Ellen M. Polamero, MSW, LCSW 27272
www.claremontcounselingservices.com

Today's Date:____

Client Name (Last, First, Middle):____

Age: ______________ Client DOB: ____

Client Street Address:____

City:____ State:_______________ Zip:________________

Client Driver's License: State:____________ Number:____

Client Home #: (_______)_______-_____________ Client Work #:(_______)________-_______________

Client Cell #:(_______)_________-__________________

Email:____

Okay to contact or leave message at:

Email? Y__ N__ Home? Y__ N__ Work? Y__ N__ Cell? Y__ N__

By entering the contact information above, you agree that I may communicate with you at the above addresses and telephone numbers. Any mail or email that is sent to the addresses above will bear my name and return address; I will also identify myself on any voicemail systems or telephone answering machines. If any changes are made to these arrangements, please let me know immediately.

Please let me know any restrictions regarding my communications with you. For example, let me know if you do not want me to leave telephone messages for you, i.e., at any specific numbers, or send any mail or email to you.

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Referred by:____

Primary Care Physician:__________________________ Phone No.:(________)______-_____________

Gender Identity: ________________ Preferred Pronouns (He/His; She/Her; They/Their)_______________

Client Relationship Status:_________________ Name of Spouse/Partner: ___________________________

Primary Language: ____

Ethnicity: _________________________ Religion/Spiritual Views: ______________________________

What type of counseling are you seeking?

Adult Individual _____ Child/Adolescent Individual_____ Couples____ Family_____

Are you taking any medication? If yes, please list.

____

Reason for medication:

____

Have you been hospitalized for physical or mental illness? Y__ N__ If yes, when?

____

Please provide details:

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Any history of mental illness in your family? If yes, who/what?

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Previous therapy/counseling? Y______ N_______

If yes, name/phone of Therapist and approximate dates:

____

Do you smoke? Y_____ N_____ How much/often?____

Are you trying to quit? Y_____ N_____

Drink alcohol? Y_____ N_____ How much/often? ____

Are you trying to quit? Y_____ N_____

Take drugs? Y_____ N_____ If yes, which kinds? ____

How much/often? ____

Are you trying to quit? Y_____ N_____

What other doctors, health providers, or mental health providers are you currently seeing? To provide the most effective treatment possible, it may be helpful for me to have contact with them. If you and I determine this could be helpful for your treatment, I will have you fill out an 'Authorization for Use or Disclosure of Confidential Information' form giving me permission to have contact and collaborate with them.

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What other mental health professionals (i.e., therapists, psychiatrists, psychologists, substance abuse counselors, etc.) have you seen in the past? In order to provide you the best psychotherapy I can, I may request that they send me their records relating to their treatment of you. If so, I would first consult with you, and would see if you are willing to sign an authorization for this. Please provide any contact or organizational information you have for them.

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Confidentiality and Limits of Confidentiality

As your therapist I am committed to maintaining confidentiality, to the extent that I can, regarding your therapy. I believe that confidentiality is vital to the therapeutic process, as it enables you to freely share your thoughts, feelings, and experiences with me.

All information between therapist and client is held strictly confidential. There are legal exceptions to this:

1. The client authorizes a release of information with a signature.
2. The client's mental condition becomes an issue in a lawsuit.
3. The client presents as a physical danger to self, others or property of others (CA EVID 1024; Tarasoff v Regents of University of California, 1967).
4. Child or Elder abuse and/or neglect are suspected (Welfare and Institution and/or Penal Codes).
5. Terrorism (U.S. Patriot Act of 2001).In cases of suspected child abuse/neglect, elder abuse/neglect and harm to others the therapist is required by law to inform legal authorities and potential victims so that protective measures can be taken.

If you have any question at all about the above statements, please do not hesitate to ask me.

Initial regarding Limits of Confidentiality here:_________

Many of these laws are based on the idea that, as important as confidentiality is, it must sometimes give way to protecting people who are in danger. If I believe that you or anyone else is in danger of serious harm, you agree that I may contact any person in a position to prevent such harm. This includes (but is not limited to) the following people, who can be reached at the following telephone numbers:

Name ____________________________ **Telephone number: __________________**

Name ____________________________ **Telephone number: __________________**

Name ____________________________ **Telephone number: __________________**

Name ____________________________ **Telephone number: __________________**

EMERGENCY ACCESS:

In case of an emergency, your therapist may not be available after business hours (8am -5pm) to handle emergencies. If you are in imminent danger, call 911 or go to your nearest emergency room. By calling my office number after hours, you will be reminded to do so.

Initial here:________

Financially Responsible Party Information

Relationship To Client:____

Name (Last, First, Middle):____

Street Address:____

City:_______________________________________ State:__________ Zip:______________

Home Telephone Number:(__________)_____________--________________________________

Driver's License State & No.____

DOB: __ __ / __ __ / __ __ __ __

Employer: ____

Employer's Street Address:____

City:______________________________________ State:______________________________

OFFICE POLICIES:

A therapy hour is 50 minutes in length. Additional time or services will be billed in 15 minute increments (including phone communications beyond 15 minutes, court attendance and/or report/letter writing).

If appointments are missed or cancelled with less than 24 hours notice, you will be responsible for the full payment, which will be due at the following session or within 60 days.

Your expected payment per session is: $_______

Initial here:___________

COLLECTION POLICY:

My office retains a professional collection agency for pursuit of accounts that become delinquent. If it becomes necessary to transfer your account to our collection agency, your financial records will be released to them and your delinquent balance will be recorded with the 3 major credit bureaus, i.e., Trans Union, Equifax and Experian. If legal proceedings become necessary, you hereby agree to bear all financial responsibility for all attorney and court costs associated with collecting an unpaid debt. Please be aware that we take this action only as a last resort.

Initial here:__________

CANCELLATION AND MISSED APPOINTMENTS POLICY:

Scheduled appointment times are reserved especially for you. If an appointment is missed or canceled with less than 24 hours notice, you will be charged the full fee. Frequent cancellations and no-shows may result in the termination of your treatment. Keeping appointments and active participation in treatment is vital. By initialing below, you acknowledge that you understand that you are responsible for payment of any services not paid by your health insurance company including charges for missed or cancelled appointments.

Initial here:__________

Consent for Treatment

I authorize and request that Ellen M. Polamero, LCSW provide psychological assessments, treatment and/or diagnostic procedures, which now, or during the course of my treatment become advisable. I understand the purpose of these procedures will be discussed between me and my therapist and that they are subject to my agreement. I understand that the frequency and type of treatment will be decided between me and my therapist and in accordance with my insurance health benefits coverage (if applicable). I also understand that that while the course of my treatment is designed to be helpful, my therapist can make no guarantees about the outcome of my treatment. Further, psychotherapy can bring up uncomfortable feelings and reactions such as anxiety, sadness and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my therapist and myself.

Initial here:__________

I have read and received the 6-page Client Intake Form. I have been given opportunities to ask any clarifying questions, and am aware that my therapist is available to clarify any questions I have moving forward.

____ _____________

Client/Guardian Signature Date

____ _____________

Therapist/Witness Signature as needed Date

If you desire a copy of this document, please inform your therapist.

GENERAL CONSENT FOR CHILD OR DEPENDENT TREATMENT

I am the legal guardian or legal representative of the dependent client and on the client's behalf legally authorize Ellen M Polamero, LCSW to deliver mental health care services to the dependent client. I also understand that all policies described in the previous three pages of the registration form also apply to the dependent client I represent.

______________________________	______________________________	
Client Name	Client Social Security Number	
______________________________	______________	______________
Signature of Legal Guardian/Legal Representative #1	Relationship to Client	Date
______________________________	______________	______________
Signature of Legal Guardian/Legal Representative #2	Relationship to Client	Date

Regarding Clients of Divorced Parents

As recommended by the California Board of Psychology, when one parent of a dependent child seeks psychiatric or psychological treatment, clarification in writing is requested regarding the presenting parent's ability to individually authorize the delivery of psychiatric/psychological services.

Thus, your therapist requests a copy of the legal papers permitting the presenting parent to seek psychological/medical services without the consent of the other parent. If such documentation cannot be presented, the second parent will also need to sign a consent for treatment. Thank you in advance for your kind understanding and compliance.