BEA ARMSTRONG, MFT
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INITIAL INTERVIEW FORM

Date: ____________________________

CLIENT INFORMATION:

Name: ____

Work Phone: ____________ Home Phone: ____________ Cell Phone: ____________

Address: ________________________ City: ________________________

State: ________________________ Zip: ________________________

May I have permission to mail to this address? Yes: __________ No: __________

Gender: Male: ________ Female: ________ Date of Birth: ____________________

Others living at home: ____

____

Employer: ________________________ Occupation: ________________________

How long have you worked there? __________ How long in this occupation? __________

Education: (List highest level of education attained) ______________________

Primary Physician: ________________________ Phone: ______________

Address: ____

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 a brief description of treatment: ____

____

How were you referred to me? ____

Who may I thank for referring you? ____

Nearest relative other than spouse: ____________________ Phone: ______________

FINANCIALLY RESPONSIBLE PERSON'S INFORMATION:

Name: ________________________ Relationship to Client: ______________

Phone (if different from above): ____

Address (if different from above): ____

Insurance Carrier (if applicable): ____

Group Number: ____________________ Member Number: ____________________

INFORMED CONSENT

CONFIDENTIALITY STATEMENT

All information shared in this treatment is confidential except in circumstances governed by law. If you would like me to confer with anyone, you will need to sign a "Release of Information" form that I will provide. This permission can be revoked by you at any time. Please see my Privacy Policy on my website for details on how your information is protected.

FINANCIAL AGREEMENT

Your fee per visit is $_____________ and is payable at the time of treatment. I accept check, major credit cards, and PayPal. If you would like me to bill your credit card at the beginning of each month for scheduled sessions in that month, please fill out my "Pre-Authorized Healthcare Form." If you choose to pay by check and your bank does not honor your check, any fees that I incur for a returned check will be passed along to you. If this happens more than once, I will require payment by credit card or PayPal. No more than two sessions can be unpaid at a time.

FINANCIAL POLICY

If you have insurance that provides coverage for this treatment, I would be happy to assist you in completing your claim forms by filling in the portion required of the provider. You are responsible for sending that form to the insurance company and tracking your reimbursement. I do not accept assignment of benefits, nor do I participate in managed care insurance plans (HMO's and PPO's). I will discuss your treatment with your insurance company in writing, if you sign a release for me to do so. You are responsible for the full fee for this treatment, regardless of your insurance company's reimbursement policies. Your regular fee will be charged for any additional professional services rendered by me at your request, such as phone contacts over 15 minutes, preparation of special forms, insurance reports, court time, consults with other professionals, etc.

YOUR PAYMENT IS TO BE PAID IN FULL AT THE TIME OF EACH SESSION. FEES ARE SUBJECT TO CHANGE, BUT NOT MORE FREQUENTLY THAN ONCE A YEAR, UNLESS WE HAVE MADE A DIFFERENT ARRANGEMENT.

NO-SHOW AND CANCELLATION POLICY

Your session time has been reserved for you. 24-hours notice is required for cancellation or you will be charged your full session fee. If you miss three (3) consecutive sessions, I cannot guarantee to hold your date and time slot. This does not apply to prescheduled vacations.

EMERGENCIES

Should I not be available at 408-486-9202, please call 911 or 855-278-4204.

GDPR COMPLIANCE

The EU's General Data Protection Regulations (GDPR) took effect May 25, 2018, and I am fully behind the spirit of these regulations.

Any information collected via this Client Intake Form and/or any additional information you provide by any means is used solely to provide you the best treatment possible.

Information Requests: At any time, you may request the information that I have on file for you to be sent to you for review, and I will be happy to provide you a synopsis of the work we've done together.

Right to Be Forgotten: If you are an EU data subject covered by the GDPR, you have a "right to be forgotten" under EU law. However, as a resident of the State of California, and a patient in my psychotherapy practice, the services I render are governed by the laws of the State of California. Those laws require me to retain patient records for 7 years for adults. In this case, the laws of the State of California govern our work together and, as such, I cannot honor any requests made by you to have your information deleted and forgotten before said timeframe has passed.

In all cases of treatment, unless specifically ordered otherwise by the Court, or state law, each client, regardless of age, is entitled to confidentiality regarding the information shared with the therapist.

STATEMENT OF UNDERSTANDING

I have read and understand this information sheet and informed consent.

______________________________ ____________________

Client Date

______________________________ ____________________

Parent or Guardian if client is a minor Date