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: ______________________

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____

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: ___/___/202__

DX Code: F______________

2 Church Street, Suite 3G
Burlington, VT 05401
866-429-2074 VM
802-540-8199 fax

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 $175; IDRP/DUI Evaluations are $200 per hour (SELF-PAY ONLY). 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 $175. 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/Vaping (i.e. Juul)						
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

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

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.) ____________________

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? ____

Trauma

Have you experienced any trauma that you believe would be important for me to know right up front?

(*If you are uncomfortable writing it down here that is fine. We can talk about it in person if you like.*)

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

____

MARC D. RICHTER, LICSW, LADC

PRIMARY CARE PHYSICIAN CONSENT FORM

2 Church Street
Suite 3G
Burlington, VT 05401
866-429-2074 VM
802-540-8199 fax
www.marcrichter.org

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.

______________ ______________ ___/___/___

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