Shainker Behavioral Therapy

(Please Print)

CLIENT INFORMATION: Today's Date: _____

Name: _____ Age: _____ Date of Birth: _____

Sex: Male _____ Female _____ Email Address_____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

May I have permission to send mail to this address? YES ____ NO _____

Where can I contact you? WORK HOME CELL (Please circle)

Employer: _____Occupation: _____

How long have you worked there? _____How long in this occupation? _____

Education: (List highest level of education attained) _____

Marital Status: _____ How long? _____

Primary Physician: _____ Phone: _____

List any significant health problems: _____

_____

List any medications you are taking and the dosage: _____

_____

_____

Have you been in therapy before? YES ___ NO ____

If yes, when, and whom did you see? How was the experience for you?

_____

I am interested in the following type(s) of counseling: (Circle all that apply)

Individual Couples Family Group

How were you referred? _____

Who may I thank for referring you? _____

Emergency Contact: Name: _____ Relationship: _____

Address: _____ Phone: _____

SPOUSE/PARTNER INFORMATION:

Name: _____ Age: _____ Date of Birth: _____

Sex: Male _____ Female _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Education: (List highest level of education attained) _____

Names of Children *Age* *Living with you?*

_____

_____

_____

_____

Please list your siblings (brothers and sisters) in order of their birth, including yourself.

Names of Siblings *Age* *City and State of Residence* *Describe your relationship (close, estranged, best friends, etc.)*

_____

_____

_____

_____

_____

_____

What issues or concerns bring you to counseling today and when did these issues arise?

_____

_____

_____

_____

_____

_____

Is there any other information that you feel is important for me to know before we begin our work together? _____

_____

_____

FINANCIALLY RESPONSIBLE PERSON'S INFORMATION:

Name: _____ Relationship to Client: _____

Phone (if different from above): _____

Address (if different from above): _____

Social Security Number of Insured: _____

Date of Birth of Insured: _____

Employer: _____

INFORMED CONSENT

CONFIDENTIALITY STATEMENT:

1. I abide by and respect the ethical code of confidentiality. This means that I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me, without your written permission. You may give written consent for me to share information with whomever you choose, and you can change your mind and revoke that permission at any time.
2. The following are the legal exceptions to your right to confidentiality. I will inform you if at any time I feel it is necessary to put these into effect.
   - If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also inform the police and ask them to protect that person.
   - If I have good reason to believe that you are someone else is abusing/neglecting a child or vulnerable adult, I must inform CPS or Social Services within 72 hours.
   - If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and contact the police or crisis team. However, whenever possible, I would explore all other options with you before taking this step. In any of these situations, I would reveal only the information necessary to protect you or the person in danger. I would not tell everything you have told me.
   - If you become involved in a court case or proceeding, a judge or court may require that I provide information or testify.
   - I may sometimes consult with another professional about your treatment. All counselors are required by professional ethics to keep your information confidential. These case consultations are helpful to both you and me in determining that I am providing you with the best treatment possible.
   - If you and your partner decide to have individual sessions as part of your couples therapy, what we discuss in those individual sessions will most likely be discussed in your joint sessions. I will not be a part of keeping secrets between partners in couples therapy. If you do not wish to work on your concerns together, I suggest you see separate counselors for individual therapy.

FINANCIAL AGREEMENT:

The regular fee for an initial assessment is $225 and a 50-minute session is $175.00 (payable at the time of treatment). I accept credit cards (processing fee applies), cash and checks. Many insurance plans are accepted with prior authorization. If your insurance is not one that I accept, you may be able to utilize your out-of-network benefits. You will need to pay your session fee in full at the time of service, and I can provide you with a HCFA billing form, which you can submit to your insurance company for reimbursement.

(Choose one and initial)

_____ I agree to pay the fee of $225 (initial assessment) and $175 (50-minute session).

_____ I agree to pay the agreed upon fee of $_____ per 50-minute session.

*Based on sliding fee scale- proof of income required.

_____ My insurance carrier is _____ Co-pay _____

Member Id # _____Provider Services ph #_____

Fees are periodically reviewed and subject to change. However, you will receive a 30-day notice of any fee increase.

***Payments made by credit card will be charged an additional 3.5% processing fee. Other acceptable payment methods include Venmo and Zelle.**

FINANCIAL POLICY:

1. You are responsible for full payment of all services. **If your insurance refuses a claim, you will be required to pay the entire amount.**
2. Payment is due at the time of treatment. If you choose to pay by check and your check is returned for insufficient funds, your account will be assessed a $25.00 returned check fee, in addition to the amount of the bounced check.
3. Any fees left unpaid for 30 days will accrue interest of 20% per month.
4. If you require a receipt for services, please indicate below.
   _____ I will need a receipt for services
5. Your appointment time has been set aside for you. You are responsible for coming to your session **on time** and at the time we have scheduled. If you are late for your session, we will still end on time and your regular session fee will apply.

CANCELLATION POLICY:

If you cannot attend your appointment, you **MUST cancel at least 24-hours in advance**. If you do not cancel within 24 hours, or miss a session without canceling, **you will be obligated to pay a $60 no show or late cancellation fee before I will schedule another visit for you (Insurance will not pay for no shows or late cancellations).** Please note that I will handle emergency situations on a case by case basis.

Initial Here _____

TELEPHONE CALLS, REPORTS AND LEGAL REPRESENTATION:

1. I prefer to see and talk with you in person at our scheduled session time. However, I am aware that telephone calls are necessary at times. If I am unable to answer, please leave a message, including your phone number, and I will return your call as soon as possible.

2. If you request that I write reports to be sent to schools, employers, lawyers, doctors, courts, Child Protective Services, etc., you will be charged for the time it takes me to write these reports. Court appearances will be billed at $200.00/hour.

3. I am not a legal consultant or representative. I do not do custody evaluations or make recommendations regarding child custody. If you do require these services I will be happy to provide you with referrals.

ENDING THERAPY:

Usually, ending therapy happens naturally and takes place over several weeks in the process of treatment. Should you wish to stop therapy at any time, I ask that you allow yourself and/or your child to have a final session, regardless of the reason for ending. Closure is an essential element in the process of good therapy, which I highly value. If you request, I will refer you to another provider.

EMERGENCIES:

In the event of a psychological emergency, please call 911. You may also call the Suicide Prevention Hotline of Nevada at 1-877-885-HOPE, Montevista Hospital at 364-1111, Spring Mountain Treatment Center at 873-2400, or Nevada Adult Mental Health at 486-8020.

STATEMENT OF UNDERSTANDING:

I have read the enclosed policies and procedures, asked any necessary questions, and understand the terms of this consent. I understand my rights and responsibilities and my therapist's responsibilities to me. I agree to these conditions and consent to treatment.

_____	_____	_____
Client Name (print)	Client Signature	Date
_____	_____	_____
Parent/Guardian if minor (print)	Parent/Guardian Signature	Date
Alyson Shainker, LCSW	_____	_____
Provider/Therapist	Provider/Therapist Signature	Date

Shainker Behavioral Therapy

The security of your personal information is extremely important. Shainker Behavioral Therapy is committed to protecting the security and privacy of any personal information you provide, including any financial information. Please inquire of any questions concerning this authorization, the "information regarding services" and/or "Notice of Privacy Policy Practices" forms provided for your review and agreement.

CREDIT CARD AUTHORIZATION

I hereby grant Shainker Behavioral Therapy permission to process credit/debit charges

Client Name/s: _____

Please read all below:

Acceptable forms of payment are: cash, check, debit card or credit card.

My initials below:

_____ Without my debit/credit card, I authorize Shainker Behavioral Therapy to use my credit/debit card number provided below to process charges/fees assigned to any named individual listed above.

_____ I authorize Shainker Behavioral Therapy to be compensated for missed appointments of which the client/s named above did now show up for session or cancel session less than 24 hours before the time of the appointment. Missed and late canceled appointment fees are billed at $60 per session.

Please complete all of the information below:

Type of card (circle) VISA, MC, Discover, American Express

Exact name on card _____

Relationship to client _____

Card number _____

Expiration Date _____

CUV _____

Billing address_____

_____

Signature _____

Date _____