Menachem
PSYCHOTHERAPY GROUP

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CONFIDENTIAL CLIENT QUESTIONNAIRE

GENERAL INFORMATION

Today's Date:_____/_____/__

Client:

Name:_____

SS #: _____- _____ -_____ Date of Birth: _____/_____/_____

Gender Identity:

☐ Male ☐ Female ☐ Transgender ☐ Genderqueer ☐ Agender ☐ Genderless ☐ Non-Binary
☐ Cis Man ☐ Cis Woman ☐ Trans Man ☐ Trans Woman ☐ Two-Spirit ☐ Genderfluid
☐ Other _____ ☐ Prefer not to answer

Preferred Pronouns:

☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ No pronoun preference
☐ Other _____ ☐ Prefer not to answer

Sexual Orientation:

☐ Straight ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Queer ☐ Asexual
☐ Other _____ ☐ Prefer not to answer

Race: *select all that apply*

☐ American Indian/ Alaska Native ☐ Black and/or African American ☐ White/Caucasion
Asian:
☐ Asian Indian ☐ Chinese ☐ Korean ☐ Fillipino ☐ Japanese ☐ Vietnamese
☐ Other _____
Native Hawaiian/ Pacific Islander:
☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan
☐ Other _____
☐ Some other race, ethnicity, or origin ☐ Prefer not to answer

Ethnicity: *select all that apply*

☐ Not of Hispanic, Latino/a/x, or Spanish origin
☐ Mexican, Mexican American, Chicano/a/x ☐ Puerto Rican ☐ Cuban
☐ Another Hispanic, Latino/a/x or Spanish origin
☐ Some other race, ethnicity, or origin ☐ Prefer not to answer

Address: _____

City: _____State: _____ Zip: _____

Phone (cell): _____ (home): _____

Email: _____

Emergency contact: _____ Contact's phone: _____

Emergency contact's relationship to you: _____

Did anyone refer you? ☐ Yes ☐ No Name of referrer _____

Areas of Concern

What issues/concerns causes you to seek treatment?

_____

_____

_____

Do you have any specific goals with regard to your treatment?

_____

_____

_____

Do you have any particular concerns/fears with regard to treatment?

_____

_____

_____

Previous Treatment

Have you ever received mental health treatment before? ☐ Yes ☐ No

If yes, when and for how long?_____

_____

If yes, what was the focus of treatment?_____

_____

Have you ever been diagnosed with an eating disorder? ☐ Yes ☐ No

If yes, what and when:_____

_____

If yes, what are your beliefs, perceptions, attitudes and behaviors regarding food?_____

Are you in recovery for addiction or compulsion? ☐ Yes ☐ No

What program(s)?_____

Are you currently sober? ☐ Yes ☐ No

How Long? _____ Sobriety Date_____

Have you ever attempted suicide? ☐ Yes ☐ No

If yes, when?_____

Did the attempt require medical attention ☐ Yes ☐ No ☐ N/A

Did you receive inpatient treatment following the attempt? ☐ Yes ☐ No ☐ N/A

If yes, Please Describe the circumstances that led to that attempt. _____

_____

_____

Are you currently having any suicidal thoughts? ☐ Yes ☐ No If

yes, please describe _____

_____

_____

In the past, have you ever had suicidal thoughts? ☐ Yes ☐ No
If yes, please describe _____

_____

_____

FAMILY & RELATIONSHIP INFORMATION

Present Relationship Status (check all that apply):

☐ Married (yrs:___ mos:___)

☐ Partnered (yrs:___mos:___)

☐ In a new relationship (6 mos or less)

☐ Single

☐ Divorced (yrs:___mos:___)

☐ Other: _____

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

Others living in your household:

Name	Relationship	Age

MEDICAL INFORMATION

Medical Doctor:_____

Date of last physical exam (approx) _/_____/_____

How would you rate your physical health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Psychiatrist:_____

Other Specialist:_____

List any medications you are currently taking (including non-prescription or herbal remedies):_____

_____

_____

_____

Describe any current physical problems or concerns that you have:_____

_____

_____

_____

List any history of significant physical problems (e.g, broken bones, head injury, surgery): _____

_____

_____

PAYMENT INFORMATION

Please provide a credit card authorization regardless of your payment method

Credit Card Authorization: I,_____(printed name) authorize the maintenance of valid credit card information to guarantee my chosen payment option.

Cardholder Name:_____

Circle Card Type: Visa MC Discover AmEx

Billing Address:_____City: _____Zip: _____

Credit Card #_____Expiration date: ___/___/___ 3 digit CVV code: _____

Cardholder/Client Signature: _____ Date:____/____/_____

Therapist Name:_____

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 via a HIPAA secure email or U.S. mail. 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 fail 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 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:

Signature: _____

Printed Name: _____ *Date:* _____

CONSENT FOR TREATMENT AND OFFICE POLICY

This consent is to certify that you give permission to your therapist at Menachem Psychotherapy Group to provide psychotherapy treatment. You have a right to terminate the therapeutic relationship at any time without fault.

NON-DISCRIMINATION POLICY

The Menachem Psychotherapy Group respects each person's right to choose their own belief system. It is the policy of The Menachem Psychotherapy Group not to discriminate against any individual on the basis of race, color, religion, ancestry, national origin, citizenship status, age, sex, marital status, genetic information, sexual orientation, gender expression, gender identity, non-disqualifying disability or veteran/military status. While our gender, ethnicity, orientation or spirituality may be different, we are open to discussing any concerns or questions you may have in working with a therapist who is either a different race, religion, orientation or gender than you. If you have any questions regarding our therapeutic approach and style, or our non-discrimination policies, please feel free to discuss this with us now and/or in the future.

CONFIDENTIALITY

Under most circumstances, all communication between you and your therapist is confidential, unless permission is given by you, after signing a release of information, to convey information to a third party. However, there are specific exceptions to this policy:

- *When there is a reasonable suspicion of child abuse, dependent-adult or elder abuse.*
- *When a client threatens violence to an identifiable victim.*
- *When a client presents a danger of violence to others.*
- *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, please let your therapist know.* Before such disclosure is made, every reasonable effort will be made to appropriately resolve these issues and to notify clients.

NO SECRETS POLICY

Please note that with couples and family therapy the couple and/or the family is the client/treatment unit, not the individuals. **The therapists at Menachem Psychotherapy Group practice a no-secrets policy when conducting couples or family therapy services.** This means that confidentiality does not apply between the couple or among family members when one member of the treatment unit requests an individual session or contacts us outside of the therapy session to share a secret. Occasionally, individual sessions may be scheduled to assist in the overall therapy process for the treatment unit and will only be scheduled when mutually agreed upon. Any information given in the individual sessions will not be held in confidence or secret in couples and/or family sessions. We will encourage the person holding the secret to share the secret in the following session and will support them in doing so. We reserve the right to share or disclose information revealed by one partner or family member in an individual session to the other partner or family members as we deem appropriate and necessary to support the treatment units overall progress and goals. If you are seeking couples therapy, or family therapy, please have each member of the treatment unit sign this agreement.

CONTACTING THERAPISTS

Clients may text, email, or leave a voicemail for your therapist at any time. Please be aware that therapists may not retrieve or respond to messages until their regular office hours. **If you have a life-threatening emergency, dial 911.**

APPOINTMENTS

Typically, sessions are 50 minutes in length and begin at the scheduled appointment time (unless another length of time is agreed upon with your therapist). If you arrive late, your session will be shorter and will end at its normal time. If your therapist begins session late, your session will be extended to make up the time. If you need to 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-hour notice. You will be responsible for the full fee of any session that is not attended without notice of cancellation within 24 hours.**

CONJOINT SESSIONS

If it benefits the client's therapy goals, we may occasionally ask that a family member or significant other join us for a conjoint therapy session. If the client would like to include a family member or significant other for a conjoint therapy session this will be done only on occasion and at the therapist's discretion (when it best serves the client). Please note that the family member or significant other is not joining the session for their own therapy, nor will we work with them as a therapist. **If we decide that this would be beneficial, you will need to sign a written release of information for this type of conjoint session.**

SOBRIETY POLICY

The Menachem Psychotherapy Group asks that all clients arrive to therapy sober and not under the influence of illegal drugs and/or alcohol. If we notice that you are intoxicated we will immediately end the therapy session, and assist you in finding a safe ride home as driving while under the influence constitutes a risk to others and is a reportable offense. We will reschedule the therapy session where we will process this occurrence. **You will be charged your full fee for the session if you arrive intoxicated.**

FEES, BILLING & PAYMENTS

All services are billed at the standard rate agreed upon with your therapist. Sliding-scale fees may be established based on ability to pay and therapist availability. The Menachem Psychotherapy Group will keep your credit card information on file and will charge for services at the end 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
(3) Superbill 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 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.

Payment Guarantee: 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.

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

Client:

Signature: ____

Printed Name: _______________________________________ *Date:* _______________________