Beryl Bloom Vincequerra LCSW
917-488-7000
BerylVincequerra@gmail.com

New Client Intake Form

Name: _____ DOB: _____ Grade: _____ Age: _____

School, if applicable: _____

Occupation, if applicable: _____

Gender Identification: _____

Address: _____

Cell: _____ Email: _____

Emergency Contact: _____

Referral Source: _____

Reason for seeking therapy at this time:

_____

_____

_____

Do you exhibit any of the following?

____ Suicidal thoughts / attempts

____ Anxiety

____ Self-injury

____ Depression

____ Eating problems

____ Sleep difficulties

____ Distractibility

____Trouble at School

____ Social withdrawal

____ Angry outburst

If yes, please explain or describe any other concerns: _____

_____

_____

My role is to help you improve your health and wellbeing and to overcome obstacles that are getting in the way of living the life you want to live. To get a quick snapshot of how you're doing in your life today, please answer the questions on the following page to the best of your ability.

Please list all individuals living in your household (name and age):

_____

Do you have a good relationship with your family? _____

_____

Are you satisfied with your social life? _____

_____

Do you work? _____

If yes, what do you do for work? _____

Do you go to school? _____

Do you enjoy work/school? _____

What do you do for fun? _____

What do you do for relaxation? _____

What do you do to connect with people in your neighborhood or community? _____

_____

Do you use alcohol or drugs? If yes, please briefly describe: _____

_____

What sort of exercise do you do? _____

Do you eat well? _____

Do you sleep well? _____

Are you currently being treated for any mental health concerns?
If yes, please briefly describe:

_____

Name of practitioner: _____

Have you been treated for any mental health concerns in the past?
If yes, please briefly describe:

_____

Name of practitioner: _____

Please list all medications you are currently taking:

_____

Is there a family history of mental health concerns or substance abuse?
If yes, please briefly describe:

_____

If our work together is successful, what will you be doing differently? _____

_____

Beryl Bloom Vincequerra LCSW
917-488-7000
BerylVincequerra@gmail.com

THERAPY AGREEMENT, POLICIES, AND CONSENT
This agreement contains important information about my professional services and business policies.

BENEFITS/OUTCOMES
The therapeutic process seeks to meet goals established by all persons involved, usually revolving around a specific complaint(s). Participating in therapy may include benefits such as the resolution of presenting problems as well as improved intrapersonal and interpersonal relationships. The therapeutic process may reduce distress, enhance stress management, and increase one's ability to cope with problems related to work, family, personal, relational, etc. Participating in therapy can lead to greater understanding of personal and relational goals and values. This can increase relational harmony and lead to greater happiness. Progress will be assessed on a regular basis and feedback from clients will be elicited to ensure the most effective therapeutic services are provided. There can be no guarantees made regarding the ultimate outcome of therapy.

EXPECTATIONS
In order for clients to reach their therapeutic goals, it is essential they complete tasks assigned between sessions. Therapy is not a quick fix. It takes time and effort, and therefore, may move slower than your expectations. During the therapy process, we identify goals, review progress, and modify the treatment plan as needed.

RISKS
In working to achieve therapeutic benefits, clients must take action to achieve desired results. Although change is inevitable, it can be uncomfortable at times. Resolving unpleasant events and making changes in relationship patterns may arouse unexpected emotional reactions. Seeking to resolve problems can similarly lead to discomfort as well as relational changes that may not be originally intended. We will work collaboratively toward a desirable outcome; however, it is possible that the goals of therapy may not be reached.

CONFIDENTIALITY
All information provided will be kept strictly private and confidential, to the fullest extent permitted by law. Anything said in therapy is confidential and may not be revealed to a third party without written authorization, except for the following limitations:
- Child Abuse: Child abuse and/or neglect, which include but are not limited to domestic violence in the presence of a child, child on child sexual acting out/abuse, physical abuse, etc. If you reveal information about child abuse or child neglect, I am required by law to report this to the appropriate authority.
- Vulnerable Adult Abuse: Vulnerable adult abuse or neglect. If information is revealed about vulnerable adult or elder abuse, I am required by law to report this to the appropriate authority.
- Self-Harm: Threats, plans or attempts to harm oneself. I am permitted to take steps to protect the client's safety, which may include disclosure of confidential information.
- Harm to Others: Threats regarding harm to another person. If you threaten bodily harm or death to another person, I am required by law to report this to the appropriate authority.

LENGTH OF THERAPY
Therapy sessions are typically 45 minutes, weekly depending upon the nature of the presenting challenges. It is difficult to initially predict how many sessions will be needed. We will collaboratively discuss from session to session what the next steps are and how often therapy sessions will occur.

PAYMENT
Payment is expected at time of service through the payment platform, Ivy Pay. I do not accept insurance, but I can provide you with a super bill with billing codes to be used for out-of-network reimbursement. Please check your benefits with your insurance provider. More on Ivy Pay: I use Ivy Pay for billing so I can accept credit cards without having access to your credit card or keeping your card on file. Setting this up is easy and involves receiving a text (to the mobile number you provide) from Ivy Pay with a link to enter your credit card information. Ivy Pay can accept any credit, debit, or HAS/FSA card. Once you input your credit card number, Ivy Pay saves it in its HIPPA compliant platform, and makes it easy to use again in the future. At the end of each session, you will receive a text with a charge. With this link you also have the option to download a superbill after each session.

COUPLES COUNSELING & "NO SECRET" POLICY:
When working with couples, all laws of confidentiality exist. I request that neither partner attempt to triangulate me into keeping a "secret" that is detrimental to couple's therapy goal. If one partner requests that I keep a "secret" in confidence, I may choose to end the therapeutic relationship and give referrals for other therapists as our work and your goals then become counterproductive.

EMAIL
Do not use e-mail for emergencies. In the case of an emergency call 911, your local emergency hotline, or go to the nearest emergency room.

I have read and understand the information contained in the Therapy Agreement, Policies and Consent. I have discussed any questions that I have regarding this information with Beryl Vincequerra LCSW. My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent.

Client Name: _____

Client Signature: _____ Date: _____

Parent Signature (if client is a minor): _____

***CANCELLATION AND RESCHEDULING POLICY**
Cancelling or rescheduling a session is easily done with appropriate notice. Please allow at least 24 hours' notice for appointment changes. Since I am unable to use this time for another client, please note that you wil l be billed for the entire cost of your scheduled appointment if it is not canceled within 24 hours of the schedu led session, unless the cancellation is due to illness or an emergency.

I appreciate your help in keeping my practice schedule running timely and efficiently.

Client Signature/Parent Signature (if client is a minor): _____

Client Signature: _____ Date: _____

Health Insurance Portability Accountability Act (HIPAA)
Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice explains HIPAA and its application to your PHI in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have acted in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier, or an authorized qualified rehabilitation provider.

5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the New York Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the New York Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- ***For Treatment –*** I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of our practice for your treatment by another health care provider, I will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- ***For Payment*** – I may use and disclose your health information to obtain payment for services provided to you as delineated in the Therapy Agreement.
- ***For Operations*** – I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

Patient's Rights:

- ***Right to Treatment*** – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
- ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advance and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- ***Right to Amend*** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days

- ***Right to a Copy of This Notice*** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- ***Right to Choose Someone to Act for You*** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
- ***Right to Choose*** – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- ***Right to Terminate*** – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
- ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of New York Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Client/Legal Guardian Signature: _____ Date: _____

Printed Name: _____ Date: _____

Client/Legal Guardian Signature: _____ Date: _____

Printed Name: _____ Date: _____

Clinician Signature: _____ Date: _____

Clinician Typed Name & Credentials: Beryl Bloom Vincequerra, LCSW