Bloom Counseling, LLC
Intake Form

702 McKinley Ave NE
Huntsville, AL 35801
Phone: 256-472-9722
Fax: 256-827-5059

Patient Information

First appointment: ______________________

Name *(legal)* ____ Date of Birth: ______________________

Preferred Name ____________________________________ Gender ☐ Male ☐ Female
(if different from above) *(as listed with insurance)*

Address ____
(complete mailing address)

Primary language used to communicate ☐ English ☐ Other ________________________________

Primary care doctor _________________________________ PCP Phone Number ______________________

Primary concern that prompted this evaluation/treatment ____________________________________

____

Referral source *(recommended by)* ____

Education
☐ Full-time student
☐ Part-time student
Highest level of education achieved:
____

Employment
☐ Full-time at ___________________
☐ Part-time at ___________________
☐ Currently unemployed

Marital Status
☐ Single/never married
☐ Married
☐ Separated/Divorced
☐ Widowed

Contact Means

Okay to leave text and voice messages about:

Home	______________________	Appointments? ☐ Yes ☐ No	Clinical information? ☐ Yes ☐ No
Cell	______________________	Appointments? ☐ Yes ☐ No	Clinical information? ☐ Yes ☐ No
Work	______________________	Appointments? ☐ Yes ☐ No	Clinical information? ☐ Yes ☐ No
Email	______________________	Appointments? ☐ Yes ☐ No	Clinical information? ☐ Yes ☐ No

Circle which number you would like to have automated reminder calls/texts sent to or none if you do not want this service.

Patient Portal Grants you free online access to schedule or change your future appointments at our office.

Would you like an email invitation to our Patient Portal (from TherapyNotes)? ☐ Yes ☐ No

Preferred email ____

Insurance Information

Insurance Company _________________________ Policy Number __________________ Group ________________

Full Name of Insured ____

Insured Person's Date of Birth _____________ Employer *(if insured through an employer)* ______________________________

Emergency Contact

Name ____ Relation to client ______________________________

Home phone ____________________ Cell phone _____________________ Work phone _______________________

Current medications *(please list names of medications and dosages)*

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Relevant treatment history *(include dates of psychiatric/psychological treatment, psychiatric hospitalizations, etc.)*

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Relevant medical history *(include chronic/major illnesses, medical hospitalizations, surgeries, head injuries, etc.)*

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People living in the household *(not including client)*

Name	Age	Relationship to client
		☐ Mother ☐ Father ☐ Step-parent ☐ Sibling ☐ Spouse ☐ Child ☐ Other: ________
		☐ Mother ☐ Father ☐ Step-parent ☐ Sibling ☐ Spouse ☐ Child ☐ Other: ________
		☐ Mother ☐ Father ☐ Step-parent ☐ Sibling ☐ Spouse ☐ Child ☐ Other: ________
		☐ Mother ☐ Father ☐ Step-parent ☐ Sibling ☐ Spouse ☐ Child ☐ Other: ________
		☐ Mother ☐ Father ☐ Step-parent ☐ Sibling ☐ Spouse ☐ Child ☐ Other: ________
		☐ Mother ☐ Father ☐ Step-parent ☐ Sibling ☐ Spouse ☐ Child ☐ Other: ________

If more space is needed, please list additional household members on a separate sheet of paper and attach.

For child/adolescent clients:

Does the client live with both parents? ☐ Yes ☐ No If no, what is the custody arrangement? ____________________

___

Please list the address of any parent/guardian who does not live at the same address as the client:

Name ____ Phone ________________________

Address ____

Symptom Checklist

Name:____ Date:______________________

Please CHECK as many of the following items which apply to you. Do you have trouble with:

SLEEP PROBLEMS:
- ☐ Difficulty falling asleep
- ☐ Early morning waking
- ☐ Waking during the night
- ☐ Feel tired when waking
- ☐ Increase in dreams
- ☐ Unpleasant dreams
- ☐ Excessive sleep

CHANGES IN:
- ☐ Weight_____lbs lost gained
- ☐ Health
- ☐ Sexual interest
- ☐ Sexual performance
- ☐ Appetite
- ☐ Energy level

FEELINGS OF:
- ☐ Anxiety
- ☐ Tiredness
- ☐ Boredom
- ☐ Lack of interest
- ☐ Sadness
- ☐ Depression
- ☐ Despair
- ☐ Worthlessness
- ☐ Helplessness
- ☐ Emptiness
- ☐ Rage
- ☐ Tension
- ☐ Loneliness
- ☐ Guilt
- ☐ Hopelessness

THOUGHTS OF:
- ☐ Harming yourself
- ☐ Harming others

DO YOU HAVE ALLERGIES?
- ☐ No
- ☐ Yes __________________________

RECENT HISTORY OF:
- ☐ Nausea/vomiting
- ☐ Diarrhea
- ☐ Fever/chills
- ☐ Sweating
- ☐ Chest pain
- ☐ Dizziness
- ☐ Headaches
- ☐ Trembling
- ☐ Lower back pain
- ☐ Dry mouth
- ☐ Shortness of breath
- ☐ Palpitations
- ☐ Rapid breathing
- ☐ Head injury
- ☐ Loss of consciousness
- ☐ Loss of memory
- ☐ Confusion
- ☐ Seizure
- ☐ Bleeding
- ☐ Swollen Joints
- ☐ Numbness, tingling
- ☐ Paralysis
- ☐ Flashbacks
- ☐ Blackouts

DIFFICULTY WITH:
- ☐ Short attention span
- ☐ Carelessness or sloppy work
- ☐ Listening when spoken to
- ☐ Following through on instructions
- ☐ Organizing tasks or activities
- ☐ Avoiding homework or paperwork
- ☐ Losing things at home or school
- ☐ Forgetfulness in daily activities
- ☐ Fidgeting or squirming in seat
- ☐ Sitting still
- ☐ Restlessness or hyperactivity
- ☐ Playing quietly
- ☐ Talking excessively
- ☐ Speaking out of turn
- ☐ Waiting for others
- ☐ Interrupting or intruding on others

CONFLICT WITH:
- ☐ Spouse
- ☐ Family member
- ☐ Other loved one

PROBLEMS WITH:
- ☐ Arguing a lot
- ☐ Lying
- ☐ Stealing
- ☐ Losing Temper
- ☐ Avoiding people
- ☐ Spending/finances
- ☐ Sexual behavior
- ☐ Gambling
- ☐ Eating
- ☐ Fighting
- ☐ Increased drinking
- ☐ Substance abuse
- ☐ Destroying things

FEAR OF:
- ☐ Loss of control
- ☐ Death
- ☐ Being alone
- ☐ Places/situations
- ☐ Objects or animals
- ☐ Cancer
- ☐ AIDS
- ☐ Being possessed
- ☐ Being insane

EXPERIENCE OF:
- ☐ Vivid dreams
- ☐ Nightmares
- ☐ Hearing voices
- ☐ Seeing visions
- ☐ Being out of body

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Outpatient Services Contract

Welcome to Bloom Counseling. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them. When you sign this document, it will represent an agreement between us.

Please initial each section to indicate that you have read and agree with each part.

______ **MENTAL HEALTH SERVICES**
initials

Diagnostic Interview: A diagnostic interview will be completed during your first visit. It is an assessment to determine diagnosis and client-therapist fit. This session will last up to one hour and include recommendations for treatment.

Psychotherapy: Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the particular problems you hope to address. There are many different methods I may use to deal with those problems. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about during our sessions on your own outside our sessions.

Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees as to what you will experience.

Therapy can involve a large commitment of time, money, and energy, so you should be very careful about the therapist you select. I will usually schedule one 53-min session (one appointment hour of approximately 53 minutes duration) every one or two weeks, at a time we agree on. If you have questions about my procedures or you feel like I am not the right therapist for you, we should discuss these concerns whenever they arise. If your doubts persist, I will be happy to try to help you set up a meeting with another mental health professional for a second opinion or as a referral.

______ **PROFESSIONAL FEES**
initials

My hourly fee is $160 for the diagnostic interview and $160 for psychotherapy. In addition to scheduled appointments, I charge $160 an hour for other professional services you may need, though I will prorate the hourly cost if I work for periods of less than one hour. Other professional services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request.

If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time I spend on your legal matter, even if the request comes from another party.

______ LATE CANCELLATION/NO SHOW CHARGES

initials

Once an appointment is scheduled, you will be expected to attend unless you provide at least 24 hours advance notice of cancellation. While a complimentary automated text reminder is offered, you maintain responsibility of tracking your scheduled appointments regardless of receipt of or lack of receipt of these reminders. **Note that insurance will not pay for late cancellation/no show charges. Late cancellations (less than 24-hour notice) will be charged $40. No shows will be charged $75. These charges will be processed to the card on file at time of missed appointment.** Services may be terminated due to excessive late cancellations and/or no shows. Typically, three or more late cancellations/no shows in a 6-month period is considered excessive.

______ BILLING AND PAYMENTS

initials

Full payment is due at the time services are rendered. I accept the following forms of payment: Cash, Check, Health Savings Account, or Credit Card. **If you would like us to keep your credit card on file and have it charged automatically at each visit, please fill out the credit card authorization form included in this packet. Otherwise, payment will be collected by your therapist prior to the start of session.** Non-sufficient funds transactions and returned checks will incur a $30 service charge.

If your account has not been paid for more than 90 days, services may be suspended and we have the option of using other legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, it's costs will be included in the claim. In most collection situations, the only information we will release regarding a patient's treatment is their name, the dates, times, and nature of services provided, and the amount due.

______ INSURANCE REIMBURSEMENT

initials

If you have a health insurance policy, it may provide some coverage for mental health treatment. It is very important that you find out exactly what mental health services your insurance policy covers and ensure that coverage is in effect at the time of service.

I will be happy to file your primary insurance and provide you with a complete itemized statement in order for you to file your secondary insurance. If you would like me to file your primary insurance, all deductibles and co-payments will be required at time of visit. By initialing this section, you are acknowledging that you (not your insurance company) are responsible for full payment for services. Should your account be turned over to an attorney/collection agency for non-payment, you will be responsible for additional attorney/collection fees as well. In addition, you are authorizing Bloom Counseling, LLC to file insurance on your behalf and to provide your insurance company any necessary information. You are also authorizing payment to be made directly to Bloom Counseling, LLC.

______ TREATMENT TERMINATION

initials

Throughout treatment, we will periodically evaluate progress towards your treatment goals. If it is mutually agreed that we have made satisfactory progress on those goals, then discussion of treatment termination will occur. This discussion will include relapse-prevention strategies, as well as the possibility of "booster" treatment sessions periodically, if appropriate.

Treatment may also be terminated if an appointment is canceled or missed and the office is not contacted within 30 days of the canceled/missed appointment to reschedule. At that time, it will be assumed that you are no longer seeking services and your therapy will be discontinued. If 30 days have passed, inactive clients are welcome to check therapist's availability, but are not guaranteed services after that time.

______ **CONTACTING ME**

initials

I am often not immediately available by telephone. Though I am usually in my office between 10:00 am and 5:00 pm, Monday through Thursday, I will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by voicemail that I check periodically throughout the day. I will make every effort to return your call within 24 hours (with the exception of Fridays, weekends, and holidays). If you are difficult to reach, please inform me of some times when you will be available. If it is urgent, please make that clear in the voicemail message and I will return the call as soon as possible. If it is an emergency, please contact emergency services at 911 or go to the closest emergency room. If I will be unavailable for an extended time, my outgoing voicemail message will provide you with instructions for contacting a covering provider, if necessary.

______ **ELECTRONIC COMMUNICATION**

initials

I use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with my office should be limited to things like setting and changing appointments, billing matters, and other related issues. I recommend that you do not email me about clinical matters because email is not a secure way to contact me. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during our next session. The telephone or face-to-face context is much more secure as a mode of communication. If you choose to email me regarding clinical information, understand that confidentiality cannot be ensured. Any phone consultations taking longer than 15 minutes will be billed as an out-of-pocket fee.

I do not contact any of my clients through social media. In addition, if I discover that I have accidentally established an online relationship with you, I will discontinue that relationship as these types of casual social contacts can potentially compromise the professional relationship.

Bloom Counseling has a website, Instagram, and Facebook page that you are free to access. They are used for professional reasons to provide information to others about the practice. You are welcome to access and review the information and, if you have questions about it, we can discuss them during your therapy sessions. I use a web-based practice management program called TherapyNotes for tasks such as scheduling, record keeping, and billing. TherapyNotes maintains HIPAA business associate agreements with its providers and is therefore held to the same standards regarding confidentiality of health information as I am. TherapyNotes has a patient portal that can be used, if you choose, to contact the office regarding scheduling.

______ **CONFIDENTIALITY**
initials

In general, the privacy of all communications between a patient and a therapist is protected by law, and I can only release information about our work to others with your written permission. There are some exceptions to this:

In many legal proceedings, you have the right to prevent me from providing any information about your treatment. In some legal proceedings, a judge may order my testimony if they determine that the issues demand it, and I must comply with that court order.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child is being or has been abused, I must make a report to the appropriate agency and can break confidentiality to do so.

If I believe that a patient is threatening serious bodily harm to another, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If a patient presents a serious risk of harm to themselves, I may be obligated to seek hospitalization for them or to contact family members or others who can help provide protection.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. I will not tell you about these consultations unless I believe that it is important to our work.

I have made advance plans to facilitate the appropriate transfer of your care and to protect the confidentiality of your records in the event of my illness, unavailability, relocation, retirement, or death. Please know that my professional executor is a licensed clinician herself and is legally and ethically obligated to maintain your confidentiality.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that we discuss any questions or concerns that you may have at our next session. If you need specific clarification that I am unable to provide, formal legal advice may be needed, as the laws governing confidentiality are quite complex and I am not an attorney.

Treatment of minors: The limits of confidentiality described above apply to the treatment of minors as well. With minors, specific information regarding treatment may also be kept confidential from parents/guardians. However, if there is information disclosed that indicates that a minor is engaging in behavior that I believe, in my professional judgment, puts themselves or others at risk for serious harm, this will be disclosed to the parent/guardian.

HIPAA

______
initials

Please acknowledge that you were offered a copy of HIPAA Notice of Privacy Practice document for review (this is available on Bloom Counseling's website at all times).

Your signature below indicates that you have read the information in this document and agree to abide by its terms.

If you do not initial a component of this agreement or choose not to sign below, please understand that this voids the agreement and services will not be rendered.

SIGNATURE ____ DATE ________________

Relationship to client ______________________________ *(if other than client, e.g., parent, legal guardian)*

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Authorization to Release Health Information

I hereby authorize the use and disclosure of any protected health information as set forth below.

I understand that I may revoke this authorization at any time by notifying my provider in writing. In the event of any revocation of this authorization, the revocation will not affect any action taken by the provider in reliance on this authorization.

I understand that the provision of treatment or health care may not be conditioned on my providing this authorization.

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the federal privacy regulations.

By signing below, I authorize Louisa N. DiLeone, LPC-S and Bloom Counseling, LLC (and/or administrative staff, if applicable) to exchange (receive and release) confidential information about my health treatment/services (including mental health services) with the persons/agencies listed below:

Insurance company (required if using insurance to pay for services) ______________________

Primary care provider ______________________

Specialty provider (e.g., psychiatrist, dietitian, etc.) ______________________

Specialty provider (e.g., psychiatrist, dietitian, etc.) ______________________

School / School District ______________________

Family Member ______________________

Other ______________________

Disclosure will be made for the purpose of coordination of care and/or access to insurance benefits.

This authorization will be valid for one (1) year from the date of signature, unless otherwise specified as expressed by the patient, parent, or guardian in writing, prior to that date.

Client's Name *(printed)* ______________________ Date of Birth ______________

Signature ______________________ Today's Date ______________

Relationship to client ______________________ *(if other than client, e.g., parent, legal guardian)*

Witness ______________________ Date ______________

Automatic Payment Processing

For your convenience, I will use this authorization to charge your credit card for charges incurred as a result of services rendered at Bloom Counseling, LLC. Your information will be kept in a secure location to ensure its safety and protection. Circumstances when your card would be charged include but are not limited to: missed or canceled sessions without 24-hour notice, unpaid co-payments, deductible and co-insurance, any non-covered services, and denial of services. Please note there will be an additional $30 charge for a non-sufficient funds transaction.

Credit Card Authorization

By signing below, I authorize Bloom Counseling, LLC to keep my credit card information on file and to charge my credit card for services rendered at Bloom Counseling, LLC for which I am responsible without my physical presence at the time of charge. I allow Bloom Counseling, LLC to charge my credit card for fees not covered by my insurance company to include co-pays, court fees, or other services not covered by my insurance policy. If I wish to pay for services in another manner, I understand that it is my responsibility to notify Bloom Counseling, LLC and make arrangements to pay for services rendered.

If the credit card that I give today changes, expires, or is denied for any reason, then I agree to immediately give Bloom Counseling, LLC a new, valid credit card, which I will allow them to key-in over the phone. Even though Bloom Counseling, LLC is not swiping this card in person, I agree that the new card will still be subject to the financial policy listed here and may be used with the same authorization as the original card that I presented in person.

I agree to not dispute charges for services I have received or for fees associated with non-compliance of the cancellation/no show policy. I further authorize Bloom Counseling, LLC to disclose information about my attendance/cancellations to my credit card issuer if I dispute the charge.

I authorize Bloom Counseling, LLC to continue to charge my credit card for fees associated with services rendered from the first day of services until the close of my case/child's case.

Patient Name: ____

Responsible Party: ____

Name exactly as it appears on card: ____

____

Card Holder's Signature   Date