Emerald Coast Collaborative Solutions
151 Mary Esther Blvd. STE 507
Mary Esther, FL 32569
Office: 850-226-7419 | Fax: 850-362-7403

Martha Van Dam, M.S., LMHC, NCC
National Board Certified Counselor

David A. Silvers, M.S., LMHC, CMAT CSAT
Clinical Director

Marital, Couples, Family, and Individual Counseling

Serving adults and teens dealing with trauma including, but not limited to, trauma caused by combat, extra-marital affairs, heartbreak, abuse, depression, and anxiety

New Client Intake Form

Client Name _____ Date _____
Parent / Guardian Name (If under 18) _____
Responsible Party of Billing Self Other _____
Referred by (if applicable) _____

Contact Information
Address of Responsible Party _____
City _____State _____ Zip Code _____
Email address: _____
Phone: _____Parent / Guardian (If under 18) _____
Do we have permission to leave a voice message? Yes No
Do we have permission to send email appointment reminders? Yes No

Client Information
Age _____DOB _____ Gender: Male Female
Employer/School _____Occupation _____
Indicate last year of school/diploma/degree completed: _____
Marital status: Single Engaged Cohabitating _____ years Married _____ years Widowed Separated
Divorced Total number of marriages for you _____ For partner _____ Other/Child

Family Information: Parent/Partner/Spouse's Name _____
Age _____ DOB _____ Gender: Male Female
Employer/School _____ Occupation _____
Indicate last year of school/diploma/degree partner has completed: _____

Please list children by name, gender, age, and living situation: (If more than four use back of form)
Name _____ M F Age _____ At home On own With Someone Else
Name _____ M F Age _____ At home On own With Someone Else
Name _____ M F Age _____ At home On own With Someone Else
Name _____ M F Age _____ At home On own With Someone Else
Others currently living in the home _____
Are you caring for someone in your home that is ill or disabled? Yes No

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Limits of Confidentiality

Contents of all therapy sessions are confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intention or plans to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client. If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has abused a child (or vulnerable adult), or in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access client's records and/or speak with the counselor regarding therapy sessions.

Insurance Providers (if applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but not limited to: types of service, date/times of service, diagnosis, reason for therapy, treatment plan, progress of therapy, progress notes, and clinical summaries.

My signature confirms I have read and understand the above limits of confidentiality.

Signature: _____
Date: _____

Insurance Agreement

Emerald Coast Collaborative Solutions is a private pay practice and does not accept insurance as payment for services; however, as a courtesy to you, we will submit insurance claims on your behalf as an out of network provider, if applicable. Emerald Coast Collaborative Solutions does not guarantee eligibility, coverage, or reimbursement from your insurance provider and recommends you contact your insurance provider.

Policy Holder: _____ Insurance: _____
Member ID: _____ Group Number: _____

My signature confirms that I have read and understand the above insurance agreement.
Signature: _____
Date: _____

PRACTICE POLICY

Read, Initial, and Sign:

_____Emerald Coast Collaborative Solutions is a time-dependent business and runs by 50 minute scheduled sessions. Should you be late for an appointment, it will remain necessary to end at the designated appointment hour so that the next client's session is not affected and the charge will be for the full amount. If the counselor causes a late start, the session will last the full length of the scheduled session or be prorated.

_____**If you find it necessary to cancel or change an appointment, we require 24-business-hours advanced notice.** As a reminder, the office is open Mondays through Thursdays and closed Fridays through Sundays. Monday appointments will need to be cancelled no later than 5 pm the previous Thursday. Your scheduled appointment time is set aside by your therapist for you. We cannot use this time for another client if missed or not given proper notice, therefore, **the charge will be the hourly fee in full**. No shows will be charged the fee in full including any outstanding balance on the account. The only consideration for this would be in the case of an emergency or illness, in which 24-hour notice would be appreciated. Schedule changes due to other appointments are not accepted. Payment for missed or canceled appointments is required prior to rescheduling. Front office staff does not have authority to waive or reduce fees associated with missed or canceled appointments. You may speak with your therapist if there are any questions or disputes regarding fee. Missed or frequent rescheduling may result in termination of counseling. In this case, the counselor will provide a list of other mental health professionals. Thank you for your consideration in this matter.

_____**I understand payment in full is due at the time of service**, prior to your appointment, unless other arrangements have been made in advance with your therapist.

_____ **I understand that any unpaid client outstanding balance over 90 days, will be sent to a third-party collections agency.** The office will be happy to offer a payment plan or monthly payment for those that may need so.

_____**Emerald Coast Collaborative Solutions is a private pay practice and does not accept insurance as payment for services**; however, as a courtesy to you, we will submit insurance claims on your behalf as an out of network provider, if applicable. Emerald Coast Collaborative Solutions does not guarantee eligibility, coverage, or reimbursement from your insurance provider and recommends you contact your insurance provider.

_____Please be advised that our purpose as clinicians is to assist individuals with life challenges and to help inner strength, not to be confused with custody or legal assistance. Therefore, we will not become involved in such matters. You agree not to subpoena the counselor for deposition or as a witness, in any legal or administrative proceedings before, during, or after the counseling process. You agree not to subpoena or demand the production of any psychotherapy notes, records, summaries, or the like of the counselor in any legal or administrative proceedings. You agree to make no request that any notes or records prepared by the counselor before, during, or after the counseling process be used or admitted as evidence in any legal proceedings. To the extent that you have the right to request these documents, that right is hereby waived. In the event that such subpoena is executed, you agree to pay any and all legal fees incurred by the counselor to enforce this agreement, quash any subpoena, or otherwise seek legal representation. You further agree to pay the regular hourly rate for all time counselor devotes to enforcing this agreement.

_____Special fees are applied to services outside the reasonable customary practice and mandatory reporting that may be associated with regard to such issues as a threat of harm to self/others or sexual abuse. In the event that you should need a clinical assessment or report, an additional fee at the regular hourly rate will apply for time committed to record, review, and formulate the report. This fee is required prior to receiving the report. At times it may be necessary to briefly contact your counselor by telephone or email for which there is no charge; however, when this exceeds 10-minutes, the charge will be the regular hourly rate, prorated (when applicable).

_____Emerald Coast Collaborative Solutions has a policy that meets government standards for HIPAA (Health Information Portability and Accountability Act) which covers privacy of all medical information. If you desire to read or have a copy of our privacy policy, please request this.

My initials above and signature below confirm that I understand and agree to the above practice policies. In the case of a minor child, signature of authorized guardian.

Print Name: _____ Date: _____

Signature: _____

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Responsible Party of Billing

Name _____
Relationship _____ Phone Number _____

Clients over 18 years of age with person other than self as responsible party of billing require a signed release of information on file for billing purposes. Scheduling will be the responsibility of the identified client.

Credit Card Pre-Authorization

I understand that my credit card will remain on file for the duration of my treatment. Should there be a change in the card to be charged, it will be my responsibility to provide a new number immediately. My card will be charged the reserved day of service, and/or should I miss a scheduled appointment without proper 24 hours advanced notice.

Credit Card Type (circle one): Visa MasterCard Discover American Express
Name _____ Card Number _____
Expiration Date _____ Security Code _____
Zip Code _____

My signature confirms I have read and understand the above credit card pre-authorization.

Signature: _____
Date: _____

Cash and Check Policy

Should cash or check be preferred, payment is required prior to your session. If you prefer to pay cash, there are some occurrences the office will need to contact you, via phone, email, or mail, in order to collect any outstanding balance that you may have. If you do not want the office to contact you, a credit card must be on file. A $50 fee will be assessed for any returned check. Returned check fees and fees associated with missed or canceled appointments without 24 hours advanced notice are due prior to rescheduling.

My signature confirms that I have read and understand the above cash and check policy.

Signature: _____
Date: _____

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New Client Assessment Form

Client Name _____ Date _____

Current Concerns

Brief description of the presenting problem or major complaint that brings you in here today: _____

_____
_____
_____
_____

Describe length of history of problem and how you have tried to handle it: _____

_____
_____
_____
_____

Medical Information

Family Physician _____ Date of last visit _____
Psychiatrist/Psychologist _____ Date of last visit _____
Do you have a serious and/or chronic medical condition, such as diabetes, cancer, heart disease, thyroid disease, asthma, rheumatoid arthritis, etc.? Yes No If yes, describe below:

_____
List Current Medications _____

_____

Counseling History

Are you currently working with any other counselor/psychologist/psychiatrist? Yes No
If yes, Name _____ Location _____
Have you previously had counseling for any reason? Yes No
List prior counseling, therapy, and hospitalizations for emotional and/or mental health issues, include reason, date, and location: _____

_____
_____
_____

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Client Name _____ Date _____

Please circle the areas below that led you to seek counseling today:

Relationship/Family Issues	Financial Problems	Physical Health Problems
Sad or Depressed Mood	Guilt/Shame	Sexual Abuse/Rape
Anxiety/Worry/Fear	Nightmares/Phobia	Pornography Use
Excessive Sleeping	Problems with Peers	Anger/Rage
Insomnia	Sexual Orientation	Abortion Issues
Memory Loss	Problems at School	Excessive Crying
Parenting	Alcohol/Substance Use	Fear of Death
Pre-Marital Counseling	Career/Occupational Issues	Marriage Issues
Step/Blended Family Issues	Eating Disorder/Weight	Panic Attacks
Behavioral Problems	Grief/Loss/Mourning	Physical Abuse
General Stress	Legal Problems	Sexual Addiction
Divorce Issues	Obsessive Thoughts	Other _____

SAFETY Issues

1.	Are you currently experiencing suicidal thoughts?	Yes	No
2.	Do you currently have a desire to cause pain to yourself or others?	Yes	No
3.	Are you in fear for your life or personal safety?	Yes	No
4.	Have you ever had serious thoughts of suicide?	Yes	No
5.	Have you ever attempted suicide?	Yes	No
	If yes, when and how _____		
	_____		
6.	Has someone close to you committed suicide?	Yes	No
	If yes, when and who _____		
	_____		

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Client Name _____ Date _____

Client Health Questionnaire

In the past 30 days, have you:

1.	Lost interest or pleasure in doing things?	Yes No
2.	Felt depressed or hopeless?	Yes No
3.	Had problems at work? How many days were you unable to work? _____	Yes No
4.	Had trouble falling asleep or staying asleep?	Yes No
5.	Sleeping too much?	Yes No
6.	Experienced feelings of guilt and shame?	Yes No
7.	Felt responsible for bad things?	Yes No
8.	Experienced changed in eating habits?	Yes No
9.	Poor appetite?	Yes No
10.	Over-eating?	Yes No
11.	Felt bad about yourself; felt that you are a failure; let people down?	Yes No
12.	Had difficulty concentrating or completing tasks?	Yes No
13.	Had a problem moving or speaking too slowly?	Yes No
14.	Felt restless or fidgety?	Yes No
15.	Lost interest in sex?	Yes No
16.	Spent a great deal of time thinking about sex?	Yes No
17.	Experienced thoughts that you would be better off dead?	Yes No
18.	Experienced thoughts about hurting yourself?	Yes No

CAGE Assessment

1.	Have you had a drink or used drugs in the past 30 days?	Yes No
2.	In the past 30 days, have you felt you ought to cut down on your drinking or drug use?	Yes No
3.	In the past 30 days, have people annoyed you by criticizing your drinking or drug use?	Yes No
4.	In the past 30 days, have you felt guilty or bad about your drinking or drug use?	Yes No
5.	In the past 30 days, have you ever had a drink or used drugs first thing in the morning to steady your nerves or relieve a hangover?	Yes No
6.	How many days in the past week did you have a drink or use drugs?	_____
7.	How many per day?	_____
8.	Have you had a problem with alcoholism or addiction in the past?	Yes No
9.	If yes, how long have you been clean and sober?	_____
10.	Are you currently participating in a recovery program such as AA, Celebrate Recovery, etc.?	Yes No

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New Client Assessment Form

Client Name _____ Date _____

PATHOS Sexual Assessment

1. Do you often find yourself preoccupied with sexual thoughts? Yes No
2. Do you hide some of your sexual behavior from others? Yes No
3. Have you ever sought help for sexual behavior you did not like? Yes No
4. Has anyone been hurt emotionally because of your sexual behavior? Yes No
5. Do you feel controlled by your sexual desire? Yes No
6. When you have sex, do you feel depressed afterwards? Yes No

PATHOS Sexual Health Partner/Spouse Questionnaire

1. Does your partner seem preoccupied with sexual thoughts and behavior? Yes No
2. Does your partner hide his/her sexual behavior from you? Yes No
3. Do you feel your partner needs help for sexual behavior? Yes No
4. Have you been hurt emotionally because of your partner's sexual behavior? Yes No
5. Does your partner seem to be controlled by his/her sexual desire? Yes No
6. Has your partner accused you of being "crazy" or "jealous" when you question his/her sexual behavior? Yes No

Relationship Information

1. On a scale of 1 – 10, least satisfactory to most satisfactory, how would you rate your relationship? _____
2. What difficulties are you facing in your relationship? _____
   _____
   _____
3. Have you or your partner threatened to separate or divorce? Yes No
   If yes, explain _____
   _____
   _____

Additional Comments: