406 W. Pennsylvania Avenue, Suite 201, Towson, MD 21204

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E: Vicky@woodruff-counseling.com

CLIENT INTAKE FORM

Client Name: ______ MI ______ Last: ______

Date of Birth: ______ Age: ______

Gender Assigned at Birth: M☐ F☐ Identified Gender: M☐ F☐

Address: ______ City: ______ Zip Code: ______

Primary Phone: ______ Alternate Phone: ______

Email: ______

Preferred Method of Communication: Email ☐ Phone ☐ Text ☐

Occupation: ______ Highest Level of Education: ______

Race/Ethnicity: White ☐ African American ☐ Asian ☐ Hispanic/Latino ☐ American Indian ☐ Other ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Sexual Identity (optional): ______ Religion (optional): ______

Primary Care Provider: ______ Contact Information: ______

Sexual Identity (optional): ____________ Religion (optional): ____________

Primary Care Provider: ____________ Contact Information: ____________

Are you currently being treated by another mental/behavioral health professional?

Yes ☐ No ☐

Name of other Provider(s): ____________

Reason for treatment: ____________

How did you hear about us? ____________

Client Name: ______________________ Date of Birth: ____________

Please initial and sign the disclosure form. If anything is unclear, please discuss it with your provider before signing.

☐ I understand that I am responsible for the entire session fee.

☐ I understand that it is my responsibility to contact my insurance company to learn about out-of-network benefits.

☐ I understand that Woodruff Counseling LLC is not responsible for issues related to potential out-of-network reimbursement.

☐ Payment is expected at the time of service. In the event that my account becomes delinquent and is forwarded to an attorney for collections I am responsible for the attorney fees and all court costs.

☐ If I cancel an appointment with less than 24 hours' notice I will be charged the full payment for the missed appointment.

☐ I give permission for Woodruff Counseling LLC to utilize HIPAA compliant electronic services for the delivery of care, documentation, and communication. Including but not limited to an EMR/EHR, online scheduling service, and telehealth platforms.

☐ I authorize Woodruff Counseling LLC to share ongoing treatment and communication with my insurance company, when needed by the insurance company. If I choose to not seek reimbursement this does not apply.

☐ I understand that I can revoke this consent at any time with a written notice.

☐ I have received copies of all the documents that I have signed today.

______________________ Signature of person responsible for payment

______________________ Signature of client/guardian

Date: ____________

Client Name: ______________________ Date of Birth: ______________

Financial Policy

Payment in full is due at the time of service. We accept check, most major credit cards, HSA and FSA. You may be asked to present identification at the time of payment. A credit card will be kept on file and charged if there is an unpaid balance.

Woodruff Counseling LLC is an out-of-network provider. Woodruff Counseling LLC will not bill your insurance. If you wish to seek reimbursement from your insurance company it will be your responsibility to submit the claim. Woodruff Counseling LLC will provide you with a superbill/receipt so that you can submit for possible reimbursement.

Reimbursement rates from insurance company are based on your individual plan. It is your responsibility to contact your insurance company and know your benefits. Any and all disputes related to reimbursement are between the member and the insurer.

Late cancellation appointments will be charged in full. We will keep your credit card on file and reserve the right to charge you for late cancelled or missed appointments. Late cancellation appointments cannot be submitted to insurance for out-of-network reimbursement as no services were rendered.

I have read, understand and agree to this financial policy.

______________________ Signature of person responsible for payment

______________________ Signature of client/guardian

Date: ______________

Client Name: ______________________ Date of Birth: ____________

Allergies and Medications

Do you have any allergies: Yes ☐ No ☐

Please list all allergies:

____

____

____

____

Please list all medications that you are currently taking

Medication	Dose	Frequency	Reason for Medication

Please list all over the counter medications, supplements, or herbal medications that you are taking:

____

____

____

______________________ Date: ____________

Signature of client or guardian

Client Name: ______ Date of Birth: ______

Medical History

Height: ______ Weight ______

Medical conditions:

- ☐ Diabetes (describe): ______
- ☐ Hypertension (describe): ______
- ☐ Cardiac condition (describe): ______
- ☐ Neurological condition (describe): ______
- ☐ Thyroid condition (describe): ______
- ☐ Kidney disease (describe): ______
- ☐ Liver Disease (describe): ______
- ☐ Chronic Pain (describe): ______
- ☐ Joint Disease (describe): ______
- ☐ Congenital Disorder (describe): ______

List all other medical conditions:

______

______

______

Any surgeries:

______

______

______

Are you pregnant? Yes ☐ No ☐

______

Signature of client or guardian

Date: ______

Client Name: ______ Date of Birth: ______

Mental Health History

Have you been diagnosed with any of the following:

- ☐ Speech disorder (describe): ______
- ☐ Learning disorder (describe): ______

Have you been diagnosed or treated for a mental health condition? If so, please list the diagnosis, the provider, and when the diagnosis was made.

______

______

______

______

Additional Substances

Do you smoke? ☐ Yes ☐ No

Do you drink? ☐ Yes ☐ No

How often do you drink? ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently

When you drink how many glasses of wine do you typically consume? ______

When you drink how many beers do you typically consume? ______

When you drink how many cocktails/mixed drinks do you typically consume? ______

Have you ever tried any recreational drugs? ☐ Yes ☐ No

Within the past 6 months have you taken any recreational drugs or substances? ☐ Yes ☐ No

______
Signature of client or guardian

Date: ______

Client Name: ______________________ Date of Birth: ______________

Woodruff Counseling LLC

HIPAA-Compliant Communications

Client Consent

In the interest of protecting your health information, we seek your guidance and authorization on how we can safely communicate with you.

Please select all that apply from the following communication methods and sign in the space provided.

I ______________________ quest that my therapist at Woodruff Counseling communicate with me via the following methods and warrant that they are secure from access by parties not authorized to view my private health information (PHI).

- ☐ Call me on my mobile number: ______________________
- ☐ Leave messages on my mobile number: ______________________
- ☐ Text me on my mobile number: ______________________
- ☐ Call me on alternate number: ______________________
- ☐ Leave messages on my alternate number: ______________________
- ☐ Email me at the following address: ______________________
- ☐ Please check if the primary client is under 18 years old and indicate your relationship to the client: ______________________

____
Signature of client or guardian

Date: ______________

Client Name: ______________________ Date of Birth: ______________

Woodruff Counseling LLC

INFORMED CONSENT FOR TREATMENT

I have read and understand the policies in the intake packet. I have also received and read the Notice of Privacy Practices. I accept these policies and practices. I understand that I may request a copy of these notices if I wish to keep them for my personal reference.

I understand that behavioral health treatment offers no guarantees. By working with my therapist, I should get help with the problems and concerns I bring up to Woodruff Counseling LLC. However, I recognize that things may get worse. I understand that I will probably need to do homework, that is, try new ways of dealing with my problems-which I develop together with my therapist. If I do not to these things outside the office, I understand that the effectiveness of treatment will be hindered.

I agree to cooperate fully with my therapist and to discuss any reasons why I cannot. I agree to ask any questions I have to clarify my therapeutic goals and how therapy is addressing them.

I understand that therapy will end when the problems and concerns I bring forth are resolved. I also understand that I can terminate therapy at any time I wish. I agree to notify my therapist of my intent to end therapy and to discuss the possible risk of premature termination of therapy.

I also understand that my therapist may end my treatment if we do not make progress, or if our relationship becomes too strained to continue working together. If I am no longer able to pay for services and treatment is to be terminated early, my therapist will make suggestions to guide me in finding another provider of my choice. It will be my responsibility to follow up with these suggestions to ensure the best outcome of my care.

______________________ Date: ______________

Signature of client

______________________ Date: ______________

Signature of legal guardian if applicable

Client Name: ______ Date of Birth: ______

Emergency Contact Form

In case of an emergency, please notify the following individuals:

Name:
Relationship:
Street Address:
Phone Number:
Alternate Number:

Name:
Relationship:
Street Address:
Phone Number:
Alternate Number:

By signing below, I'm giving Woodruff Counseling LLC permission to contact the above-mentioned individual/s in case of an emergency.

______
Signature of client or guardian

Date: ______