Yara A. Perez, LCPC, CST
HOLISTIC PSYCHOTHERAPY

PATIENT INTAKE FORM

PATIENT NAME: _____ M □ F □

Street Address: _____

City/State/Zip: _____ Email Address: _____

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

Date of birth (mm/dd/yyyy):_____ Social Security #: _____

SPOUSE/PARTNER NAME: _____ M □ F □

Spouse/Partner Email: _____ Phone: _____

RESPONSIBLE PARTY Name *(if other than patient)*: _____

Date of birth (mm/dd/yyyy):_____ Social Security #: _____

Relation (circle one): SPOUSE PARENT CHILD OTHER: _____

PRIMARY Insurance (circle one): ANTHEM/BCBS AETNA MAINE COMMUNITY HEALTH OPTIONS (BHCP)
HARVARD PILGRIM (BH) UNITED HEALTHCARE MEDICARE

Id/Cert #:_____ Group: _____ Copay: $_____

SECONDARY Insurance (circle one): ANTHEM/BCBS AETNA MAINE COMMUNITY HEALTH OPTIONS (BHCP)
HARVARD PILGRIM (BH) UNITED HEALTHCARE MEDICARE

Id/Cert #:_____ Group: _____ Copay: $_____

***** ATTACH PHOTOCOPIES OF INSURANCE CARDS FOR ANY OTHER PRIMARY AND/OR SECONDARY CARRIERS *****

INSURANCE POLICY SUBSCRIBER Name *(if other than patient)*: _____

Date of birth (mm/dd/yyyy): _____ Employer #: _____

Relation (circle one): SPOUSE PARENT CHILD OTHER: _____ M □ F □

INITIAL AUTHORIZATION Start Date: _____ End Date: _____ #Visits: ____ Auth #: _____

***** PATIENTS ARE RESPONSIBLE FOR UNDERSTANDING THEIR OWN INSURANCE POLICIES *****

- You are financially responsible for any services your insurance company does not pay.
- Services denied as not covered by your insurance company are your responsibility.
- You need to direct any coverage, benefit, or participation questions directly to your insurance company.
- We cannot change how your insurance company processes or pays your claims. Your insurance company decides what you are responsible for paying for your services at our office.
- Patient balances are due within 30 days of first statement. If payment in full cannot be made, please contact our billing service, Alternative Billing Solutions (207) 838-0064, to discuss payment options. It is important to us that we work with you to ensure continuity of care.
- If the patient account balance is still outstanding after 90 days, the account will be automatically submitted to our collection agency. The patient will be responsible for any reasonable collection costs, including attorney fees if incurred. Accounts that are placed with our collection agency will be charged $125 in addition to the outstanding balance due.

_____ _____

Patient/Responsible Party Signature Date

(207) 749-9116 | fax **(207) 631-2339** | yara@yaraperez.com | www.yaraperez.com | **200 High Street** | **Portland, Maine 04101**

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DISCLOSURE STATEMENT

Degree:
Master of Arts in Counseling Psychology from John F. Kennedy University, CA (conferred 03/2003)

Licensure: LCPC (Licensed Clinical Professional Counselor) Issue date: 09/1/16 Expiration date: 10/31/18
Being fully licensed means that I have met all requirements for LCPC licensure as defined in section 13858.

Certification: CST (AASECT Certified Sex Therapist) Issue date: 4/10/15 Expiration date: 4/10/18
The American Association of Sexuality Educators, Counselors, and Therapists recognizes having satisfied the requirements for sex therapist.

Areas of Competence:
I am trained to provide mental health counseling to children, adolescents, and adults, as individuals, couples, families, and groups. My experience includes working with clients who present with a variety of mental health symptoms and/or behavioral issues. I have been working in the social services field since 2002, and am experienced in providing both short and longer-term treatment. Currently, I work with adolescents, and adults, individually, as couples and families. My clinical work normally takes place at my private practice office, although I am able to attend meetings in the community, if clinically indicated.

Course of Treatment:
During the initial interview, I meet with the client to complete an assessment of the current problem. Required paperwork will be explained, discussed, and then signed by the client. A subsequent session will be scheduled, if the client and I determine my services will be a good match to the client's needs. (I am able to provide referral information, if not.) In upcoming sessions, a plan of treatment will be determined to outline goal areas. Goals will be based on assessment and diagnosis supported by the DSM. We will revisit the plan periodically to assess progress and identify remaining and/or new needs. Some of the techniques utilized in treatment include, but are not limited to:

- Individual therapy, both brief treatment and depth psychotherapy
- Family therapy
- Couples therapy
- Parent support/education
- Crisis intervention
- Animal assistance therapy
- Sex Therapy

Confidentiality:
A client's confidentiality is of the utmost importance. The main situation in which treatment information is shared is in my individual or group supervision, and with the identified treatment team, as necessary. If it is deemed beneficial for the client's progress for me to correspond with an outside source, written permission will be obtained outlining the specific reasons and constraints regarding the information to be shared. I utilize an authorization form for obtaining and disclosing information. Treatment information is confidential, except as determined in the *Rights of Recipients of Mental Health*, which is available to the client (parent(s) or guardian) upon request. Noted exceptions are explained in the initial interview. A document is signed by the client (parent(s) or guardian) indicating s/he has been informed of these exceptions.

The exceptions from confidentiality are listed below:

1. Threat of serious harm to self and others.

2. Reasonable suspicion of child abuse (physical, sexual, emotional, or neglect) or abuse of an elder or incapacitated person.
3. Court order.
4. Voluntary release signed by client, parent or guardian.
5. In defense against legal action or formal complaint which client makes before a court or regulatory board.

Consultation and Supervision:
I participate in an ongoing clinical consultation group and individual consultation as well as individual and group supervision. Supervision may include video or tap recorded session for the purpose of professional evaluation of my work and skill. When participating in consultation with other clinicians, client contact information and other identifying factors will be kept confidential.

Payment and Scheduling:
I am able to accept commercial insurance and fee-for-service payment in the form of cash or checks. Receipts can be provided upon payment for services rendered and a record of payment will be kept. Copy of this record is available upon request. There is a $20 fee for checks returned for insufficient funds. Dependent on ability to pay, fees may be negotiated, discounted, or delayed.

My office hours are Monday through Friday, with morning and evening appointments available. Other hours may be scheduled by appointment. I request that clients provide at least 24 hours notice if canceling a scheduled appointment*. If a client provides less than 24 business hours notice, and the appointment is not rescheduled for later that same week, he or she may be required to pay for the session in full.*

I have both a direct phone number (with voicemail) and email for my private practice where clients can leave me confidential messages regarding scheduling or other work-related matters. I check my messages daily and will return calls and email messages as soon as possible. *Email is for non-urgent correspondence only.*

If a client calls about an emergency situation, and I cannot be reached, the client is encouraged to call a 24-hour emergency service such as Crisis Response at 1-888-568-1112 or 774-HELP for immediate assistance. Both of these contact numbers are made available through my outgoing voicemail message. Both numbers are also provided to clients during the opening paperwork process.

Accountability:
If a client feels his or her needs are not being met by the services provided, the client is encouraged to contact me immediately to discuss their concerns. Clients also have the right to contact an advocate from the Office of Advocacy or Maine Advocacy services. The practice of counseling in Maine is regulated by the Department of Professional and Financial Regulation, and complaints may be registered by contacting:

Board of Counseling Professionals Licensure
35 State House Station
Augusta, ME 04333
(207) 624-8674

Patient/Client Signature _____ Date _____

Signature _____ Date _____

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Date(s) of Assessment: _____

INITIAL ASSESSMENT

REASON FOR SEEKING SERVICE

Please note presenting problem. Include perception of needs, and family's perception of needs, as appropriate:

_____

_____

_____

_____

_____

BARRIERS TO OBTAINING SERVICES

Please note any physical or environmental barriers that may impede your ability to engage in services:

☐ Physical health ☐ Transportation ☐ Financial limitations ☐ Lack of family support

☐ Others:

_____

_____

_____

_____

LIVING SITUATION

Please describe your living situation. For example, in what type of setting do you live, with whom?

☐ On Own ☐ With Parents ☐ With Spouse/Partner ☐ At Friend's home
☐ Foster Care ☐ Homeless ☐ Other:

_____

_____

_____

_____

EDUCATION INFORMATION

Please provide information regarding your history of education:

☐ Received special education services ☐ Dropped out of school ☐ No school problems

Highest diploma or degree earned:

☐ High School ☐ GED ☐ Associate's Degree ☐ Bachelor's Degree ☐ Graduate Degree

Other information regarding education you'd like to share:

_____

_____

_____

_____

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EMPLOYMENT INFORMATION

Please provide information regarding work history and status:

Currently employed? ☐ Yes ☐ No Currently disabled? ☐ Yes ☐ No

Other information regarding employment history:

SOCIAL & LEISURE INFORMATION

Please identify social and leisure activities:

☐ None identified ☐ Religious/spiritual ☐ Ethnic/cultural ☐ Community ☐ Recreational

Other information regarding employment history:

LEGAL INFORMATION

Please provide information about your current or past legal involvement:

☐ None identified ☐ Charges pending ☐ Conditional release ☐ Probation
☐ Other:

HEALTH INFORMATION

Current & historical:

Current medication (both prescription and over-the-counter):

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Allergies and adverse reactions (food and/or drug): _____

_____

_____

MENTAL HEALTH TREATMENT HISTORY

Please address mental health treatment history for you,as well as significant family mental health treatment or history. Prior mental health treatment? ☐ Yes ☐ No

If yes, please provide information about prior treatment providers: _____

_____

_____

Past suicidal ideation? ☐ Yes ☐ No
Past suicide attempts? ☐ Yes ☐ No
Past inpatient admissions? ☐ Yes ☐ No
Family mental health history? ☐ Yes ☐ No

If yes to any of the above, please provide additional information: _____

_____

_____

TRAUMA HISTORY

Please provide information regarding history of trauma, including physical and/or sexual abuse:

☐ No report of abuse/violence ☐ Victim of bullying ☐ Physical abuse ☐ Sexual abuse
☐ Physical or emotional neglect ☐ Witness/victim of domestic violence ☐ Community violence
☐ Other: _____

_____

_____

CLIENT AND/OR FAMILY LEGAL HISTORY

_____

_____

_____

OTHER PERTINENT FAMILY & SOCIAL HISTORY

Please note any pertinent family relationships or issues, which might be impacting you, significant family history, or other relevant social history:

☐ Parents divorced or unmarried ☐ Significant family losses ☐ Chaotic early family life
☐ Family member incarcerated ☐ Other: _____

_____

_____

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RELEVANT DEVELOPMENTAL HISTORY

Please provide information about pertinent developmental history such as complications at birth, developmental milestones, or other relevant factors:

☐ Information not available ☐ Met developmental milestones on schedule
☐ Cognitive function within normal limits ☐ Complications in mother's pregnancy

☐ Other: _____

_____

_____

_____

SUBSTANCE USE/ABUSE

Please complete for each substance used presently or in the past. Include controlled substances, alcohol, over-the-counter medications, and nicotine products:

☐ No substance abuse issues (skip to next section)

Substance	Amount	Frequency/patterns	Age began	Last used

CONSEQUENCES OF SUBSTANCE USE

Please address health impacts, financial or legal problems, behavior or personality changes, or problems with job, school, or other social functioning related to substance use:

☐ Health problems ☐ Financial problems ☐ Legal problems ☐ Employment problems
☐ Relationship problems ☐ Other: _____

_____

_____

_____

_____

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PAST SUBSTANCE ABUSE TREATMENT

☐ None

Please describe types of previous treatment. Include information about response to previous treatment:

FAMILY SUBSTANCE USE AND ABUSE

☐ None

Please describe family's substance use patterns and history:

ADDITIONAL INFORMATION YOU THINK I SHOULD KNOW