CONFIDENTIAL CLIENT INTAKE

THE KRAFT GROUP, INC.

GENERAL INFORMATION

Name:_____ Date:____/____/____

Social Security #: ____-____-____ Date of Birth:____/____/____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (home)_____ (cell)_____

Email: _____ May we email you? ❑ Yes ❑ No

May we call you at home? ❑ Yes ❑ No Okay to leave a message at home? ❑ Yes ❑ No

May we call your cell? ❑ Yes ❑ No Okay to leave a message on cell? ❑ Yes ❑ No

May we text your cell? ❑ Yes ❑ No

Person to notify in the event of an emergency: _____

Emergency contact's relationship to you: _____ Contact's phone: _____

Whom may we thank for referring you? _____

PERSONAL INFORMATION

What is your gender?:

_____

EDUCATION & VOCATIONAL INFORMATION

Highest grade completed and/or degree(s) obtained: _____

Current Occupation:_____ Employer: _____

FAMILY INFORMATION

Present Relationship Status (check all that apply):

❑ Married/Partnered (yrs:___ mos:___)

❑ Single (yrs:___ mos:___)

❑ In a new relationship (6 mos or less)

❑ Dating: ❑ one person ❑ several persons

❑ Widow/Widower (yrs:___ mos:___)

❑ Other: _____

If married, partnered or in a primary relationship, do you live with your significant other? ❑ Yes ❑ No

Others living in your household:

Name	Relationship	Age

MEDICAL INFORMATION

Medical Doctor:_____ Phone: _____

Date of last physical exam (approx) __/____/_____

How would you rate your physical health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Psychiatrist:_____ Phone: _____

Other Specialist:_____ Phone: _____

List any medications you are currently taking (including non-prescription or herbal remedies): _____

_____

_____

Describe any current physical problems or concerns that you have: _____

_____

_____

List any history of significant physical problems (e.g, broken bones, head injury, surgery): _____

_____

_____

List any current or past legal issues: _____

_____

_____

CONSENT FOR TREATMENT AND OFFICE POLICY

This consent is to certify that you (client) give permission to the clinical staff at The Kraft Group Inc. to provide psychotherapy treatment. This includes but is not limited to all clinical and administrative staff members of The Kraft group Inc. You have a right to terminate the therapeutic relationship at any time without fault.

The clinical staff at The Kraft Group Inc. work as a treatment team and consult together regarding cases and you authorize the exchange of information between clinicians in order to provide the most effective treatment.

CONFIDENTIALITY

Under most circumstances, all communication between you and your therapist is confidential, unless permission is given by you to convey information to a third party outside of The Kraft Group Inc. Please be advised there are certain exception to confidentiality:

- If appropriate, your counselor may consult with your treating physician or other healthcare provider to coordinate your care;
- If you pose a threat of harm to yourself, to another person, or to the community, we will take whatever steps are required by law, or permitted by law, to help prevent the potential harm from happening;
- In the event of a psychiatric hospitalization;
- If you report information indicating that a child, disabled, or elderly person is suffering abuse or neglect;
- If a court order, issued by a judge, which could require us to release information contained in your records, or could require a therapist to testify.

CONTACTING THERAPISTS

You may email your therapist at any time. Please be aware that therapists may not retrieve messages until their regular office hours. **If you have a life-threatening emergency, dial 911.** It is impossible to guarantee the confidentiality of email or text messaging content. By signing below, you grant The Kraft Group Inc. permission to email and text you. You acknowledge the risks, and release The Kraft Group Inc. therapists from liability for the risk to your confidentiality. Emails and texts should be limited to administrative issues such as scheduling or billing questions. The Kraft Group Inc. and its therapists do not accept friend requests from clients on Facebook, LinkedIn or other social media websites.

APPOINTMENTS

Sessions are 50 minutes in length and begin at the scheduled appointment time. If you arrive late, your session will be shorter; if your therapist arrives late, your session will be extended to make up the time. If you must cancel a session, please let your therapist know at least 48 hours in advance. **You will be responsible for the full fee of any session cancelled with less than 48 hours notice.** Appointments must be canceled via voice mail or email. All appointments with (name) therapists are to occur at the (practice name and address). For psychotherapy to be most effective, clients must not be under the influence of intoxicating substances. If your therapist feels it necessary, you may be asked to reschedule your appointment for another time; this will be considered a late cancellation.

FEES, BILLING & PAYMENTS

All services are billed at the standard rate. Sliding-scale fees may be established based on ability to pay. Clients pay for services at the beginning of each session, unless other arrangements have been made. Please notify your therapist if any problems arise that affect your ability to make timely payments. All payments for services are to be made payable directly to (name), never to the name of the individual therapist.

If document preparation is required (e.g. legal proceedings, insurance appeals), clinicians reserve the right to bill for services at 100% of full fee.

In order to prevent any misunderstandings about payment for services, please be advised of the following:

(1) All services provided are billed directly to the client unless other arrangements have been made;
(2) Clients are personally responsible for payment at time of service via cash, credit card, check or money order;
(3) Statements can be provided for you to submit for insurance reimbursement;
(4) You are responsible for submitting all claims to your insurance provider;
(5) If payment is not received when services are rendered, payment may be applied to the credit/debit card on file if no other payment arrangements have been made.

(6) If your credit card is invalid and you have made no other payment arrangements, your past due balance may be sent to an agency for collection.

If you commit to group therapy, the weekly fee for group sessions is due even if you do not attend.

Payment Guarantee: You are individually responsible for all incurred charges, even if you direct us to bill another person. If you direct charges to be billed to another person, you represent that you are authorized to give you such direction. If you have directed charges to be billed to another person who fails to make payment, you will promptly pay on demand.

Therapist under whose license your intern is practicing.

MINOR CLIENTS

In the event that client is a minor (under age 18), signature of parent/guardian indicates permission to treat.

I have read, understand and agree to the information, guidelines and office policies stated above.

_____ _____

Signature Date

_____ _____

Printed Name Date of Birth

PAYMENT INFORMATION

Credit Card Authorization: I,_____(printed name) authorize the maintenance of valid credit card information to guarantee my chosen payment option. Charges will appear on your credit card statement as "The Kraft Group Inc."

Cardholder Name:_____

Circle Card Type: Visa MC Discover AmEx

Billing Address:_____ City: _____Zip: _____

Credit Card #_____3 digit CVV code: _____

Expiration date _____/_____/_____

Email Address: _____

Cardholder/Client Signature: _____Date:/_____/_____

Therapist Name:_____

Please check your payment preference:

____ 1. Cash / Check. Pay when services are rendered.
If payment is not made for two consecutive sessions, then your credit card on file will be charged in the amount of the outstanding balance plus a 4% processing fee.

_____ 2. Credit Card. Automatic billing. Plus 4% processing fee.

NOTE: Monthly statements will be provided upon request via email. Clients are responsible for submitting all claims to their insurance provider.

Payment Guarantee: I understand that I am individually responsible for all incurred charges, even if I direct you to bill another person. If I direct charges to be billed to another person, I represent that I am authorized to give you such direction. If I have directed you to bill charges to another person who fails to make payment promptly when due, I will promptly pay on demand. I understand that if I commit to joining a weekly therapy group, I am responsible for paying for the month of sessions in advance on the first day of the month, regardless of the number of group sessions I attend. I understand that all payments for services are to be made payable directly to (name), never to the name of the individual therapist. I understand there is a 48 hour cancellation policy and that I will be charged without providing 48 hours advance notice to cancel a session.

I have read, understand and agree to the information, authorization and guarantee stated above.

_____ _____
Signature Date

_____ _____
Printed Name Date of Birth