FOUNDRY
CLINICAL GROUP

CONFIDENTIAL CLIENT INTAKE

GENERAL INFORMATION

Today's Date:_____/_____/_____

Client #1:

Name: _____ SS #: _____-____-_____ Date of Birth: _____/_____/_____
Address: _____
City: _____ State: _____ Zip: _____
Phone/cell: _____ Okay to text? ❑ Yes ❑ No
Email: _____
Emergency contact: _____ Contact's phone: _____
Emergency contact's relationship to you: _____

Client #2:

Name: _____ SS #: _____-____-_____ Date of Birth: _____/_____/_____
Address: *(if different from above)* _____
City: _____ State: _____ Zip: _____
Phone (cell): _____ (home): _____
Phone/cell: _____ Okay to text? ❑ Yes ❑ No
Email: _____
Emergency contact: _____ Contact's phone: _____
Emergency contact's relationship to you: _____

FAMILY & RELATIONSHIP INFORMATION

Present Relationship Status (check all that apply): ❑ Married (yrs:___ mos:___) ❑ New relationship (6 mos or less)
❑ Partnered (yrs:___mos:___) ❑ Other:_____

If married, partnered or in a primary relationship, do you live with your significant other? ❑ Yes ❑ No

Others living in your household:

Name	Relationship	Age

EDUCATION & VOCATIONAL INFORMATION

Client #1:

Current Occupation:_____ Employer: _____
Highest grade completed and/or degree(s) obtained: _____ Annual HH income: _____

Client #2:

Current Occupation:_____ Employer: _____
Highest grade completed and/or degree(s) obtained: _____ Annual HH income: _____

MEDICAL INFORMATION

Client #1:

Primary Therapist: _____ Phone: _____
Psychiatrist: _____ Phone: _____
Medical Doctor: _____ Phone: _____
Other Specialist: _____ Phone: _____
Are you in recovery for addiction or compulsion? ❑ Yes ❑ No What program(s)? _____
Are you currently sober? ❑ Yes ❑ No
List medications you are currently taking (including non-prescription or herbal remedies): _____
_____
Describe any current physical and/or psychiatric concerns that you have: _____
_____

Client #2:

Primary Therapist: _____ Phone: _____
Psychiatrist: _____ Phone: _____
Medical Doctor: _____ Phone: _____
Other Specialist: _____ Phone: _____
Are you in recovery for addiction or compulsion? ❑ Yes ❑ No What program(s)? _____
Are you currently sober? ❑ Yes ❑ No
List medications you are currently taking (including non-prescription or herbal remedies): _____
_____
Describe any current physical and/or psychiatric concerns that you have: _____
_____

CONSENT FOR TREATMENT AND OFFICE POLICY

This consent is to certify that you give permission to the clinical staff at Foundry Clinical Group to provide psychotherapy treatment. This includes, but is not limited to, the following clinicians: Aaron Alan, MFT, CSAT; Jenner Bishop, MFT, CSAT; Thuy Bui, LCSW, CSAT; and Rory Reid, PhD, LCSW.

FOUNDRY ORGANIZATION

The clinical staff at Foundry work as a treatment team and consult together regarding cases and you authorize the exchange of information between clinicians in order to provide the most effective treatment.

CONFIDENTIALITY

Under most circumstances, all communication between you and your therapist is confidential, unless permission is given by you to convey information to a third party. There are certain legal exceptions to this:

(1) When there is a reasonable suspicion of child abuse, dependent-adult or elder abuse.
(2) When a client threatens violence to an identifiable victim;
(3) When a client presents a danger of violence to others;
(4) When a client is likely to harm him/herself unless protective measures are taken.

Disclosure may also be required in certain legal proceedings. *If you have concerns about the content of our sessions and any legal proceedings in which you are involved or expect to be involved (e.g., divorce, child custody cases), please let your therapist know.*

Before any disclosure is made, every reasonable effort will be made to appropriately resolve these issues or to notify clients.

ALL clients shall maintain the confidentiality of other clients and are not permitted to disclose any personal and/or identifying information about any other client. This boundary is critical for client safety.

CONTACTING THERAPISTS

Clients may email, text or leave a voicemail for therapists at any time. Please be aware that therapists may not be able to immediately retrieve messages. **If you have a life-threatening emergency, dial 911.**

APPOINTMENTS

Sessions are 45-50 minutes in length and begin at the scheduled appointment time. If you arrive late, your session will be shorter; if your therapist begins late, your session will be extended to make up the time. If you must cancel a session, please let your therapist know at least 24 hours in advance. **You will be responsible for the full fee of any session canceled with less than 24 hours notice.** Appointments must be canceled via text or voicemail, as email is not checked regularly. For psychotherapy to be most effective, clients must not be under the influence of intoxicating substances. If your therapist feels it necessary, you may be asked to reschedule your appointment for another time; this will be considered a late cancellation.

FEES, BILLING & PAYMENTS

All services are billed at the standard rate. Sliding-scale fees may be established based on ability to pay and therapist availability. Clients pay for services at the beginning of each session, unless other arrangements have been made. Please notify your therapist if any problems arise that affect your ability to make timely payments.

If document preparation is required (e.g. legal proceedings, insurance appeals), clinicians reserve the right to bill for services, plus fees for materials (copies, outside services, etc).

In order to prevent any misunderstandings about payment for services, please be advised of the following:

(1) All services provided are billed directly to the client unless other arrangements have been made;
(2) Clients are personally responsible for payment at time of service via credit card, cash, check or money order;
(3) Statements can be provided for you to submit for insurance reimbursement;
(4) You are responsible for submitting all claims to your insurance provider;
(5) If payment is not received when services are rendered, payment may be applied to the credit/debit card on file if no other payment arrangements have been made.
(6) If your credit/debit card is invalid and you have made no other payment arrangements, your past due balance may be sent to an agency for collection.

If you commit to group therapy, the weekly fee for group sessions is due even if you do not attend.

You are individually responsible for all incurred charges, even if you direct us to bill another person. If you direct charges to be billed to another person, you represent that you are authorized to give you such direction. If you have directed charges to be billed to another person who fails to make payment, you will promptly pay on demand.

REGISTERED MFT INTERNS

If your therapist is an intern, s/he is an prelicensed counselor who will be consulting regularly regarding your case with their supervisor, the licensed Marriage and Family Therapist under whose license they are practicing.

MINOR CLIENTS: For clients under age 18, a signature of parent/guardian indicates permission to treat.

I have read, understand and agree to the information, guidelines and office policies stated above:

Client #1:
Signature:_____ Date:_____

Printed Name: _____

Client #2:
Signature:_____ Date:_____

Printed Name: _____

Please fill out the payment information (next page)

PAYMENT INFORMATION

Please provide a credit card authorization regardless of your payment method

Credit Card Authorization: I authorize the maintenance of valid credit card information to guarantee my chosen payment option. Charges will appear on your credit card statement as "Aaron Alan, Inc."

Cardholder Name:_____

Billing Address:_____

City: _____Zip: _____

Circle Card Type: Visa MC Discover AmEx

Credit Card #_____Expiration date: ____/____/_____

3 digit CVV code: _____

Cardholder/Client Signature: _____Date:_____/____/_____

Payment is due when services are rendered. If payment is not made when services are rendered, or if you have an outstanding balance, then your credit card on file will be charged in the amount of the outstanding balance.

Monthly statements will be provided upon request. Clients are responsible for submitting all claims to their insurance provider.

Payment Guarantee: I understand that I am individually responsible for all incurred charges, even if I direct you to bill another person. If I direct charges to be billed to another person, I represent that I am authorized to give you such direction. If I have directed you to bill charges to another person who fails to make payment promptly when due, I will promptly pay on demand. If I commit to group therapy, I understand that the weekly fee for group sessions is due even if I do not attend.

I understand there is a 24-hour cancellation policy for sessions and that I will be charged without providing 24 hours advance notice to cancel a session.

I have read, understand and agree to the information, authorization and guarantee stated above.

Client #1:

Signature:_____ Date:_____

Printed Name: _____

Client #2:

Signature:_____ Date:_____

Printed Name: _____