**Anna T. Micci, LICSW**

**P.O. Box 613**

**Cohasset, MA 02025-0613**

**INTAKE FORM** **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**CLIENT INFORMATION:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:(home)\_\_\_\_\_\_\_\_\_\_\_\_(work)\_\_\_\_\_\_\_\_\_\_\_\_\_(cell)\_\_\_\_\_\_\_\_\_\_\_\_\_

**Which number may I contact you and leave messages?** \_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_e-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May I send mail to this address? \_\_Yes \_\_No

Sex: Male\_\_\_ Female\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Others living at home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation;\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have your worked there?\_\_\_\_How long in this occupation?\_\_\_\_\_

Education: (highest level attained) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any significant health problems:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medications you are taking and the dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you seen this type of therapist before? \_\_\_yes \_\_\_no

If yes, when and with whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Give brief description of treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who may I thank for referring you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL INFORMATION:**

Subscriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to client:\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (if different from above):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Carrier:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Phone number and Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INFORMED CONSENT**

**CONFIDENTIALITY STATEMENT**

My communications are confidential except according to limitations outlined by Massachusetts. These apply in situations of child and elder abuse and neglect, which are mandated by law to report, situations in which there is a danger to self or others, and the basic data needed by your insurance company to process claims. It may also be necessary to discuss your treatment plan and specific medical problems with your primary care physician. The following are legal exceptions to your right to confidentiality:

* If I have credible reason to believe that you will harm another person, I must attempt to contact them and the police .
* If I have good reason to believe that you are abusing or neglecting a child, or vulnerable adult.
* If I believe you are in imminent danger of harming yourself, I may legally break confidentiality and call your family, the police and/or local crisis team.

**QUALITY ASSURANCE:** I understand that I may be contacted by my health insurance company to ensure the continuity and quality of my treatment or, after treatment is completed, to assess the outcome of treatment.

**FEES:** The initial consultation fee is $175.00. Additional sessions are 50 minutes and the fee is $150.00. Family sessions are 60 minutes with a fee of $160.00. I will bill Blue Cross/Blue Shield, Tufts, Harvard/Pilgrim, United Behavioral Health, Aetna and Medicare. For other private insurances I will bill you directly, and it will be your responsibility to seek reimbursement from you carrier. All co-pays are payable at the time of service.

**YOUR RESPONSIBILITY:** You are responsible for contacting your insurance company and/or physician, and obtaining referral authorization for my services. You should familiarize yourself with information regarding deductibles and co-pays. See your subscriber manual or the back of your insurance card for telephone numbers and instructions.

**CANCELLATIONS:** Your appointment time is reserved for you exclusively. Please give at least 24 hours notice for cancellations or you will be charged a late cancellation fee of $60.00.

**AVAILABILITY/EMERGENCIES:** I have an answering machine that I check frequently throughout the day should you need to contact me with messages and/or cancellations. In the event of an emergency or some other vital reason to contact me immediately, please follow the directions on my answering machine. If you believe that you are in danger of harming yourself or someone else, and are unable to reach me. Please go to the nearest emergency room for immediate assistance.

**STATEMENT OF UNDERSTANDING:**  I understand that my therapist, insurance company representatives and my primary care physician may exchange any and all information pertaining to my therapy, to the extent such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance or utilization review purposes. I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that it I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in my insurance benefit plan. I also agree that I have read and understand all of the information contained in this document.

**In signing this document, I admit to receiving a Notice of Privacy.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Client Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent of Guardian if minor Date