Molly Kasper, LMFT
4300 Bayou Blvd Suite 21
(850) 889-1119

PATIENT 1 INTAKE INFORMATION

Date:_____

Name:_____ Age: _____ DOB:_____

Ethnicity:_____ Social Security Number:_____

Insurance Type and Number:_____

Phone number on back of card:_____

Current Address:_____

City/State:_____ Zip Code:_____

Phones (home):_____ (cell): _____ (work):_____

Email address:_____

Place/type of Employment:_____

Please check one: ☐ Married ☐ Divorced ☐ Single, never married

Is the client currently seeing any other counselors or mental health therapists: ☐ Yes ☐ No
If yes, please list name of counselor and date of last appointment:_____

Payment:

Type of payment: ☐ Private Pay ☐ Insurance:_____Copay amount: _____

Accepted forms of payment: Cash, check, and most major credit cards

Person responsible for payment (if different from above): ☐ Same as above

Name: _____ Age: _____DOB: _____SS#:_____

Insurance Type/ Number:_____

Address on file with insurance company: ☐ Same as above

Address:_____

City/State:_____ Zip Code:_____

Phones (home): _____ (cell): _____ (work): _____

E-mail Address:_____

Place/type of Employment: ☐ Same as above

_____

*Patient is responsible for payment (co-payment) upon receipt of services.

Referral Source:

Name:_____ Email (if available)_____

Emergency Contact (in case of an emergency please provide name and contact information of a person Molly Kasper, LMFT may notify):

Name: _____Phone number:_____

Relationship to client: _____

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Family Information:

Spouse's Name: ☐ N/A _____
Current Address:_____
Phone:_____ Email:_____

Father's Name: ☐ N/A Client is not a minor _____
Current Address:_____
Phone:_____ Email:_____

Mother's name: ☐ N/A Client is a minor _____
Current Address:_____
Phone:_____ Email:_____

Current Caregivers
☐ Same as above ☐ N/A Client is not a minor

Name:_____ Relationship:_____Phone:_____
Address:_____

Does the Client have any Children? ☐ Yes ☐ No If yes, please list:
Name Date of Birth/Age:

_____
_____
_____
_____

Does the Client have any Siblings? ☐ Yes ☐ No If yes, please list:
Name Date of Birth/Age:

_____
_____
_____
_____

Patient Health History:
Client's Primary Care Physician Name and Phone Number:
_____Date of last Apt:_____
Any other Healthcare Provider(s) Name and Phone Number:
_____Date of last Apt:_____

Current Health History:
Does the client have any current or chronic health issues? ☐ Yes ☐ No If yes, please list:
Is client currently taking any medication? ☐ Yes ☐ No If yes, please list:

Type:	**Start Date:**	**Dosage:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Family Medical History (Current or past):

Client	☐ Unknown	Mother ☐ Unknown	Father ☐ Unknown
High blood pressure	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Lung problems (asthma)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Heart problems	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Miscarriages	☐ Yes ☐ No	☐ Yes ☐ No	
Learning problems	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Nerve problems	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Mental illness	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Drinking problems	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Domestic violence	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Does the Client have any Allergies? ☐ Yes ☐ No If yes, please list:
Allergy to: _____
Reactions: _____
Are you allergic to any medications? ☐ Yes ☐ No If yes, please list: _____

Psychiatric History:
Psychiatric Hospitalization: ☐ Yes ☐ No If yes, describe for what reason, when, and where.

_____

Outpatient Treatment: ☐ Yes ☐ No If yes, describe reason, when, and where.

Presenting Problem
What are the problem(s) for which you are seeking help?
1. _____
2. _____
3. _____
What are your treatment goals?
1. _____
2. _____
3. _____

Are there any recent changes in your life? ☐Yes ☐ No If yes, how have these changes affected you?

_____

_____

What are some of your strengths? _____
What are some of your limitations? _____
Have you ever attempted suicide? ☐ Yes ☐ No If yes, when:_____How_____

Family Psychiatric History:
Has anyone in your family been diagnosed or treated for any of the following: (Check all that apply.)

☐Bipolar disorder ☐Depression ☐Anxiety ☐Alcohol abuse ☐Anger ☐Suicide ☐Violence
☐Schizophrenia ☐Post-traumatic Stress ☐Other substance abuse

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(continued psychiatric history) If yes, describe family member and problem:

_____

_____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ☐ Yes ☐ No
If yes, for which substances?_____
If yes, when and where did you receive treatment?_____
Do you think you have a problem with alcohol or drug use? ☐ Yes ☐ No
Have you used any street drugs in the past 3 months? ☐ Yes ☐ No
If yes, which substances?_____

Educational History:

Highest grade completed _____Where_____
Did you attend college_____Where _____Major_____
What is your highest educational level or degree attained? _____

Abuse History:

Have you ever been abused?: ☐ Physical ☐ Sexual ☐ Emotional ☐ Verbal ☐ Other
When did the abuse occur?_____
Was the abuse reported?_____
Have you sought treatment in relation to the abuse?_____
If so, where and when? _____

Relationship History:

Are you currently: ☐ Married ☐ Partnership ☐ Divorced ☐ Single ☐ Widowed

Legal History:

Have you ever been arrested? _____
Do you have any pending legal problems: _____

Spiritual Life:

Do you have spiritual/religious beliefs? ☐ Yes ☐ No
If yes, is this an area you want incorporated into your treatment? _____

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PATIENT 2 INTAKE INFORMATION

Date:_____

Name:_____ Age: _____ DOB:_____

Ethnicity:_____ Social Security Number:_____

Insurance Type and Number:_____

Phone number on back of card:_____

Current Address:_____

City/State:_____ Zip Code:_____

Phones (home):_____ (cell): _____ (work):_____

Email address:_____

Place/type of Employment:_____

Please check one: ☐ Married ☐ Divorced ☐ Single, never married

Is the client currently seeing any other counselors or mental health therapists: ☐ Yes ☐ No
If yes, please list name of counselor and date of last appointment:_____

Payment:

Type of payment: ☐ Private Pay ☐ Insurance:_____Copay amount: _____

Accepted forms of payment: Cash, check, and most major credit cards

Person responsible for payment (if different from above): ☐ Same as above

Name: _____ Age: _____DOB: _____SS#:_____

Insurance Type/ Number:_____

Address on file with insurance company: ☐ Same as above

Address:_____

City/State:_____ Zip Code:_____

Phones (home): _____ (cell): _____ (work): _____

E-mail Address:_____

Place/type of Employment: ☐ Same as above

_____

*Patient is responsible for payment (co-payment) upon receipt of services.

Referral Source:

Name:_____ Email (if available)_____

Emergency Contact (in case of an emergency please provide name and contact information of a person Molly Kasper, LMFT may notify):

Name: _____Phone number:_____

Relationship to client: _____

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Family Information:

Spouse's Name: ☐ N/A _____
Current Address:_____
Phone:_____ Email:_____

Father's Name: ☐ N/A Client is not a minor _____
Current Address:_____
Phone:_____ Email:_____

Mother's name: ☐ N/A Client is a minor _____
Current Address:_____
Phone:_____ Email:_____

Current Caregivers
☐ Same as above ☐ N/A Client is not a minor

Name:_____ Relationship:_____Phone:_____
Address:_____

Does the Client have any Children? ☐ Yes ☐ No If yes, please list:
Name Date of Birth/Age:

_____
_____
_____
_____

Does the Client have any Siblings? ☐ Yes ☐ No If yes, please list:
Name Date of Birth/Age:

_____
_____
_____
_____

Patient Health History:
Client's Primary Care Physician Name and Phone Number:
_____Date of last Apt:_____
Any other Healthcare Provider(s) Name and Phone Number:
_____Date of last Apt:_____

Current Health History:
Does the client have any current or chronic health issues? ☐ Yes ☐ No If yes, please list:
Is client currently taking any medication? ☐ Yes ☐ No If yes, please list:

Type:	**Start Date:**	**Dosage:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Family Medical History (Current or past):

Client		Mother		Father	
☐ Unknown		☐ Unknown		☐ Unknown	
High blood pressure	☐ Yes ☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Diabetes	☐ Yes ☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Lung problems (asthma)	☐ Yes ☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Heart problems	☐ Yes ☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Miscarriages	☐ Yes ☐ No	☐ Yes	☐ No		
Learning problems	☐ Yes ☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Nerve problems	☐ Yes ☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Mental illness	☐ Yes ☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Drinking problems	☐ Yes ☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Domestic violence	☐ Yes ☐ No	☐ Yes	☐ No	☐ Yes	☐ No

Does the Client have any Allergies? ☐ Yes ☐ No If yes, please list:
Allergy to: _____
Reactions: _____
Are you allergic to any medications? ☐ Yes ☐ No If yes, please list: _____

Psychiatric History:
Psychiatric Hospitalization: ☐ Yes ☐ No If yes, describe for what reason, when, and where.

_____

Outpatient Treatment: ☐ Yes ☐ No If yes, describe reason, when, and where.

Presenting Problem
What are the problem(s) for which you are seeking help?
1. _____
2. _____
3. _____
What are your treatment goals?
1. _____
2. _____
3. _____

Are there any recent changes in your life? ☐Yes ☐ No If yes, how have these changes affected you?

_____

_____

What are some of your strengths? _____
What are some of your limitations? _____
Have you ever attempted suicide? ☐ Yes ☐ No If yes, when:_____How_____

Family Psychiatric History:
Has anyone in your family been diagnosed or treated for any of the following: (Check all that apply.)

☐Bipolar disorder ☐Depression ☐Anxiety ☐Alcohol abuse ☐Anger ☐Suicide ☐Violence
☐Schizophrenia ☐Post-traumatic Stress ☐Other substance abuse

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(continued psychiatric history) If yes, describe family member and problem:

_____

_____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ☐ Yes ☐ No
If yes, for which substances?_____
If yes, when and where did you receive treatment?_____
Do you think you have a problem with alcohol or drug use? ☐ Yes ☐ No
Have you used any street drugs in the past 3 months? ☐ Yes ☐ No
If yes, which substances?_____

Educational History:

Highest grade completed _____Where_____
Did you attend college_____Where _____Major_____
What is your highest educational level or degree attained? _____

Abuse History:

Have you ever been abused?: ☐ Physical ☐ Sexual ☐ Emotional ☐ Verbal ☐ Other
When did the abuse occur?_____
Was the abuse reported?_____
Have you sought treatment in relation to the abuse?_____
If so, where and when? _____

Relationship History:

Are you currently: ☐ Married ☐ Partnership ☐ Divorced ☐ Single ☐ Widowed

Legal History:

Have you ever been arrested? _____
Do you have any pending legal problems: _____

Spiritual Life:

Do you have spiritual/religious beliefs? ☐ Yes ☐ No
If yes, is this an area you want incorporated into your treatment? _____

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CONSENT TO TREATMENT

Today's Date: _____

Patient(s) Name(s):_____ Dates of Birth:_____

I, _____, hereby voluntarily consent to outpatient mental health services from Molly Kasper, LMFT, MFCS which encompasses assessments and subsequent therapeutic treatments, if indicated.

I understand and agree that all charges incurred on behalf of my care here are my responsibility. I understand that if I have insurance, it will be billed as a courtesy and payments/credits from my insurance company will be made accordingly.

I authorize any holder of medical or other information about me to be released to Electronic Data Systems, Federal, Department of Public Health or other carriers any information needed for any related claim. I permit a copy of this authorization to be used in place of the original to request payment of medical benefits.

I, the undersigned, authorize payment of medical benefits to Kasper Couple & Family Therapy, LLC for any services furnished to me by the mental health therapist. I authorize any holder of medical information about me to release to the Health Care Financing Administration, Social Security Administration and its agents any information needed to determent these benefits or benefits payable for related services.

I understand that this consent form will be valid and remain in effect as long as I receive services from Molly Kasper, LMFT.

HIPPA/Notice of Privacy Practices: By signing below, I understand that the information contained within this document pertains to certain rights to how my protected health information is utilized in the treatment, payment and healthcare operations at this facility.

Please check any method of communication that is **not** acceptable for us to contact you:
☐ Phone ☐ Text Message ☐ E-mail ☐ Physical Mail

Reason for visit:
__ stress/anxiety __ depression __ anger issues __ divorce/relational problems
__ communication difficulties __ traumatic event__ behavioral problems __ ADHD
__ school/job related stressors __ other _____

This form has been explained to me and I fully understand this ***Consent To Treatment*** and agree to its contents.
Signature of Patient or Person Authorized to consent for patient:

X_____ Date:_____

X_____ Date:_____

Signature of Witness (Name and Credentials) who explained the contents of this "Consent to Treatment" form:

_____ Date:_____ _____

☐ I have seen and been offered a copy of HIPPA's Patient's Bill of Rights and Privacy Policies

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Grievance Policy

As a client of Molly Kasper, LMFT, we want to ensure that you are satisfied with the mental health services that you are receiving. If you are not satisfied, you have the right to file a ***grievance.*** A g*rievance* is an expression of dissatisfaction about the services that you are receiving. If you decide to file a grievance, you can do so without fear of punitive action by your mental health counselor.
Examples of types of grievances include the following areas:

a. **Access-to-Care**: This category addresses the provider's capacity to arrange a timely first visit.
b. **Clinical Care:** This category relates to any aspect about the assigned consultant and the quality of services that are provided by the therapist (e.g. their manner, competency, the treatment, etc.).
c. **Service Provision (timeliness and quality):** This category relates to a member who is already in the system and has issues with the timeliness of services offered or dissatisfaction with the number or frequency of services (e.g. the front desk staff was rude, lost the appointment, didn't pass on a message etc.).
d. **Claims:** category applies to issues related to claims or the payment of claims.

If you decide to file a grievance you must do the following:

a. You must file a grievance within one year after the date of the occurrence that initiated the grievance.
b. You may file the grievance either orally or in writing however an oral request must be followed with a written request but the time frame for resolution begins the date of the oral filing. You will receive written notification acknowledging receipt of the grievance.
c. If your grievance is with your clinician, talk to the clinician first.
d. If you are still not satisfied, contact your insurance provider.
e. If you are still not satisfied you may go to www.flhealthsource.com to file an official complaint.
f. Each grievance is to be resolved and written notice provided within 90 days.

My signature acknowledges that grievance policy has been reviewed with me.

_____ _____

Client/Caregiver Printed Name Client/Caregiver Signature

_____ _____

Client/Caregiver Printed Name Client/Caregiver Signature

_____

Date

_____

Signature of Mental Health Counselor

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Limits of Confidentiality

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____ _____

Signature of Client or Parent / Guardian if client is a minor Date

_____ _____

Signature of Client or Parent / Guardian if client is a minor Date

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Financial Policy

We make every effort to keep our costs down. All co-pays, co-insurance, deductibles and payments for non-covered services are to be paid at the time the services are rendered.

For patients with insurance policies for which our office does not participate, or patients who are self-pay, we require payment upon receipt of service.

Due to an increased number of patients cancellations/no shows for scheduled appointments, we have been forced to institute a cancellation policy. When appointments are cancelled without adequate notice, we are unable to schedule another patient in that appointment time slot. Any cancellations without one business day notice will risk a charge of $35.00. You will receive a phone call, text, or email regarding your missed/cancelled session and your card will be charged immediately. Exceptions will be made for emergencies and will be taken into consideration session by session. Thank you for your understanding and attention to this policy.

Credit Card Information
Name on card: _____
Card number: _____ Exp. Date_____
Security code:_____ Zip code of billing address: _____

By signing here you are authorizing Molly Kasper, LMFT to charge your card for the missed session.

Patient Signature: _____ Date: _____

Molly Kasper, LMFT
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(850) 889-1119

Information Sheet for the office of Molly Kasper, LMFT

PLEASE TAKE THIS FORM HOME WITH YOU

Cancellation Policy

If you are unable to make your appointment, a 24-hour notice is required. If not cancelled in the required amount of time, there is a $35 cancellation fee. If you miss your appointment and do not call ahead to cancel at all, there is a $60 no show fee.

If you miss more than 3 sessions (either no-shows or last minute cancellations), therapy will be terminated and you will be referred to a different therapy agency.

Scheduling

Due to the high volume of clients, if there is a specific day/time that you prefer, I suggest making several appointments at a time in order to guarantee an appointment.

Social Media

No, we cannot be Facebook friends, but you can (and please do) "like" my business page, Molly Kasper, LMFT. This is where you can find updated information on office closings, insurance changes, policy changes, and helpful articles and/or tools.

Contact Information

Office location: 4300 Bayou Blvd Suite 21, Pensacola, FL 32533
Email: mollykkasper@gmail.com*
Call/text: 850-889-1119*

*I return emails, phone calls, and text messages during business hours, Monday through Friday 9:00-5:00 pm.

Thank you so much for all your friendship and support. I am so blessed by all of you!

Molly Kasper