

Confidential Client Questionnaire

Adult Intake Form. Your answers are strictly confidential and help your therapist understand how best to support you.

Main Office: 12840 Riverside Drive, Suite 208, Valley Village, CA 91607

Mid City: 7257 Beverly Boulevard, Suite 106, Los Angeles, CA 90036

Phone: (323) 524-3868 | Email: info@menachemgroup.com | menachemgroup.com

Please return completed forms using the secure method provided by your therapist. Do not send completed intake forms by ordinary email unless your therapist has specifically provided a secure encrypted method.

GENERAL INFORMATION

Client Name

Today's Date

Date of Birth

Preferred Name

Phone (cell)

Email

Alternate Phone

Street Address

City

State

Zip

Preferred Therapist (if any)

EMERGENCY CONTACT

Emergency Contact Name

Relationship to You

Contact's Phone

REFERRAL SOURCE

Did anyone refer you?

☐ Yes

☐ No

Name of referrer

How did you hear about us?

OPTIONAL: GENDER, PRONOUNS, ORIENTATION, RACE & ETHNICITY

Gender (optional)

Pronouns (optional)

Sexual Orientation (optional)

Race (optional)

Ethnicity (optional)

AREAS OF CONCERN & TREATMENT GOALS

What issues or concerns cause you to seek treatment?

Do you have any specific goals with regard to your treatment?

Do you have any particular concerns or fears with regard to treatment?

PREVIOUS TREATMENT

Have you ever received mental health treatment before?

☐ Yes ☐ No

If yes, when and for how long?

If yes, what was the focus of treatment?

Have you ever been diagnosed with an eating disorder?

☐ Yes ☐ No

If yes, what and when?

If yes, what are your beliefs, perceptions, attitudes and behaviors regarding food?

RECOVERY, SUBSTANCE USE & ADDICTION HISTORY

Are you in recovery for addiction or compulsion?

☐ Yes ☐ No

What program(s)?

Are you currently sober?

☐ Yes ☐ No

How long?

Sobriety date

SAFETY HISTORY

If you are in immediate danger or thinking about harming yourself, call or text 988 (Suicide & Crisis Lifeline) or dial 911. Your therapist will review any safety concerns with you.

Have you ever attempted suicide?

☐ Yes ☐ No

If yes, when?

Did the attempt require medical attention?

☐ Yes ☐ No ☐ N/A

Did you receive inpatient treatment following the attempt?

☐ Yes ☐ No ☐ N/A

If yes, please describe the circumstances that led to that attempt.

Are you currently having any suicidal thoughts?

☐ Yes ☐ No

If yes, please describe.

In the past, have you ever had suicidal thoughts?

☐ Yes ☐ No

If yes, please describe.

FAMILY & RELATIONSHIP INFORMATION

Present relationship status (check all that apply):

☐ Married ☐ Partnered ☐ Single ☐ Divorced ☐ In a new relationship (6 mos or less) ☐ Other

Married - years

Married - months

Partnered - years

Partnered - months

Divorced - years

Divorced - months

Other (please describe)

If married, partnered or in a relationship, do you live with your significant other?

☐ Yes ☐ No

Others living in your household:

Name	Relationship	Age
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MEDICAL INFORMATION

Medical Doctor

Date of last physical exam (approx.)

How would you rate your physical health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Psychiatrist

Other Specialist

List any medications you are currently taking (including non-prescription or herbal remedies):

Describe any current physical problems or concerns that you have:

List any history of significant physical problems (e.g. broken bones, head injury, surgery):

PAYMENT INFORMATION

Please provide a credit card authorization regardless of your payment method.

Credit Card Authorization: I, (printed name)

authorize the maintenance of valid credit card information to guarantee my chosen payment option.

Cardholder Name

Card Type ☐ Visa ☐ MC ☐ Discover ☐ AmEx

Billing Address City Zip

Credit/Debit Card Number Expiration Date CVV / Security Code

Cardholder/Client Signature Date

Therapist Name

Payment is due when services are rendered. If payment is not made when services are rendered, or if you have an outstanding balance, then your credit card on file will be charged in the amount of the outstanding balance. Monthly statements will be provided upon request via a HIPAA secure email or U.S. mail. Clients are responsible for submitting all claims to their insurance provider.

Payment Guarantee: I understand that I am individually responsible for all incurred charges, even if I direct you to bill another person. If I direct charges to be billed to another person, I represent that I am authorized to give you such direction. If I have directed you to bill charges to another person who fail to make payment promptly when due, I will promptly pay on demand. If I commit to group therapy, I understand that the weekly fee for group sessions is due even if I do not attend.

I understand there is a 24-hour cancellation policy and that I will be charged without providing 24 hours advance notice to cancel a session.

I have read, understand and agree to the information, authorization and guarantee stated above.

Client Signature Printed Name Date

This consent is to certify that you give permission to your therapist at Menachem Psychotherapy Group to provide psychotherapy treatment. You have a right to terminate the therapeutic relationship at any time without fault.

NON-DISCRIMINATION POLICY

The Menachem Psychotherapy Group respects each person's right to choose their own belief system. It is the policy of The Menachem Psychotherapy Group not to discriminate against any individual on the basis of race, color, religion, ancestry, national origin, citizenship status, age, sex, marital status, genetic information, sexual orientation, gender expression, gender identity, non-disqualifying disability or veteran/military status. While our gender, ethnicity, orientation or spirituality may be different, we are open to discussing any concerns or questions you may have in working with a therapist who is either a different race, religion, orientation or gender than you. If you have any questions regarding our therapeutic approach and style, or our non-discrimination policies, please feel free to discuss this with us now and/or in the future.

CONFIDENTIALITY

Under most circumstances, all communication between you and your therapist is confidential, unless permission is given by you, after signing a release of information, to convey information to a third party. However, there are specific exceptions to this policy:

- o When there is a reasonable suspicion of child abuse, dependent-adult or elder abuse.
- o When a client threatens violence to an identifiable victim.
- o When a client presents a danger of violence to others.
- o When a client is likely to harm him/herself unless protective measures are taken.

Disclosure may also be required in certain legal proceedings. If you have concerns about the content of our sessions and any legal proceedings in which you are involved or expect to be involved, please let your therapist know. Before such disclosure is made, every reasonable effort will be made to appropriately resolve these issues and to notify clients.

NO SECRETS POLICY

Please note that with couples and family therapy the couple and/or the family is the client/treatment unit, not the individuals. The therapists at Menachem Psychotherapy Group practice a no-secrets policy when conducting couples or family therapy services. This means that confidentiality does not apply between the couple or among family members when one member of the treatment unit requests an individual session or contacts us outside of the therapy session to share a secret. Occasionally, individual sessions may be scheduled to assist in the overall therapy process for the treatment unit and will only be scheduled when mutually agreed upon. Any information given in the individual sessions will not be held in confidence or secret in couples and/or family sessions. We will encourage the person holding the secret to share the secret in the following session and will support them in doing so. We reserve the right to share or disclose information revealed by one partner or family member in an individual session to the other partner or family members as we deem appropriate and necessary to support the treatment units overall progress and goals. If you are seeking couples therapy, or family therapy, please have each member of the treatment unit sign this agreement.

CONTACTING THERAPISTS

Clients may text, email, or leave a voicemail for your therapist at any time. Please be aware that therapists may not retrieve or respond to messages until their regular office hours. If you have a life-threatening emergency, dial 911.

APPOINTMENTS

Typically, sessions are 50 minutes in length and begin at the scheduled appointment time (unless another length of time is agreed upon with your therapist). If you arrive late, your session will be shorter and will end at its normal time. If your therapist begins session late, your session will be extended to make up the time. If you need to cancel a session, please let your therapist know at least 24 hours in advance. You will be responsible for the full fee of any session canceled with less than 24-hour notice. You will be responsible for the full fee of any session that is not attended without notice of cancellation within 24 hours.

CONJOINT SESSIONS

If it benefits the client's therapy goals, we may occasionally ask that a family member or significant other join us for a conjoint therapy session. If the client would like to include a family member or significant other for a conjoint therapy session this will be done only on occasion and at the therapist's discretion (when it best serves the client). Please note

that the family member or significant other is not joining the session for their own therapy, nor will we work with them as a therapist. If we decide that this would be beneficial, you will need to sign a written release of information for this type of conjoint session.

SOBRIETY POLICY

The Menachem Psychotherapy Group asks that all clients arrive to therapy sober and not under the influence of illegal drugs and/or alcohol. If we notice that you are intoxicated we will immediately end the therapy session, and assist you in finding a safe ride home as driving while under the influence constitutes a risk to others and is a reportable offense. We will reschedule the therapy session where we will process this occurrence. You will be charged your full fee for the session if you arrive intoxicated.

FEES, BILLING & PAYMENTS

All services are billed at the standard rate agreed upon with your therapist. Sliding-scale fees may be established based on ability to pay and therapist availability. Payment is due when services are rendered, unless other arrangements have been made. Please notify your therapist if any problems arise that affect your ability to make timely payments.

If document preparation is required (e.g. legal proceedings, insurance appeals), clinicians reserve the right to bill for services, plus fees for materials (copies, outside services, etc).

In order to prevent any misunderstandings about payment for services, please be advised of the following:

- (1) All services provided are billed directly to the client unless other arrangements have been made.
- (2) Clients are personally responsible for payment at time of service.
- (3) Superbill statements can be provided for you to submit for insurance reimbursement.
- (4) You are responsible for submitting all claims to your insurance provider.
- (5) If payment cannot be processed and you have made no other payment arrangements, your past due balance may be sent to an agency for collection.

If you commit to group therapy, the weekly fee for group sessions is due even if you do not attend.

Payment Guarantee: You are individually responsible for all incurred charges, even if you direct us to bill another person. If you direct charges to be billed to another person, you represent that you are authorized to give such direction. If you have directed charges to be billed to another person who fails to make payment, you will promptly pay on demand.

I have read, understand and agree to the information, guidelines and office policies stated above:

Client

Signature

Printed Name

Date

Therapist Name

Date