EKP CLIENT INTAKE

Practitioner: Choose Your Practitioner

How did you find out about us?	Today's date:_____

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status: Single☐ Mar☐ Div☐ Sep☐ Wid☐

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Email address:	Birth date:	Age:	Sex: M F

Street Address:	Driver's Lic.#:	Home Phone
	SSN#:	( )

City:	State:	Zip Code:	Cell Phone ( )

Occupation/Employer	Employer Address:	Employer phone ( )

Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family or Friend	❑ Online	☐ Other

Do you have children? ◯ Yes ◯ No

1) Name Birth date:

2) Name Birth date:

3) Name Birth date:

4) Name Birth date:

Medical Problems:

Religious/ Spiritual preference

How important is this in your life?

Not important ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ Important
0 1 2 3 4 5 6 7 8 9 10

Previous Psychotherapy

Experience:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone ( )

Is this person a patient here? ○ Yes ○ No

Occupation:	Employer:	Employer address:	Employer phone ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance:		Member ID:		
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #:	Work phone #:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize EK Psych or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ *Date*

Informed Consent

Sessions are 50 minutes, unless other arrangements have been made.

Approved third-party written correspondence will be billed at $300 an hour.

If you are unable to keep an appointment, please call 714-494-1867 and leave a voicemail message. Please cancel as soon as possible and no later than 24 hours before your appointment. Less than 24 hours notice will be considered a missed appointment.

x_____ (Initial)

It is best to talk with your insurance company representative about your mental health benefits and coverage details, such as copays, deductible, and the latest policy updates. We're not part of your insurance company, so we're not responsible for verifying your copay and deductible amount. Patients and clients are responsible for paying any balances that are caused by changes or different coverage amounts in their insurance policy after we receive the EOB (Explanation of Benefits).

Insurance does not cover missed appointments. Therefore, a missed appointment fee will be assessed at $100 per session. If you normally use insurance to pay for services, you acknowledge and agree to personally pay the fee as stated above. You will not receive additional services until all fees are up to date.

x _____ (Initial)

Missed appointment fees will be charged to the credit card received at the time of consent for services.

x_____ (Initial)

Thank you for your cooperation in helping us to provide the best services we can.

Client Printed Name

Date

x_____

x_____

Client Signature

x_____

Emotive Knowledge Psychology

A felt sense for the study of psyche.

CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients.
Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.
I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____

Client Signature (Client's Parent/Guardian if under 18)

Today's Date _____

Emotive Knowledge Psychology
CreditCardAuthorizationForm

I _____, authorize **EK Psych - Emotive Knowledge Psychology** (via PayPal) to charge my credit card monthly or weekly for professional services.

There will be a 4 % service charge for credit card payments. Charges will appear on your credit card statement as **EK Psych - Emotive Knowledge Psychology**.

_____ _____
Signature Date

Credit Card Information:

Type of Card: _____

Name on Card: _____

Expiration Date: _____

Credit Card Number: _____

3 or 4-digit security code on back of card: _____

Billing Address: _____

Email Address: _____

Emotive Knowledge Psychology
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Emotive Knowledge Psychology
Consent for Telehealth Services

What are "Telehealth services?"

Telehealth services are used when mental health staff cannot be physically present with the client to evaluate or treat his/her/hir mental health needs. Mental health staff may be present at another location and available to serve the client using technology. Telehealth services vary from regular over-the-phone sessions as they typically utilize video through certain media platforms (e.g., Zoom, Google Hangout).

How do Telehealth services work?

The client and mental health staff will decide together which media platform to utilize for sessions. Then, sessions will be held as they typically would, only via video chat rather than in-person. Clients and staff will most often conduct sessions from their home environments, although it is possible for them to be in other locations (e.g., staff utilizing video from their office computers). It is essential to maintain confidentiality and keep the privacy of sessions regardless of whether it is in-person or online. Thus, it is recommended that clients disengage from others in their households and find a private space during sessions. Headphones are also recommended to help maintain the privacy of sessions. Despite our best efforts, it is important to be aware that utilizing technology for sessions—although unforeseen—comes with the chance of security breaches. Therefore, it is essential to try and reduce this as much as possible by having sessions via video chat with particular privacy settings established by the client and mental health staff ahead of time.

Lastly, in order to receive services via Telehealth, I understand that:

1. I have the option to withhold consent at this time or to withdraw this consent at any time.
2. There is no permanent video or voice recording kept of Telehealth sessions.
3. All existing confidentiality protections apply, and privacy settings will be established prior to the first telehealth session. However, I acknowledge the increased risk in the chance of a security breach that accompanies telehealth services.

I, _____, consent to receive telehealth services in circumstances in which mental health staff and/or the client are unable to meet in-person. Emotive Knowledge Psychology has discussed with me the information provided above and I

understand this information. I further understand that this is a voluntary service. Finally, I have had the opportunity to ask questions about this information, and all of my questions have been answered.

_____	_____
Client's Name (Print)	Date
_____	_____
Signature of Client	Date
_____	_____
Client's Caregiver's Signature (If Client is a dependent or minor)	Date