Family Systems Therapy Associates
New Client Intake Form

Date: ____/_____/_____

Legal Last Name: _____Legal First Name:_____Chosen Name_____

Address _____City_____ST_____Zip_____

Email: _____Phone:_____

DOB_____ Age _____ O Male O Female O Non-binary

How would you describe your gender? (Feel free to write as much or as little as you'd like)

_____

Social Security # _____

Marital Status	Employment	Student
○ Single	O Working O fulltime O part time	O Full time
○ Married	O Not working	O Part time
○ Divorced	O Retired	O Not a student
○ Separated		
○ Partner		

Emergency contact Name: Last _____First_____

Ph_____Relation_____

Insurance_____ID#_____Auth#_____

O Copayment $_____

How were you referred to us? (Thank you for taking the time to complete this!)

O Insurance #_____O Friend/Family Member: _____

O Other Please explain _____

Website name: _____

Search word(s) used: _____

(over)

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Name of Medical Doctor_____Ph_____

Have you been to therapy before? O Yes O No When _____Duration _____

With whom _____Was it helpful O yes O No

Are you taking medication? O Yes O No Please list all medication:

Have you ever considered or attempted suicide? O No O Yes When_____

Reason for today's visit_____

_____

_____

_____

_____

Other information you would like for us to know? _____

_____

_____

Sometimes we like to follow-up with clients by letter, phone or email after our work together has stopped. Please check yes or no if you agree to be contacted.

O Yes O No

By signing bellow I acknowledge that all information given is accurate, I have received a copy of the Notice of Privacy Practices (HIPA) to read over, and was able to discuss and have answered any questions I may have about it.

Signature _____Date_____

Patient or Legal Guardian

Therapist signature_____Date_____

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Therapy Agreement and Consent

Please read carefully

1. I understand that counseling sessions for me and/or my children are strictly confidential with the following exceptions:

My therapist must honor court subpoenas that require the release of specified information. My therapist may take professional action to protect those in immediate danger of physical harm. My therapist is mandated by Florida law to report suspected child or elder abuse or neglect. My therapist may share information with me from my children's therapy sessions if he or she believes that my children are in imminent danger.

I understand that my therapist is not available 24 hours a day and that in a crisis situation I should call the Dade County Crisis Hotline at (305) 358-HELP, in Broward (954) 467-6333. You may also contact 911 or go to the nearest emergency room.

2. I understand that payment for services is due at the time of service. Payment can be made with cash, personal check, credit card I understand I will be charged $20.00 for returned checks. We appreciate payments of $20.00 or less to be made in cash.

3. I agree to notify my therapist at least 24 hours in advance should I need to cancel an appointment. If I fail to do so, I understand that I will be charged for the time I had booked, payable at or before my next appointment at a rate of 70.00 which is not billable to my insurance with the exception of an emergency. ***If you are not able to make your appointment you may have the option of either a Skype, Face time or phone session. Please consult your therapist to see which option may be available.***

All sessions are made and canceled through your therapist. Please contact them at their personal cell number. If you are unable to reach them you may leave a message at (305) 773-6752

4. I understand that if my therapist is asked or required to provide a summary of my records, he or she will charge a minimum of his or her one-hour fee, which must be paid before the records being sent.

5. I understand that the fee for service is $120.00 for a 45-minute appointment ($240 for a 75 minute appointment). The same fee (prorated) is charged for between-session telephone consultations lasting longer than 5 minutes.

6. Family Systems Therapy Associates has contracts with most insurance carriers to provide services to their members. In these contracts we accept assignment of benefits from them and you as a member agree to accept responsibility of copayment, co-insurance and or deductible at the end of each session. You are responsible to be sure your coverage is active. If for any reason an insurance claim is denied you assume the responsibility for payment.

Fees: O copayment _____ O co –insurance_____ Visits per year_____

O Deductible _____ O CY O PY O FY O met_____ Date_____

Printed Name _____

Signature _____ Date _____

(over)

Credit Card Authorization

I _____, herby authorize Family Systems Therapy Associates, LLC, to charge the following credit card for all payments due of which I am financially responsible for myself and/or:

_____

This agreement will be in effect until services have been paid in full or by the request of myself in writing.

Card information:

Card Type: O Visa O Master Card O American express

Billing Zip Code_____

Name on Card_____

Credit Card #_____

CVV Authorization Code #_____

Expiration Date_____

Card holder's signature _____