MARC D. RICHTER, LICSW, LADC

Client Information Form

Client Name _____

Street Address _____

City/State/Zip _____,VT _____

Social Security #____-____-____ Date of Birth___/___/___

Contact Info:

Home: _____

Work: _____

Cell: _____

Email: _____

Name of Guardian/Parent (if applicable): _____ Phone: _____

Emergency Contact: _____ Phone: _____

PCP/Pediatrician: _____ Phone: _____

Who referred you to my office? ☐Doctor? ☐Another therapist? ☐Other? Their name? _____

PRIMARY Insurance Company*:* _____ Phone: _____

Certificate #: _____ Group #: _____

_____ ____-____-____ ___/___/___

Policy Holder Name (if different from client) Social Security # Date of Birth

_____ _____ _____

Street Address City / State Zip code

Place of employment: _____ Amount of Copay: _____

Relationship to client: ☐ Self ☐Spouse ☐Child ☐Other _____

SECONDARY Insurance Company Information: _____

Responsible party for payment of services not covered by insurance: The undersigned agrees to be responsible for the cost of treatment services provided not covered by insurance. The undersigned further agrees that in the event of non-payment for services such that collections action is required to enforce the payment terms of this agreement, Marc D. Richter. PLLC shall be entitled to collect from the client any balances due plus reasonable attorneys' fees and other expenses incurred by Marc D. Richter, PLLC for such collection action. I acknowledge in the event that collection action is needed that the collection agency, RCMC of Vergennes, VT will be in receipt of my contact information and will be in communication regarding such collection action.

Please Sign here →

Name: _____

_____

Street Address (if different from client) City / State Zip code

_____

Signature of responsible party

For Therapist Use Only

First DOS: ___/___/201___

DX Code: F

MARC D. RICHTER, LICSW, LADC

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Welcome to My Practice

The following information describes my business practices and professional services. Please read it carefully. If you have questions, it is important that you clarify them with me prior to signing.

Appointments & Professional Fees: Individual, Couples and Family sessions are billed at an hourly rate of $145; Group sessions - $60 per session. All individual sessions are 50-53 minutes. Time is set aside by me specifically for your session. Except in the case of a severe weather emergency, medical illness or unforeseen crisis, please provide at least 24 hours advance notice should you need to cancel or change an appointment. Please call me (*no text or email*). Without this notice, you will incur a "no show" fee and will be charged for a broken appointment at my customary rate of $145. Insurance companies will only pay for services rendered and cannot be billed, nor will they reimburse for no-shows or late cancelations. Providing advance notice of a cancellation allows me to schedule another client who may be on a waiting list for an appointment. When you have a scheduled session and have not canceled, and if I have not heard from you by phone if you'll be late, I will wait in my office for 20 minutes after which time you will be billed for a broken appointment. **Please indicate your understanding by initialing here:** _____

Miscellaneous Service Charges: Please be advised that therapist time spent on client-related professional services outside of the therapy session is not billable to insurance. These services include but are not limited to: report writing, written assessments, court diversion/DOC written evaluations, phone consultations with clients or others (exceeding 15 minutes); face to face consultations with others such as attending school IEP meetings (exceeding 15 minutes), etc. Utilizing the above rates as a guide, this time is billed directly to the client and is pro-rated in quarter hour units (with the minimum of 15 minutes) charged at the quarter hour rate.

Confidentiality: Privacy and confidentiality are important to the relationship between client and therapist. There is legal and ethical protection for the information that you share with your therapist and it cannot be released without your express written consent. This also covers my written record. There are exceptions to confidentiality that include but are not limited to: when there is reason to believe that you intend to harm yourself or another person; when there is suspicion, observation or report of a child or vulnerable adult that has been or might be abused or neglected; or if information has been requested by a judge's court order. If you have any questions about confidentiality, now or at any time, prior to or even following treatment, please by all means raise those concerns with me immediately. Your trust and your confidentiality is of the utmost importance to me.

Confidentiality & Insurance Companies, etc: If you are using benefits under a managed care plan including Medicaid and Medicare, I may be required to provide information related to your case to the managed care reviewer and your primary physician, in writing and verbally. I will follow these procedures unless otherwise notified by you in writing. I acknowledge the use of a billing service (Claims Connection) located in Plattsburgh, NY to bill for those charges to be issued to my insurance company. When technology permits, these claims may be submitted electronically. Signing below is an acknowledgement that Claims Connection will be given a copy of your "Client Information Form" page (included in this intake packet) in order to process these claims and/or to maintain a record of your account. Signing below also acknowledges that you are authorizing Claims Connection to contact your insurance company to check on claims submitted for payment for services. You are authorizing your insurance benefits to be paid directly to Marc Richter, PLLC and acknowledge that you are financially responsible for any unpaid balance. You are also authorizing the release of information needed to verify the medical necessity for your evaluation and treatment to your insurance. I acknowledge the use of a collections service, Revenue Cycle Management Corp. (RCMC) located in Vergennes, VT to collect any longstanding (over 4 months) unpaid client balances. Should collections become necessary, signing below is an acknowledgement that RCMC will be given a copy of your "Client Information Form" page (included in this intake packet) in order to facilitate any needed collections. You agree to never subpoena Marc Richter to court and understand he will not participate if asked. You also understand that if you do subpoena him to court that he will immediately terminate the relationship.

If your insurance coverage, address or phone number changes, YOU are responsible for immediately notifying me of the change.

Person responsible for charges not covered by insurance: _____

Mental Health Emergencies: If you are having a mental health emergency, please call 911, go to your nearest Hospital Emergency Department or call crisis services at 1-802-488-7777.

Consent for Treatment: ***My signature below indicates that I am giving voluntary consent for Marc D. Richter, LICSW, LADC to provide clinical evaluation/ treatment to myself (us) or my minor child (or children) listed below. I also consent to release information for the purpose of treatment, payment and healthcare operations. I understand that there are both benefits and risks involved with engaging in psychotherapy and that there are no guarantees about the outcome. My signature also indicates I have had an opportunity to ask and have my questions answered about the above information and I have read, understand and agree to abide by all of the above outlined terms.***

Signature _____ _____ _____
Client Signature | Print Name of Client | Date

Signature _____ _____ _____
Signature of Parent or Legal Guardian | Print Name of Parent or Legal Guardian | Date

Witness Signature _____ _____ _____
Witness Signature (can be therapist) | Printed Name | Date

Would you like a copy of this page for your records? Yes ☐ No ☐

INTAKE ASSESSMENT

Client Information

Client Name: _____

What are your reasons for seeking therapy at this time? _____

_____

_____

_____

Demographics and Current Living Situation

Please list current family including partner and any children

Full-Name	Age	Gender	Relationship	Comments

Description of Current Living Situation: _____

Please list family of origin (if same as above please check here ☐

Full-Name	Age	Gender	Relationship	Comments
For Example: Sarah Smith	27	Female	Half-sister	I saw her every other weekend. We were and still are very close.
For Example: Greta Smith	93	Female	Paternal grandmother	My grandmother and grandfather were my primary caretakers.
For Example: John Smith	53	Male	Father	My father died age 53. Bladder Cancer. We were very close.
For Example:	74	Female	Mother	Currently living in senior living community in nearby town.
For Example: Jim Rose	14	Male	Brother – 2 years older	Jim died age 14 in a freak skiing accident. We were best friends.

Race/Ethnicity (Optional): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic/Latino ☐ White/Caucasian ☐ Non Hispanic ☐ Other _____

Native Language: _____

Gender Identity: _____ Sexual Orientation: _____

Relationship Status: ☐ Single ☐ Partnered ☐ Married ☐ Civil Union ☐ Divorced ☐ Separated ☐ Widowed Comments: _____

Highest level of education: ☐ grade school ☐ some high school ☐ high school/GED ☐ technical school ☐ some college ☐ college degree ☐ some post grad. ☐ graduate degree

Currently a Student?: ☐ yes ☐ no Comments: _____

_____

Military Veteran?: ☐ yes ☐ no Comments: _____

_____

Employment status: ☐ full time ☐ part time ☐ seasonal ☐ looking for work ☐ disabled ☐ retired

Employer: _____

Client Information (continued) **Client Name:** _____

Description of career, employment, work history: _____

Financial concerns: ☐ Yes ☐ No If Yes, Describe: _____

Current legal issues: ☐ Yes ☐ No If Yes, Describe: _____

History of legal issues: ☐ Yes ☐ No If Yes, Describe _____

Client's developmental history:

Childhood milestones (talking, walking, etc., school/learning difficulties, social development, age at first menses)

Mental Health Treatment History:

Psychologist/Therapist/Counselor: _____ Dates _____

_____ Dates _____

_____ Dates _____

Psychiatric provider (MD, NP, PA): _____ Dates _____

_____ Dates _____

_____ Dates _____

Hospitalizations, Intensive Day Treatment, drug/alcohol rehab: _____ Dates _____

_____ Dates _____

_____ Dates _____

Family history of mental health issues, drug dependency and/or alcohol problems (Include parents, grandparents, siblings, aunts, uncles and cousins) Yes☐ No☐ If yes, explain _____

Any family history of psychiatric hospitalizations? Yes☐ No☐ If yes, explain _____

Client Information (continued) **Client Name:** _____

Substance Abuse History

Substances	Date of First Use?	Date of Last Use?	Time Period of Heaviest Use Including Quantities	Any Current Use of this Substance?	Frequency and Amounts	Route of Administration (i.e.: smoke, ingest, IV, snort)
Caffeine						
Tobacco/Nicotine						
Marijuana/Cannabis/Dabs/Hash						
Alcohol						
Heroin						
Other Opioids: Codeine, Morphine, Fentanyl, Bup, Methadone, hydrocodone (Vicodin), hydromorphone (Dilaudid), oxycodone/Oxycontin (Percoset), oxymorphone (Opana).						
Cocaine/Crack						
Other Stimulants: Amphetamines (Adderall), Methamphetamines, MDMA (ecstasy/Molly), Khat						
Hallucinogens (LSD, PCP, mushrooms)						
Sleeping Pills (Lunesta, Ambien, Sonata) Benzodiazepines (Klonopin, Ativan, Xanax, Valium) Barbiturates (Seconal, Amytal)						
Inhalants						
Over the Counter (Robitussin, NyQuil, Sudafed, Advil)						
Other (Synthetic cannabinoids, Ketamine, bath salts, steroids, salvia, etc.)						

Have you ever felt that you should cut down on your drinking or use of drugs? Yes☐ NO☐

Have people ever annoyed you by criticizing your drinking or use of drugs? Yes☐ NO☐

Have you ever felt bad or guilty about your drinking or use of drugs? Yes☐ NO☐

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get over a hang-over? (an eye-opener) Yes☐ NO☐

Active with any 12 step groups? Describe? _____

_____

Please describe anything more regarding alcohol/drug use that you believe would be important (periods of heavy use, withdrawal symptoms, hangovers, affected relationships, etc.) _____

_____

_____

_____

Client Information (continued) **Client Name:** _____

Physical Health

Current Medical Condition(s): _____

_____

Current nutritional/exercise habits/physical issues: _____

_____

Allergies (drugs, foods, environment): _____

_____

Eating Disorder History: _____

_____

Primary Care Provider: _____

Address: _____ Tel # _____

When was your last Physical & Where? _____

List all Medications you are **currently** taking (including psychiatric, medical and over the counter):

Drug	Dose	Start Date	Condition Treated

Who is currently prescribing your medications? _____

Address: _____ Tel # _____

List all **previous** psychiatric medications and how you responded to them:

Drug	Condition Treated and Response

Have you or anyone in your family (parents, siblings, children, grandparents, aunts, uncles, cousins) been treated for any significant medical issues? If so, who, what and when? _____

_____

_____

Social and Spiritual Assets

What are your strengths? _____

_____

Recreational activities/Hobbies? _____

Social groups or activities? _____

Other interests? _____

Religious affiliation/practice/identification? _____

Spiritual beliefs/higher power concepts? _____

❖❖❖ **If client is a child, please complete child intake addendum.** ❖❖❖

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PRIMARY CARE PHYSICIAN CONSENT FORM

Communication with your primary care provider (PCP) can be important to make sure all care is complete, comprehensive and well coordinated. This form allows for that exchange of information. I do not release information without your signed authorization.

CLIENT & PCP INFORMATION

Name _____ SS # or ID# _____ D.O.B. __/__/__ ID # _____

Insurance _____ First Date of Service __/__/201__

Referred By: Self_____ Other:_____

Name of Physician _____ Facility / Practice Address _____

Phone number (___) ___-____ Fax number (___) ___-____

CLIENT Consent to Communicate with Primary Care Physician

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CFR Part 2, 45 C.F.R. parts 160, 162 & 164 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and prohibits any further disclosure by the designated recipient of this information unless expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. I have not been coerced to sign this authorization. I understand that I might be denied services if I refuse to consent to a disclosure for the purposes of treatment, payment, or health care operations, if permitted by state law. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits nor will I be denied services if I refuse to consent to a disclosure for other purposes. I understand that prepayment for copies of my records as well as payment for services rendered may be required for copies of my record when released to anyone other than a medical provider, facility or institution. I understand that by signing this form I am confirming my authorization for use and/or disclosure of the protected health information described above with the people and/or organizations named above. I have read this release and understand its contents. I have also been provided a copy of this form. I also understand that I may revoke this consent at any time by notifying the provider in writing (except to the extent that action has already been taken in reliance on it). This release will automatically expire twenty-four (24) months from the date signed below or upon the date specified here _____.

I, _____ hereby authorize **Marc D. Richter, LICSW, LADC** to:
(PRINT name of patient/client)

CLIENT PLEASE CHECK ONE:

☐ **NOT** release any applicable information to my physician.

☐ release applicable information to my physician.

Print Name of Client _____ Signature of Client _____ Date signed __/__/__

I, _____ hereby authorize **Marc D. Richter, LICSW, LADC** to:
(PRINT name of parent/legal guardian)

PARENT/LEGAL GUARDIAN PLEASE CHECK ONE:

☐ **NOT** release applicable information to the child's physician.

☐ release applicable information to the child's physician.

Print Name of Parent or Legal Guardian _____ Signature of Parent or Legal Guardian _____ Date signed __/__/__

TO BE FILLED OUT BY PROVIDER

Reason for Report: *(to be completed by Marc)*

Initial Report ☐ Treatment Update ☐ Discharge ☐ Other ☐_____

Treatment Information: *(to be completed by Marc)* Diagnosis: _____

Presenting Problem:_____

Type / Dosage of Psychotropic Medication:_____ MD_____

Type / Frequency of treatment: Weekly ☐ Bi Weekly ☐ Monthly ☐ Other ☐: _____

Mental Health Care Provider Information:

Marc D. Richter, LICSW, LADC _____ __/__/__
Signature Date