aaron airozo, m.s., mft
licensed marriage and family therapist

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INTAKE FORMS PACKET

Included in this Packet

(1) Intake Form (p.2)
(2) Client Information Form (p. 3)
(3) Information and Consent Form (pp. 4-5)
(4) Confidentiality Statement (p. 6)
(5) Authorization to Treat Minor Children (p. 7)

Instructions

Before your Appointment:

(1) Complete the **Intake Form**
(2) Complete the **Client Information Form**
(3) Read and sign the **Information & Consent Form**
(4) Read and sign the **Confidentiality Statement**
(5) If counseling involves a child under the age of 18, a parent or legal guardian must complete and sign the **Authorization to Treat Minor Children Form**

Bring all completed forms to your first appointment:

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INTAKE INFORMATION

Date:_____ Referral Source:_____

Availability: Days of Week_____ Times: _____

CLIENT INFORMATION

Primary Client(s):_____AGE:_____DOB:_____SEX: M / F

_____AGE:_____DOB:_____SEX: M / F

_____AGE:_____DOB:_____SEX: M / F

Marital Status: Single Married (# of years_____) Separated Divorced Widowed

Address:_____ City:_____ State:_____ Zip Code: _____

Home Phone:_____ Cell Phone:_____ Work Phone: _____

May I leave messages at all these numbers? Yes or No (other) _____

In Case of Emergency Notify:_____ Phone:_____ Relationship: _____

Physician:_____ Address:_____ Phone: _____

FINANCIAL RESPONSIBILITY INFORMATION (GUARANTOR)

Name:_____ Relationship to Client: _____

Address:_____ City:_____ State:_____ Zip Code: _____

Home Phone:_____ Cell Phone:_____ Work Phone: _____

Place of Employment:_____ # of Years_____ Annual Income: _____

Guarantor Agreement: *I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for any and all services rendered by Aaron Airozo, MFT.*

Signature: _____ Date:_____

Date / Time of 1st Appointment: ___/___/____ @ ___:___ AM / PM Fee: $_____

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CLIENT INFORMATION

Name:_____Date:_____

MEDICAL HISTORY

Do you have any physical problems at this time? Yes or No

If yes, please explain: _____
_____
_____

How often do you drink alcohol? _____ times per week

Do you use any other drugs? _____
_____
_____

Are you currently taking any medication? Yes or No

If yes, please list dosage and frequency _____
_____
_____
_____

Please list any previous counseling, mental health treatment and/or psychiatric hospitalizations with approximate dates: _____
_____
_____

What are the areas of your life for which you are seeking assistance? _____
_____
_____
_____
_____

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PATIENT INFORMATION AND CONSENT TO TREATMENT

Thank you for choosing Aaron Airozo, MFT for your counseling needs. I am committed to giving you the best care possible. The following information is being provided to acquaint you further with the procedures and policies of this counseling office:

1. APPOINTMENTS:

When I set an appointment with you, that time is yours and yours alone. **If you need to cancel your appointment, I require a minimum of 6-hours notice; otherwise, you are subject to a full charge for the missed appointment**. Messages may be left with on my voicemail which will accurately record the date and time you called. Upon approval, grace may be provided for late cancellations caused by certain emergencies.

The counseling sessions last 50 minutes. I will do my best to be punctual for your appointment unless I have an emergency call. I ask that you be punctual as well. If you are late, for any reason, you will receive the remainder of your scheduled time. This is necessary so I can see following clients at their scheduled times. You will, however, be required to pay the full fee.

2. COUNSELING FEES:

Counseling fees are set prior to your first appointment. A sliding scale based upon your annual income is used to calculate the fee per session, with a maximum fee per session of $100.00.

Your are fully responsible for all services rendered. Full payment is expected at the time of service unless other contractual arrangements have been made. Fees are to be paid before the beginning of your session. You may pay with cash or check.

I do not routinely bill insurance. I require full payment at the time of service and you may bill your insurance directly. If you should choose to go this route, be sure to ask for a receipt of payment. In giving you a receipt, I am making no guarantees that your insurance will reimburse you.

3. RETURNED CHECKS:

A penalty fee of $20.00 will be assessed on all checks returned by the bank for any reason. Re-payment of the returned check must be made by cash, cashier's check, or money order only.

4. UNPAID BALANCES:

Payment must be made within 30 days of a missed session or a late charge of $20.00 will be assessed. Any accounts with a past due balance of 60 days or more will be handed over to the collection agency, and will incur a $50.00 processing fee. **If your account has an unpaid balance at any time, it may be necessary to suspend counseling sessions until the account is paid**.

5. CHILDREN:

I do not provide care for your children while you are in a counseling session and I am not responsible for any child that is left unsupervised. Young children can be disruptive to other clients, so I ask that you do not bring children to the center unless they are receiving counseling themselves. Should you leave children unattended in the waiting room, I will request that you leave your counseling session to attend to them.

I am dedicated to you and your counseling needs and we appreciate your cooperation in these matters. Should you have any questions or concerns regarding fees, payments, or policies, feel free to address them with me.

_____

Please sign below to indicate that "I have read the above policies, and I understand and agree to comply with them. I further agree that I am personally responsible for all financial obligations incurred. I also consent to receive treatment by Aaron Airozo, MFT."

Signature:_____ Date:_____

Signature:_____ Date:_____

(Parent/Guardian if client is less than 18 years of age)

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CONFIDENTIALITY STATEMENT

Your patient records are the property of Aaron Airozo, MFT and shall be treated as confidential. To comply with state and federal laws regarding patient confidentiality, your records will not be released without properly executed written consent. Everything about your care will be held in strictest confidence (with the exception of those situations which we are required by law to report). If you choose to have a third party informed of your progress in counseling, it will be necessary to complete a ***"Release of Information Form"*** that will be kept on file.

The following circumstances are an exception to keeping confidentiality and are required by law to report:

A. When a client communicates threat of bodily injury to self another person or is suicidal.

B. When there is reasonable suspicion of abuse to a child, elder, or dependent adult which has occurred or will occur.

C. When information is ordered by the court.

Aaron Airozo, MFT regularly consults with a team of licensed therapists. Therefore, he reserves the right to consult and discuss pertinent information within this context. If your case is discussed, no personal information will be used that might identify you to the other therapists.

It is important to remember that electronic communication such as e-mail, text messages, faxes and cell phone calls are not secure. Please keep this in mind if you choose to communicate with Aaron using these methods. If you have any questions about confidentiality, please discuss them with him at any time.

I have read and understood the above information regarding confidentiality. I agree to disclose personal information with these exceptions in mind.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Guardian of Minor Date

_____ _____
Signature of Therapist Date

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AUTHORIZATION TO TREAT MINOR CHILDREN

I/we , _____, give my/our permission to
(Name of parent(s) or guardian(s))

Aaron Airozo, MFT (MFC #46599) to see
(Counselor)

_____ for treatment or counseling,
(Name of minor child)

with or without me being present in the same session. I/we understand that we are the holder of confidential privilege – the right to withhold disclosure of private counseling information about my child.

However, in the interest of developing a trust relationship between the counselor and my/our child(ren), I/we give the counselor permission to reveal or withhold information that in his clinical judgment is necessary to best help and protect my/our child(ren).

The only exception to this discretion would be in the case of _____
_____
_____
_____

Parent / Guardian Signature _____ Date_____

Parent / Guardian Signature _____ Date_____

Therapist / Witness Signature _____ Date_____