OSHITA COUNSELING

NORMA L. OSHITA-DUNN, LMFT
LICENSED MARRIAGE & FAMILY THERAPIST • MFC #103325
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INTAKE FORM – ADULT – PRIVATE-PAY AND INSURED

All information is kept confidential and will not be released without your written permission.

TODAYS DATE:________________

☐Private Pay ☐Insurance Carrier___________________________

First Name:_______________________________ Last Name:___________________________

DOB:___/____/_____ Age_______ ☐Gender: ☐ Female ☐Male ☐Other________

Address:____

City:_________________________ State:________________ Zip Code:____________________

Phone:__________________________________

Marital Status: ☐Single ☐ Married ☐Divorced ☐Widow ☐ Co-habituating

Occupation/Name of Employer:____

Phone Number:____

How did you hear about us?

____

Dependents in your home?: ☐Yes….How Many___ ☐ No

Emergency Contact/Relationship :____

Phone:_____________________

Reason(s) for Seeking Therapy

____

____

Have you been in any type of counseling in the past? ☐Yes ☐No (If yes, please explain below)

____

Symptoms: Please circle any symptoms that apply:

Aggression/Anger Outbursts	Anxiety	Chest Pains/Tightness
Eating Disorder	Fatigue	Worrying
Irritability	Memory Problems	Worthlessness
Suicidal Thought	Weight Loss/Gain	Restlessness
Alcohol/Drug Abuse	Avoidance of people	Depression
Elevated Mood	Fears	Gambling
Loneliness	Mood Swings	Panic Attacks
Trembling	Withdrawal	Racing Thoughts
Difficulty Thinking	Helplessness	Sleeping Disorder
Difficulty Concentrating	Dizziness	Impulsivity
Headaches	Sexual Addiction	Stress
Other	Sexual Difficulties	Hopelessness

Current Stressors : Please Circle all that apply

Marital/Relationship conflict	Health problems	Conflict with parents
Poor Peer relations	Physical	Recent move
Legal problems	Conflict with children	Housing problems
Victim of abuse	Job loss or change	Conflict with family
Separation/Divorce	Recent death	Financial Problems
Problems at work	Emotional	Other (Please write below)

Anything else you want the therapist to know? (Please write below)

____

____

Are you seeing a psychiatrist : ☐Yes ☐ No (If yes, please fill out information below)

Name and Phone Number____

Last time seen by Psychiatrist:____

Primary care Physician:_______________________ Phone Number:________________________

Date of last visit:_________________ Date of last physical:___________________

Current Medication:_________________________________ Dosage:_____________________

Current Medication:_________________________________ Dosage:_____________________

Past Medication:_____________________________________Dosage:_____________________

Past Medication:_____________________________________Dosage:_____________________

CLIENT ATTESTATION REGARDING THE INFORMATION PROVIDED ON THIS INTAKE FORM
I do hereby attest and verify that the information I have provided above is true to the best of my knowledge. If, at some later time I recall information not on this form that I feel would be relevant to my treatment, I will update my therapist. Date:__________________________ Print Name:____ Sign Name:____

NO CALL / NO SHOW / LATE CANCELLATION POLICY

This policy has been established in order to provide the highest level of clinical services to all of our clients. It has been proven that consistent attendance to one's treatment provides the greatest opportunity for success. By providing proper notice of a cancellation, we may be able to accommodate other clients with your appointment slot. Additionally, I schedule time aside to ensure that you receive my undivided attention and the expectation is that you will arrive at least 5 minutes early for your session.

Please make arrangements for childcare

I DO NOT ALLOW CHILDREN IN THE WAITING AREA

A late arrival of 15 minutes of more does not allow time for a proper session and will be identified as a missed appointment - your insurance carrier (***if applicable***) will be notified. If you need to cancel or reschedule I require 24 hours' notice. Cancellation calls with less than 24 hour notice will be considered a late cancellation and will be assessed a fee of $55.00.

• A Client will be allowed to continue with their therapy after two no-show/late cancellations, provided an acceptable explanation is supplied to the Therapist.

• After three (3) no shows/late cancellations, the Client will be discharged from treatment, as the client will have demonstrated a lack of commitment to the therapeutic process and would therefore not be an appropriate candidate for treatment. Notice will be sent to both you and your insurance carrier (***if applicable***) explaining the reason for discharge and all future appointments will be removed from the schedule.

• While we do understand that emergencies arise and that it may not be possible to give such a notice, exceptions to the No-Show/Late Cancellation Policy will be discretionary and an ultimate decision made by the treating therapist.

I have discussed, acknowledge and fully understand the No Call/No Show Late Cancellation Policy.

Date:____________________________________

Print Name:_______________________________

Sign Name:_______________________________

FINANCIAL RESPONSIBILITY:

Payments to be rendered the same day as service

Oshita Counseling takes great care to ensure that each client's therapeutic needs are met in a manner that is both ethical and beneficial to the client. We recognize that there may be situations where a client's insurance carrier no longer covers their therapy sessions. Because Oshita Counseling does not provide pro bono (free) services we ask that you verify that your insurance coverage is active prior to your session. We also make an attempt to do the same.

Once a Client is no longer eligible for insurance coverage, we will notify you prior to your appointment and will be given the option to transition to a private/cash pay client .

Policy for Collections:
In the event that a client fails to render payment for a session no longer covered by their insurance provider, or fails to pay any No Show fees, Oshita counseling will notify the client twice within a 30-day period to allow them time to remedy the past-due amount. After 30 days has lapsed without payment, the matter will be submitted to collections.

I have read, understand and agree to the terms and conditions set forth above and my obligation as set forth in the Financial Responsibility section.

Date:________________________ Print___________________________________

Sign____________________________________

CONFIDENTIALITY DISCLOSURE

During therapy we will explore different aspects of functioning including difficult emotional stories from different stages of your life. Sometimes these issues will include things you don't want others to know. As a general rule, I keep all information you share with me confidential, however, by law I am required to disclose information whether or not I have your permission. I have listed some of these situations below:

- **You tell me you plan to cause serious harm or death to yourself**, and I believe you have the intent and ability to carry out this threat in the near future. I must take steps to inform a family member, parent/ guardian, or specialized team of what you have told me and how serious I believe this threat to be. I must make sure that you are protected from harming yourself.

- **You tell me you plan to cause serious harm or death to someone else** who can be identified, and I believe you have the intent and ability to carry out this threat in the very near future. In this situation, I must inform the authorities and I must inform the person who you intend to harm.

- **You tell me a child is being abused physically, sexually, emotionally** or that you have been abused in the past. In this situation, I am required by law to report the abuse to Child Protective Services.

- **You tell me an elderly person is being abused, physically, sexually, financially, or emotionally,** at which point I will have to report to Adult Protective Services.

- **Subpoena**. You are involved in a court case and a request is made for information about your counseling or therapy. If this happens, I will not disclose information without your written agreement unless the court requires me to do so through subpoena. I will do all I can within the law to protect your confidentiality, and if I am required to disclose information to the court, I will inform you that this is happening.

I have discussed these issues with my therapist, and I understand that confidentiality can be broken when there is serious threat of self-harm, harm to others, or the safety of children and elderly people, or if subpoenaed by the court.

Date:____________________________

Print Name:____

Sign Name:____

TERMINATION OF TREATMENT

Termination of services can occur for different reasons and may be terminated when any of the following occurs:

- Completion of services is achieved
- You choose to discontinue treatment
- I feel that you may be in need of a higher level of treatment and your issues fall out of the scope of my practice. In this case, appropriate referrals will be provided
- Excessive missed appointments
- Inappropriate behavior and/or comments during treatment

DISCLOSURE REGARDING TREATMENT OUTCOMES
CONSENT FOR TREATMENT

I have been informed and understand that while there are significant benefits to participating in therapy, as it may have an impactful and positive effect in mitigating symptoms related to each individual's issues, it is in no way a guarantee of a favorable outcome regarding the therapy process. As such, I do hereby consent to treatment.

I have read, discussed and understand the "Termination of Treatment", and "Disclosure Regarding Treatment Outcomes / Consent for Treatment".

Date:______________________

Print Name:____________________________ Sign: _______________________________

This page for Therapist's use only

Therapist's Attestation

I have reviewed this intake form and asked the client if they understood and agreed to the terms and conditions of treatment as set forth above. Additionally, I addressed any concerns and/or questions the client had related to this form.

Date:_________________________

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Norma L. Oshita-Dunn, M.S., LMFT
State License: MFC#103325

Notes: ☐ None

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