Kim Wright, LCSW
Kim@kimwrightwellness.com
267.888.7511

Virtual Therapy Intake / Comprehensive Assessment Questionnaire with Consent to Treat

Section 1: Personal and Contact Information

- Legal Name:
- Preferred Name:
- Pronouns:
- Date of Birth
- Age
- Full Address:
- Phone:
- Email:
- Preferred Method of Communication:

Ok to leave: **Voice Mail**: ☐ YES ☐ NO **Text**: ☐ YES ☐ NO **Email**: ☐ YES ☐ NO

Emergency Contact:

- Name:
- Relationship:
- Phone:
- Email:

Ok to leave: **Voice Mail**: ☐ YES ☐ NO **Text**: ☐ YES ☐ NO **Email**: ☐ YES ☐ NO

Referred By:

Reason for seeking help:

Previous Counseling? **YES/NO** **If YES**: Name/Location:

Do you understand that ALL sessions will be via Telehealth (Zoom/Phone)?:

Do you have any questions or concerns about Virtual Therapy?:

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Coverage for Session: **INSURANCE or SELF-PAY?**

If Insurance: Company_____ MEMBER ID# :

If using insurance, was it checked by Ann Schuster? NO / YES

If YES, what did she say the COPAY would be?_____

**Some Insurance Companies Require Pre-Authorization for Mental Health and Behavioral Health Service. If this is Required by your Insurance Carrier and you did Not Call, Be Aware that you May be Penalized with Denial or Reduced Benefits.*

I, Kim Wright, LCSW, will file insurance encounters as a courtesy if FULL INSURANCE information is provided.
A photocopy of the card is Acceptable. It is up to the client to know their insurance coverage, including knowledge of Co-payment amounts and yearly Deductibles.
Please Note: I may look up client insurance coverage, but it is NOT a guarantee of coverage, deductible or copayment amount.

***** If payment of the bill has NOT been satisfied by the insurance company within 90 days, it is the Responsibility of the CLIENT or PARENT/Guardian to PAY the Bill in FULL.***

***Copayments and Deductibles are always due at the time of service, before sessions take place.**

**Please Sign your name, indicating understanding of the information above regarding Insurance, Copayments and Client responsibilities: _____

Missed Appointment and Cancellation Policy:
As noted in prior email labeled *New Client Info: If you do not show up for your scheduled therapy appointment, and/or you have not notified me at **least 24 hours in advance** or **rescheduled within the same week**, you will be required to pay the FULL COST of the session ($165/$250), which is NOT able to be paid via your Insurance company or HSA plan.

**Please Sign your name, indicating understanding of the information above regarding the Missed Appointment/Cancellation Policy: _____ DATE:

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MEDICATIONS:

Are you currently taking any medications (Prescribed/Over the Counter)? **YES / NO** If YES, Please list below:

Medication:	**Dosage**:	**Frequency:**	**Reason:**	**Start Date:**	**Prescriber: Name/#**

Allergies? YES / NO *If **YES, List:**

Substance Usage*: Drugs/Alcohol/Caffeine/Nicotine:*

Substance:	**Frequency:**	**Amount:**	**Date of Most Recent Use**	**Age Started:**	**Wish to Reduce/Quit?**

Any Additional Information that you believe your therapist should know about before starting treatment? :

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ACKNOWLEDGEMENT OF CLIENT CONTRACT and ALL Consent FORMS

Please Initial, Sign and Date the Following:

_____ I have read and understand the **Client and Therapist Services Agreement**, including the **Client's Right and Responsibilities** during their treatment under Kim Wright, LCSW

_____ I have read and understand the privacy practices outlined by **HIPAA**, which was in the **Client and Therapist Services Agreement**.

_____ I understand and agree to the rules and limits of **Confidentiality**, which was in the **Client and Therapist Services Agreement**.

_____ I have read and understand the information regarding **Insurance** Claims, **Copayments** and **Fees**, which was in the **Client and Therapist Services Agreement**.

_____ I understand the **24 hour Cancellation Policy** and the **Client's Responsibility to Fees and appointments**, which was in the **Client and Therapist Services Agreement**.

_____ I understand the **Limits to Confidentiality when dealing with Media, Electronics, and other electronic/internet/web based Correspondence** and will **NOT** hold Kim Wright, LCSW, liable in the event my information has been compromised. This information was contained in the **Informed Consent for the Use of Electronic Communications Agreement**.

_____ I have been provided an opportunity to discuss the documents with Kim Wright, LCSW, about any questions regarding this contract and the contents within.

_____ I understand and agree that sessions and correspondences are **NOT to be Recorded or published/shared** unless given prior written consent by Kim Wright, LCSW and if found to be shared, it is grounds for immediate termination and legal recourse.

_____ I understand the **FINANCIAL AGREEMENT FOR LEGAL/COURT INVOLVEMENT FORM**

Your signature below indicates that I, Kim Wright, LCSW, have *Emailed a copy of All Contracts/Consent Forms/Agreements*, and that You have read, understand and agree to ALL its terms.

Also, by Signing below, you indicate that you have read, understand and agree with the *Fee Information guidelines* outlined above and in other correspondences.

Client Signature: _____ Date: _____