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ADULT INTAKE FORM

Name:	
Address:	
Home phone:	
Work phone:	
Fax number (if applicable):	
Email address (if applicable):	
Date of birth:	
Marital status:	
Date of marriage:	
Date of separation (if applicable):	
Date of divorce (if applicable):	
Date widowed (if applicable):	
Place of employment and address:	
Occupation:	

Whom may we thank for referring you?

_____ (name)

(address)
_____() _____()
(phone) (FAX)

Family information:

NAME	DOB	RELATIONSHIP (e.g., spouse, child, step-child)	CURRENTLY LIVING (in or out of home)

MEDICAL INFORMATION

Name of physician: _____

Physician's address:

Physician's phone: _____

What is your present health condition? _____

Do you smoke? _____ **If so, how much?** _____

Do you drink alcoholic beverages? _____ **If so, how much** _____
and how often? _____

Date of most recent physical examination: _____

Please list your medications below, beginning with current medication, and working backward:

Dates	Name of Medication	Amount (ex -10 mg.)	Taken when:	Prescribed by:	Your reaction:

SOCIAL ADJUSTMENTS:

How would you describe your interpersonal relationships?

With spouse/partner _____

With mother _____

With father _____

With brother(s) _____

With sister(s) _____

With peers _____

With employer _____

With others (specify) _____

PRESENTING PROBLEMS:

Please describe in detail the issues which have brought you to counseling:

Medical History

List any current/past illnesses/injuries that have impacted you or your family:

Marital History

Describe your current marriage, including both positive and negative qualities (e.g., intimacy, communication, problem-solving, togetherness).

Briefly list and describe any previous marriages.

THERAPEUTIC CONTRACT

PART 1: PATIENT RIGHTS

1. You have the right to a confidential relationship with me. Within certain legal limits (see #4 below), information revealed by you during the course of therapy will be kept completely confidential and will not be revealed to any agency or other person without your written permission.
2. You have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances.
3. If you ask for it, any part of your records on file with me can be released to any agency or person you specify. I will inform you at the time of your request whether or not I think releasing that information to that agency or person might be harmful to you in any way.
4. Under certain legally defined situations, I am required to reveal information given during the course of therapy to other agencies or persons without your written consent. I am not, however required to inform you of my actions if this occurs. These situations include:
 - a) If you reveal information to me about child abuse, or neglect or physical abuse of a dependent adult or an elderly person, I am required by law to report this to the appropriate authority. I will direct you to report spousal abuse.
 - b) If you threaten bodily harm or death to another person I am required by law to warn the intended victim and notify the appropriate law enforcement agencies.
 - c) If you threaten bodily harm or death to yourself, I am required by law to refer you immediately to an inpatient psychiatric program.
 - d) If you are in therapy or being tested by order of a Court of law, the results of the treatment or tests ordered must be revealed to that Court.
 - e) If a Court of law issues a legitimate subpoena, I am required by law to provide the information specifically described in the subpoena.
5. You have the right to ask questions about any of the procedures used in the course of therapy. If you ask, I will explain my customary approach and methods to you.
6. You have the right to choose **Not** to receive therapy from me. If you choose this, I will provide you with names of the other qualified professionals whose services you might prefer.
7. You have the right to terminate therapy with me at any time without any financial, legal or moral obligations other than those you have already incurred.

PART II: THE THERAPY PROCESS

Participation in therapy can result in a number of benefits to you, including a better understanding of your personal goals and values, improved interpersonal relationships, and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part and may result in your experiencing considerable discomfort.

Remembering and resolving unpleasant events through therapy can bring on strong feelings of anger, depression, fear, etc. Attempting to resolve issues between marital partners, family members, and other individuals can also lead to discomfort and may result in changes that were not originally intended.

PART III: LENGTH OF THERAPY

- 1. I agree to enter therapy with Connie Hornyak, LCSW.
- 2. I understand that I can leave therapy at any time.

Client's Signature(s) _____ Date: _____

Address: _____

Phone: Home _____ work _____

DOB: _____ SSN: _____

Therapist's Signature: _____

FEE AGREEMENT

I(We), _____ agree to pay for the treatment of _____ by The Institute for Child and Family Development.

I(We) agree to be responsible for payment to The Institute for Child and Family Development for all services rendered. I(We) understand that the staff of The Institute for Child and Family Development will assist us in collecting insurance reimbursement, but that I am (we are) ultimately responsible for obtaining this reimbursement. Costs of sessions are as follows:

PSYCHOTHERAPY FEES

Individual or Family Psychotherapy, 100 minutes	\$300.00
Individual or Family Psychotherapy, 75 minutes	\$225.00
Individual or Family Psychotherapy, 50 minutes	\$150.00
Individual or Family Psychotherapy, 25 minutes	\$ 70.00
Individual or Family Psychotherapy, 15 minutes	\$ 35.00
Three-session assessment	\$675.00
Three-session assessment with report	\$975.00

INTENSIVE PSYCHOTHERAPY FEES

One-week intensive program (children)	\$4,950.00*
Additional sibling intensive done concurrently	\$2,475.00*
Two-week intensive program (children)	\$9,900.00*
Additional sibling intensive done concurrently	\$4,950.00*
One-week intensive program (adults)	\$3,000.00*
Two-week intensive program (adults)	\$6,000.00*

*If the level of complexity for any particular case requires the use of additional treatment professionals other than those included in the intensive program, this rate may increase. In this event, clients will be so advised and additional fees discussed in advance.

Additional intensive program charges, if needed:

Follow-up treatment	150.00/hr. per therapist
Psychological testing	dependent upon tests needed
Follow-up consultation with hometown therapist	no charge

NOTE: There is a 50% non-refundable deposit required for intensive programs, due one month prior to the start of the intensive. The balance is due the first day of treatment. Payment is accepted by cashier's check only (no personal checks).

Clients are expected to pay for services at the time they are rendered unless other arrangements have been made. Please notify your therapist if any problem arises during the course of your therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. You will be provided with a receipt that you can submit to your insurance company for reimbursement. If the insurance company has forms for the psychotherapist to complete, be certain to give them to the therapist at your earliest convenience. In instances where extraordinary professional time is required, you may incur additional fees.

The above costs include administrative fees. We do not charge for phone conversations unless they exceed ten minutes or they become excessive in frequency. If you become involved in any litigation and we have to appear in Court, write a report, or give testimony, we will charge \$260 per hour, payable in advance. The same charges apply to travel time.

Extra services such as contacts with others (e.g. psychiatrists, social workers, previous psychotherapists, school personnel), correspondence or report writing will be billed at \$150 per hour.

Travel time (such as travel to and from home visits, school conferences, meetings with others involved in client's treatment) will be at \$150 per hour or fraction thereof. Report writing will be billed at \$150.00 per hour or fraction thereof.

We do understand that emergencies can arise which may prevent you from keeping your weekly appointment. We will therefore balance off your needs and ours in the following fashion: If you give us 24 hours notice of your intention not to use your appointment time, we will not charge you for the time. With such notice, we can make alternative plans. If you fail to provide us notice at least 24 hours in advance, or if you fail to show up as expected, we shall charge you for the time at the usual rate. Please note that insurance carriers do not reimburse for missed appointments and often require that such missed appointments be so noted on your statement of charges. Repeated failures to

attend scheduled sessions or to provide adequate rescheduling notice may lead to termination of our work together.

I (We) understand that Intensive Programs require at least two weeks notice for cancellation.

I(We) have carefully read and fully understand this Fee Agreement and will abide by its terms.

_____ Date: _____
Client (if minor, parent or guardian)

_____ Date: _____
Parent or guardian

_____ Date: _____
Parent or guardian