (List) _____

Has he/she ever had any surgeries? (List) _____

2. **Client Name** _____

Has your child ever been treated for emotional difficulties before (When and Where?) _____

_____

Physician: Name/Practice _____ Address_____ Phone _____

Date of last physical exam _____ Height _____ Weight _____

How is your child's general health now? _____ Medications? _____

Is he/she presently being treated by a physician for any conditions? _____

Has he/she had any serious illness or injury? (List) _____

Has he/she ever had any surgeries? (List) _____

***If more than two clients, please indicate above medical information on separate sheet for other clients.**

PLEASE MARK ALL THAT APPLY: (If more than one patient, please separately initial)

___Anger	___Grief	___Paranoia
___Anxiety	___Guilt	___Physical Aggression
___Behavior Problems	___Hallucinations	___School/Work Problems
___Changes in Appetite/Eating Habits	___Hopelessness	___Self Abusive Behavior
___Criminal Activity	___Hyperactivity	___Sleep Disturbance
___Decreased Energy	___Impulsiveness	___Somatic Complaints
___Delusions	___Interpersonal Conflicts	___Suicidal Thoughts /Attempt
___Depressed Mood	___Irritability	___Weight Gain
___Disruption of Thought Process/Content	___Manic	___Weight Loss
___Emotional/Physical/Sexual Trauma	___Mood Swings	___Worthlessness
___Excessive Crying	___Oppositional	___Other (Specify)
___Family Conflicts	___Panic Attacks	

What are your goals for therapy?

KiteString Counseling

You, or a member of your family, are about to become involved in counseling and/or psychoeducational assessment with a trained and licensed educational psychologist. We wish to take this opportunity to welcome you and also to state some basic principles we believe essential in establishing a good counseling relationship between us. Please read through this information, asking questions as needed.

1. INITIAL INTERVIEW: Your first visit is considered a diagnostic or evaluation interview. At the time of this appointment, the following decisions will be made with you:
   a) Frequency of therapy sessions (weekly, biweekly, etc.)
   b) Goals of therapy (what you hope to gain from this process.)

2. APPOINTMENTS: Each appointment is approximately 50 minutes. At the end of each appointment you can discuss future appointments with your counselor.

3. CANCELLATIONS: If you find that you need to cancel an appointment, please give as much notice as possible so that we can schedule people that are on our waiting list. You will be personally charged for your appointment if not canceled in at least 24 hours in advance, other than for emergency reasons.

4. PAYMENTS: We would greatly appreciate payment in full for each office visit when you come for your appointment. KiteString's rate for each counseling session is $130.00. We accept cash, check, Venmo and credit card. Please make checks out to "KiteString, LLC".

5. INSURANCE: Insurance is an agreement between you and your insurance company as to how counseling will be paid for. We will assist you in any way possible by providing receipts and documentation. We currently do not directly participate with insurance plans. However, we will assist you in contacting your insurance, giving you receipts to submit, and follow up contacts. Many insurance companies will pay for a portion of outpatient mental health services. You should check with your insurance company representative to find out specific requirements and limitations of this coverage. The hourly rate will apply. Payments for services received through KiteString Counseling are ultimately your responsibility. If your insurance company requires that outpatient mental health services be preauthorized, it is your responsibility to initiate the reauthorization process, i.e. contacting your primary care physician, insurance company, or a third party "gate keeper". Failure to obtain required preauthorization for outpatient mental health services will result in you being held 100% responsible for all charges. Late charges of 2% per month will be added to balances existing for more than 30 days.

6. CONFIDENTIALITY: All information regarding the specific nature of your counseling is maintained at KiteString Counseling and is considered confidential within the office unless specified by you in writing. We follow HIPAA and maintain confidentiality. We are bound to report suspected child abuse/neglect, harm to self/others, or follow a court-issued subpoena.

   Please check and initial each box below.

   ☐ Yes ☐ No I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions.
   ☐ Yes ☐ No I have received a copy of the Privacy Practices Form.
   ☐ Yes ☐ No I consent to the exchange of treatment information between KiteString and my primary care physician.

Patient(s):
Physician's Name/Office and Phone Number _____

Signed: _____ Date: _____

Signed: _____ Date: _____

KiteString Counseling

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5. INSURANCE: Insurance is an agreement between you and your insurance company as to how counseling will be paid for. We will assist you in any way possible by providing receipts and documentation. We currently do not directly participate with insurance plans. However, we will assist you in contacting your insurance, giving you receipts to submit, and follow up contacts. Many insurance companies will pay for a portion of outpatient mental health services. You should check with your insurance company representative to find out specific requirements and limitations of this coverage. The hourly rate will apply. Payments for services received through KiteString Counseling are ultimately your responsibility. If your insurance company requires that outpatient mental health services be preauthorized, it is your responsibility to initiate the reauthorization process, i.e. contacting your primary care physician, insurance company, or a third party "gate keeper". Failure to obtain required preauthorization for outpatient mental health services will result in you being held 100% responsible for all charges. Late charges of 2% per month will be added to balances existing for more than 30 days.

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Patient(s):
Physician's Name/Office and Phone Number _____

CLIENT COPY – KEEP THIS FORM FOR YOUR RECORDS