Joshua Kates, LCSW, ACSW
1645 Palm Beach Lakes Blvd Suite 1200
West Palm Beach, FL 33401
Office: 561-693-8840

Client Intake Form **(Your information is protected by HIPAA)

CLIENT NAME:

_____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

CLIENT BIRTH DATE: _____ /_____ /_____ Age: _____

CLIENT ADDRESS:

_____
Street and Number Apt # if any

_____
City State Zip

HOME PHONE: _____ May I leave a message? □ Yes □ No

MOBIL/CELL PHONE: _____ May I leave a message? □ Yes □ No

E MAIL: _____ May I email you? □ Yes □ No
(Email is not considered to be a confidential method of communication)

MARITAL STATUS:

☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Domestic Partner ☐ Widowed

If you have children please list their names & ages:

_____
How did you find me or who referred you to me:

_____
Have you ever received behavioral health services (psychotherapy or psychiatric services)?
□ No □ Yes (if so, please list therapist, psychiatrist or other services & approximate dates):

_____

Are you currently taking any prescription medications? □ No □ Yes (If yes please list):

_____

Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes - If yes, for approximately how long? _____

Do you ever think suicide is an option or solution to your problems? □ No □ Yes

Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes - If yes, please describe briefly what is it and when you began experiencing this:

_____

Have you had any significant life changes or stressful events recently? If so, please describe:

_____

Are you currently in a romantic relationship? □ No □ Yes If yes, for how long? _____

If yes, on a scale of 1-10, how would you rate your relationship overall? _____

If you are in a relationship, please use this scale to rate the following questions:

1 – Not at all; 2 – Rarely; 3 – Sometimes; 4 – Almost always

- I feel emotionally connected to my partner: (1 – 4) _____
- I feel my partner is emotionally connected to me: (1 – 4) _____
- I feel needed by my partner: (1 – 4) _____
- I feel I need my partner: (1 – 4) _____
- I feel desired by my partner: (1 – 4) _____
- I feel I desire my partner: (1 – 4) _____
- I feel respected by my partner: (1 – 4) _____
- I feel I respect my partner: (1 – 4) _____
- I feel a sense of joy & passion in my relationship: (1 – 4) _____
- I feel independent, strong & competent: (1 – 4) _____
- I feel my partner and I are spontaneous: (1 – 4) _____

Is there something else that is significant you feel I should know about your relationship?

_____

_____

GENERAL HEALTH INFORMATION:

How would you rate your current physical health?

☐ Poor ☐ Satisfactory ☐ Good ☐ Very good

Please list any difficulties you experience with your appetite or eating patterns:

_____

Please list any current health problems:

_____

How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any sleep problems you are experiencing:

_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in _____

Are you currently experiencing any chronic pain? □ No □ Yes - If yes, please describe:

_____

Do you drink caffeinated beverages? □ No □ Yes – If so, how much: _____

Do you drink alcohol more than 3 X weekly? □ No □ Yes – If so, how much: _____

Do you use recreational drugs? If so: □ Daily □ Weekly □ Monthly □ Infrequently □ Never

FAMILY MENTAL HEALTH & SUBSTANCE ABUSE HISTORY:

In the section below **please identify if there is a family history** of any of the following and if so, please indicate the family member's relationship to you (father, mother, uncle, etc.).

Alcohol/Sub Abuse: __yes ___no If so, who, what: _____
Anxiety: __yes ___no If so, who, what: _____
Depression: __yes ___no If so, who, what: _____
Domestic Violence: __yes ___no If so, who, what: _____
Eating Disorders: __yes ___no If so, who, what: _____
OCD Behaviors: __yes ___no If so, who, what: _____
Schizophrenia: __yes ___no If so, who, what: _____
Suicide or Attempts: __yes ___no If so, who, what: _____

ADDITIONAL INFORMATION:

Are you currently employed? □ Yes □ No If yes, what do you do? _____

Do you enjoy your work? Is there anything stressful about your current work?

_____

Do you consider yourself to be spiritual or religious? □ Yes □ No

If yes, please describe your faith or belief: _____

What do you consider to be some of your strengths?

_____

What do you consider to be some of your weaknesses?

_____

Do you know what you would like to accomplish in therapy?

_____

_____

Thank you!

** Your personal, health and behavioral health information is protected by HIPAA: The Health Insurance Portability and Accountability Act of 1996.

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LIMITS OF CONFIDENTIALITY

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

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in 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.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or If a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when 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 is not limited to types of services, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Client Signature (Client's Parent/Guardian if under 18)

Today's Date

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CANCELLATION POLICY

If you fail to cancel a scheduled appointment without 24 hour notice, it is very unlikely I will be able to fill that time on such short notice and you may be charged a full session fee. This would not be just your copay as insurance companies will not pay for missed appointments. If your missed session is not due to illness or an emergency and I cannot fill the space, you will be billed for the missed session.

Thank you for your consideration regarding cancellations.

_____

Client Signature (Client's Parent/Guardian if under 18)

_____

Today's Date

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Client's name: _____
   First Name Middle Name Last Name
2. Date of Birth: __ _/__ _/_ __
3. Date authorization initiated: __ _/__ _/_ __
4. Authorization initiated by: _____
   Name (client, provider or other)
5. Information to be released:

□ (Typical): Authorization for Josh Kates to disclose your psychotherapy notes to your insurance company.

□ Other (Describe information in detail): _____

6. Purpose of Disclosure: The reason I am authorizing the release of my protected health information is:

   □ This is my request (client's request) so that Josh Kates, LCSW, can communicate with my insurance company ONLY (listed below*) to submit claims on my behalf, for obtaining authorizations for my treatment if my insurance company requires them or to engage in a clinical review of my treatment with my ins. co. if they request this.

   □ Other (i.e. family member, family doctor, friend or other – please specify):

   _____

7. **Person(s) Authorized to Make the Disclosure**:

   _____Joshua Kates, LCSW, ACSW_____

8. Client's Insurance Company Name or **Person(s) Authorized to Receive the Disclosure**:

   _____

9. **This Authorization will expire on ___/___/___ or upon the occurrence of the following event**:

   _____

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Signature of Patient: _____

Signature of Personal Representative (if client is a minor or unable to sign):

_____

Relationship to Patient if Personal Representative: _____

DATE OF SIGNATURE: _____

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PATIENT COPY

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.

5. If this office initiated this authorization, you must receive a copy of the signed authorization.

6. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes***. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

   In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.