Family First Psychotherapy Services, LLC
Adult Intake Form

Date of Intake: *(mm/dd/yyyy)*		**Date of Birth:** *(mm/dd/yyyy)*	**Age:**
File Number:		**S.S. #:**	
Name: *(Last, First, MI)*		**Insurance:**	
Address:		**Insurance ID #:**	
		Diagnosis:	
Phone: *(Home)*	*(Work)*	*(Cell)*	
Email:			
(Giving my email address means that I approve of receiving emails from FFPS) Initial_____			

OCCUPATIONAL DATA:				
Place of Employment		Length of Employment		
Position		Recent reprimands	□ Yes	□ No
Emergency Contact Information:				
Name:	Relationship:	Phone:		
Name:	Relationship:	Phone:		
Referral Source:				
Brief Description of Problem:				
How have you attempted to deal with this problem thus far?				
Family and significant others:				

POTENTIAL GOAL AREAS
Functioning at home:
Functioning at work:
Functioning in social relationships and leisure activities:
How have your faith-based principles affected your life?

Legal Involvement: (Criminal/ Civil)			□ Yes	□ No
Describe:				
Substance Abuse Dependence:			□ Yes	□ No
Describe:				
How Many Alcoholic Beverages do you consume per:	□ Day	□ Week	□ Month	□ Year
Do You Smoke?			□ Yes	□ No
If yes,		□ Cigarettes	□ Cigars	□ Pipe
Appetite:				
Sleep Pattern:				
Last Physical:				
Major/ Chronic Health Problems:				
Medications:				
Primary Physician:				

MENTAL STATUS		
Psychological Diagnosis:		
Medications:		
Name of Psychiatrist:		
Date of last psychiatric visit:		
Have you had individual therapy or counseling before?	□ Yes	□ No
If yes, please list the dates, names, and location of the provider(s):		
Hospitalizations for Mental Diagnosis:		
If so, what was the nature of the therapy?		
Was therapy helpful to you?	□ Yes	□ No
If not, why?		
Do you have a history of trauma?	□ Yes	□ No
If yes, please describe:		
Describe any Suicidal Ideations or Homicidal Ideations (Present or Previous)		

RELATIONSHIP AND SEXUAL HISTORY
How did you learn about sex and who told you?
What type of contraceptives do you use?
What are your thoughts on sex?
How often do you have sexual activity?
Is this your first sexual relationship?
How has desire played a role in your life previously?
Many people engage in self-pleasures; tell me about your experiences.
Many people have marital affairs, tell me about your experiences.
Are you sexually satisfied in this marriage?
Have you experienced any sexual traumas?
Sexual pain, obsessions, or perceived abnormalities?

Consent to Treatment

I, _____, do hereby acknowledge, understand and consent to the following conditions of counseling or therapy:

1. The counseling or therapy I will receive is conducted by a licensed professional or a supervised licensed graduate professional.

2. I understand this counseling will utilize verbal psychotherapeutic techniques intended to assist me in growing as an individual, within a relationship and/or as a member of a family or social group.

3. I understand that the therapists at Family First Psychotherapy Services (FFPS) are not physicians and therefore cannot prescribe medications.

4. I understand that in this office no nudity, no physical examination, nor any overt sexual behavior will be involved in the treatment of sexual concerns.

5. It is understood that a therapist is a "consultant" and a professional resource only and that the interventions, suggestions and recommendations offered may be freely accepted or rejected. I understand that no promises are made about the therapeutic consultation. Therefore, decisions made during and after the counseling are the responsibilities of the client.

6. I, the client, understand that any social relationship outside of the therapy office is prohibited.

7. I, the client, am entitled by law to freely ask questions about the therapist's education, training and philosophies, and this therapeutic process.

8. I understand termination of therapy is predicated upon reaching the agreed upon treatment goals and/or intentional ending of therapy. I understand that to terminate without the consent of the therapist therefore not reaching all agreed upon goals would be at my own risk.

9. Once it is determined that my goals cannot be reached in treatment with aforementioned therapist then said therapist will make referrals to a more appropriate resource.

10. I understand that after I sign this documentation it will constitute a binding agreement between myself and the staff of FFPS.

_____

Client Signature

_____

Date

Office Agreement

Appointments cancelled or rescheduled after 7:00 am the day of the appointment will be assessed a $30 fee for the time that has been booked. All appointments that need to be rescheduled should be done 24 hours before the scheduled appointment.

Appointments in which the client does not show (no show, no call) will be assessed a $50.00 missed appointment fee.

Checks that are returned will be assessed a $35.00 returned check fee to cover bank costs.

All fees will be assessed to the (credit card-Visa, MC, etc.) _____ (number) _____ (expiration date) _____ with (CVV code) _____ and name on card_____, on file with FFPS.

Check cards with the Visa, Discover, Master Card, and American Express logo are accepted. You will incur a $2.00 service fee each time the card is swiped.

Agreement to Pay for Professional Services

I am requesting professional psychotherapy consultation with Nicole Daniels, a Licensed Marriage & Family Therapist. **The fee for a 60-minute session is $120. The fee for time beyond the 60-minutes for individuals, couples, and families can be discussed with the clinician. I am aware that payment is collected at the time of service. The accepted payment methods include cash, check, and credit cards**. **All other fees different than previously stated, have to be agreed upon by provider of service rendered.** Also, payment is collected at the time of service for insurance co-pay or co-insurance fees. If I use my insurance, I also agree to pay any remainder of the balance not paid by the insurance. I am aware that Nicole is paneled on some insurance companies and can also act as an "Out of Network" provider. In that case, she will provide a detailed receipt as necessary. By signing below, I am consenting to this "Agreement to Pay for Professional Services" giving authorization to disclose PHI for the purpose of collection of payment from my insurance company for psychotherapy services, and understand the conditions explained.

_____
Client Signature

_____
Date Signed

Welcome to Family First Psychotherapy Services, LLC

Dear Family First Psychotherapy Services Client:
You are an important part of the treatment process and will be expected to attend all counseling sessions unless otherwise agreed upon or directed. Your therapist will do everything he/she can to schedule appointments at a convenient time.

The Counseling Process
The benefits of counseling can include growth of family members and positive changes in behavior and feelings. However, like any worthwhile project, it requires commitment, hard work, and sticking through the tough times. Your commitment and effort can have great outcomes. Counseling can last from a few weeks to several months depending on the nature of the problem. The therapeutic approach used tends to be experiential and humanistic oriented. The models/approaches used are Emotionally Focused Therapy, Cognitive-Behavioral, Developmental, Spiritual, and Psycho-Educational to aid in reaching treatment goals. Within a reasonable period of time after the initiation of treatment, the therapist will be able to offer you some initial impressions of what your work will include. You should also make your own assessment about whether you feel comfortable in the therapeutic environment established. If you have any questions about the process of therapy, please make them know.

Recordkeeping
As required by state laws, your therapist will keep written records documenting counseling services. Reports of counseling progress may be made available only to the client or designated individual when requested in writing, and when agreed upon by the counselor or supervisor.

When the participant's case is closed, their record will be placed in our inactive archives. After five years, the record will be destroyed (unless the participant resumes counseling here before the five-year period ends).

An assessment of your functioning will be documented in the file in order to best identify the proper course of counseling treatment. You have the right to be made aware of your diagnosis and treatment plan. (The diagnosis will also be shared with your insurance carrier as necessary for reimbursement.)

On occasion, your counselor may ask your permission to make an audio or videotape of a counseling session. These recordings are made in order to assist your counselor in helping you. However, you have the right to refuse any request for taping. These tapes/recordings are destroyed or recorded over after viewing.

Ethical and Professional Standards
Family Psychotherapy Services, LLC licensed professionals or supervised licensed graduate professionals will adhere to the standards for ethical and professional conduct established by the State of Maryland, Professional Counseling Board.

"This information is required by the Maryland Board of Examiners of Professional Counselors which regulates all certified and licensed counselors and therapists."

Maryland Department of Health and Mental Hygiene Board of Professional Counselors and Therapists
4201 Patterson Avenue Baltimore, Maryland 21215 | 410-764-4732
Please keep this document for your records

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