

JONATHAN KRUGER COUNSELING

INITIAL INTERVIEW FORM

ALL PERSONAL INFORMATION IS CONFIDENTIAL.
To be completed by client. Please print clearly.

Date: ___ / ___ / ___ Email Address: _____

Name: _____ Female Male

Address No. & Street (no P.O Box): _____

Apt. #: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ - _____ Message OK No message No calls

Work Phone: (_____) _____ - _____ Message OK No message No calls

Cell Phone: (_____) _____ - _____ Message OK No message No calls

Age: ___ Birth Date: ___ / ___ / ___ Birth Place: _____ SSN: _____

Have you or anyone in your immediate family served in the United States Military? Yes No

If yes, how are you related to that person? _____

Relationship Status: Single Separated Divorced Married Widowed Partners

If married, how long? _____ If partnered, how long? _____

If divorced, how long? _____ If widowed, how long? _____

Please list names and ages of your children, if any:

Child 1: _____ Age: ___ Child 2: _____ Age: ___

Child 3: _____ Age: ___ Child 4: _____ Age: ___

Names and ages of persons living in your home, and your relationships to them:

Emergency Contact Information

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

How is this person related to you? _____

How did you hear about Jonathan Kruger Counseling (referred by)? _____

OFFICE POLICIES & GENERAL INFORMATION AGREEMENT FOR PSYCHOTHERAPY SERVICES

CONFIDENTIALITY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law.

When Disclosure is Required By Law: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder, abuse or neglect; or where a client presents a danger to self, to others, to property, or is gravely disabled.

When Disclosure May Be Required: Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by the custodian of records. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. Jonathan Kruger Counseling (JKC) and all its counselors will not release records to any outside party unless authorized by all family members who were part of the treatment.

Emergencies: If there is an emergency during our work together where JKC becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychological care, he will do whatever she can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, the law permits Jonathan Kruger Counseling to contact the person whose name you have provided on the intake form as the emergency contact, without your verbal or written consent.

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by your health insurance carrier or HMO/PFO/MCO/EAP in order to process the claims. If you so instruct Jonathan Kruger Counseling, only the minimum necessary information will be communicated to the carrier. Unless authorized by you explicitly, the Psychotherapy Notes will not be disclosed to your insurance carrier.

JKC and/or its counselors have any control or knowledge over what insurance companies do with the information submitted or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carriers a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance.

Legal Issues: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), you agree to pay the fee of \$200.00 per hour for any expert witness and/or court appearance made by a representative of JKC on your behalf. Further, you agree to pay \$50.00 per letter written on your behalf for legal, medical, educational, or social service matters.

Consultation: Jonathan Kruger is an LMFT (Licensed Marriage and Family Therapist). He will use your health information to make decisions about the provision coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. JKC is a general practice counseling agency and is not a crisis or urgent care behavioral health entity. JKC may refer clients(s) in need of a higher level of care to other organizations or private practice therapist who could better treat the presenting issue(s) anti diagnosis. Confidentiality is fully maintained.

Considering all of the above exclusions, if it is still appropriate, upon your request, JKC will release Information to any agency/person you specify after you complete and sign The Authorization to Release Information Form.

Client Initial _____ **Counselor Initial:** _____

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact JKC between sessions, please leave a message at (310) 729-9062. Your call will be returned as soon as possible. JKC checks his/her messages a few times a day, unless s/he is out of town. If an emergency situation arises, please indicate it clearly in your message. If you need to talk to someone immediately, you can call Olive View / UCLA Medical Center at (818) 364-1555 or 9-1-1.

PAYMENTS & FEES: YOUR OUT OF POCKET FEE WILL BE DETERMINED DURING THE INTAKE BASED ON YOUR INCOME DOCUMENTS AND ABILITY TO PAY AND IS CONTRACTUALLY AGREED UPON AT THAT TIME TO BE PAID IN FULL AT THE TIME OF EACH VISIT. THE INTAKE FEE IS A NON-REFUNDABLE ONE TIME FEE. Your out of pocket fee will be re-evaluated as your financial circumstances change. JKC's fee for counseling is \$200.00 per session. You will fully cooperate with this process of collection as it pertains to you.

MEDIATION & ARBITRATION: All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before, and as a pro-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of JKC and you. The cost of such mediation, if any, shall be split equally, unless otherwise agreed. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Los Angeles County, California in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event your account is overdue (unpaid) and there is no agreement on a payment plan, Jonathan Kruger Counseling can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum for attorneys' fees. In the case of arbitration, the arbitrator will determine that sum.

CANCELLATION: Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours (1 days) notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions.

RETURNED CHECKS: If the bank returns any of your checks made payable to Jonathan Kruger unpaid, you will be responsible for the amount of the check and an additional \$25.00 service charge.

CONFIDENTIALLY: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without client's written permission, except where disclosure is required by law.

WHEN DISCLOSURE IS REQUIRED BY LAW: Some of the circumstances where disclosure is required by the law are: where there is reasonable suspicion of child, dependent or elder, abuse or neglect; or where a client presents a danger to self, others, to property, or is gravely disabled.

WHEN DISCLOSURE MAY BE REQUIRED BY LAW: Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by the custodian of records. In couples and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. Jonathan Kruger Counseling ("JKC") will not release records in any outside party unless authorized by all family members who were part of the treatment.

EMERGENCIES: If there is an emergency during our work together where your counselor becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychological care, s/he will do whatever s/he can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive proper medical care. For this purpose, the law permits Jonathan Kruger Counseling to contact the person whose name you have provided on the intake form as the emergency contact, without your verbal or written consent.

Client Initial _____ **Counselor Initial:** _____

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS: Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. If you instruct Jonathan Kruger Counseling, only the minimum necessary information will be communicated to the carrier. Unless authorized by you explicitly, the Psychotherapy Notes will not be disclosed to your insurance carrier. Neither JKC and/or its counselors have any control or knowledge over what insurance companies do with the information submitted or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance.

OPERATIONS: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

LEGAL ISSUES: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), you agree to pay the fee of \$200.00 per hour for any expert witness and/or court appearance made by Jonathan Kruger Counseling on your behalf. Further, you agree to pay \$25.00 per letter written on

Client Initial _____ **Counselor Initial:** _____

FINANCIAL INFORMATION – CONFIDENTIAL –

Only need fill if applying for sliding scale.
If more space is needed, use reverse side of this page. Please print clearly.
Please provide proof of income (check stub, W2 tax form, etc.).

Employer: _____

Address: _____

Occupation: _____

WEEKLY COUNSELING FEE DETERMINATION: \$ _____

Average monthly salary <u>after</u> taxes are deducted:	\$
Your income:	\$
Spouse or Partner:	\$
Parent (if client is a minor):	\$
Other source of income:	\$
Number of dependants:	
Rent/Mortgage:	\$
Transportation:	\$
Food:	\$
Telephone:	\$
Insurance:	\$
Alimony/Child Support	\$
Monthly Income:	\$
Monthly Expenses:	\$
Total disposable monthly income:	\$

ACKNOWLEDGEMENT OF FEE ARRANGEMENT: I understand and agree that Jonathan Kruger Counseling provides fee for service counseling. I understand that my fee per session is \$ _____ and I am contractually obligated to pay this agreed upon fee at each session.

Signature Client: _____ Date: ____/____/____

Comments on Fee: _____

CLIENT AVAILABILITY FOR WEEKLY APPOINTMENTS

Please circle all hours client can be available to come to counseling.

Monday	9a	10a	11a	12p	1p	2p	3p	4p	5p	6p	7p	8p
Tuesday	9a	10a	11a	12p	1p	2p	3p	4p	5p	6p	7p	8p
Wednesday	9a	10a	11a	12p	1p	2p	3p	4p	5p	6p	7p	8p
Thursday	9a	10a	11a	12p	1p	2p	3p	4p	5p	6p	7p	8p
Friday	9a	10a	11a	12p	1p	2p	3p	4p	5p	6p	7p	8p
Saturday	9a	10a	11a	12p	1p	2p	3p	4p	5p	6p	7p	8p
Sunday	9a	10a	11a	12p	1p	2p	3p	4p	5p	6p	7p	8p

Comments related to availability and counselor preference:

CONSENT FOR SERVICES

I have received a copy of the Office Policies and General Information Agreement for Psychotherapy Services. I have read them and understand them, and agree to comply with them.

Client Name: _____ Signature: _____ Date: ____/____/____

Client Name: _____ Signature: _____ Date: ____/____/____

Therapist Name: _____ Signature: _____ Date: ____/____/____

INTAKE QUESTIONS

Please describe the problem(s)/symptom(s) that bring you into counseling today:

Have you ever had a problem like this before? Yes No

If YES, when did it happen and how did you deal with it?

Have you ever been in psychotherapy/counseling? Yes No

If YES, give dates & type:

In the past, have you ever contemplated or attempted suicide? Yes No

If YES, please give dates and circumstances:

Have you ever experienced physical, sexual or emotional abuse (circle one)? Yes No

If YES, when? _____

Have you ever had a physical fight with your spouse or partner (such as throwing things, shoving, or hitting)?

Yes No

If YES, please explain specifically:

Have you ever physically harmed anyone (circle one)? Yes No

If YES, please describe:

Have you ever been arrested for a crime (circle one)? Yes No

If YES, please explain:

Have you ever been hospitalized for:

Psychological or emotional difficulties: Yes No

Eating disorder: Yes No

Alcohol/drugs: Yes No

Surgery or childbirth: Yes No

If YES to any of the above, please explain and give dates:

Has a physician ever prescribed medication for psychological problems/emotional difficulties or on eating disorder? Yes No

If YES, please name physician, dates of prescription and type of medication:

Are you currently using any prescribed or non-prescribed medication? Yes No

If YES, name of medication, dosage and reason prescribed:

Has anyone in your family been diagnosed with psychological or emotional problems? Yes No

If YES, please specify:

Has anyone in your family ever contemplated or attempted suicide? Yes No

If YES, please identify family member:

Has anyone in your immediate family had a substance use or abuse problem? Yes No

If YES, who, what problem, when?

HOW DO YOU FEEL TODAY?

One a scale of 1 to 10, please rate how you feel for the following emotions. Please circle the number that best represents how you feel today.

	<i>Least</i>			<i>Medium</i>				<i>Most</i>		
Happy:	1	2	3	4	5	6	7	8	9	10
Angry:	1	2	3	4	5	6	7	8	9	10
Anxious:	1	2	3	4	5	6	7	8	9	10
Sad:	1	2	3	4	5	6	7	8	9	10
Happy:	1	2	3	4	5	6	7	8	9	10

SUBSTANCE USE

Please place a check next to all the substances you have taken in the past six weeks and fill in a description of how you use(d) them.

	How Much Do You Use (e.g., 2 bottles of beer, 2 cigarettes)	How Often Do You Use (e.g., once a day, twice a day)	Date of Last Use
<input type="checkbox"/> Amphetamines Speed, meth, non-prescribed diet pills			
<input type="checkbox"/> Marijuana Pot, bud			
<input type="checkbox"/> PCP Angel dust			
<input type="checkbox"/> Heroin			
<input type="checkbox"/> Cocaine (rock)			
<input type="checkbox"/> Barbituates			
<input type="checkbox"/> Ecstasy			
<input type="checkbox"/> Inhalantes Glue, aerosol			
<input type="checkbox"/> Hallucinogens LCD, acid, mushrooms			
<input type="checkbox"/> Alcohol			
<input type="checkbox"/> Cigarettes			
<input type="checkbox"/> Prescribed Drugs Valium, Xanax, Zoloft. Prozac			
<input type="checkbox"/> Other			

Please answer the following questions by checking the box that corresponds to how you feel:

Yes No Sometimes

I am satisfied with my life in general.			
I am satisfied with my relationship with my spouse or partner.			
I am satisfied with my job.			
I am satisfied with my relationship with my children.			
I am satisfied with my relationship with my friends.			
I am satisfied with my relationship with my family.			
I have a hard time getting up in the morning.			
I have a hard time staying focused at work or at home.			
I feel hopeful and look forward to my day.			
I feel helpless during the day.			
I am interested in things and am active in sports or hobbies.			
I have trouble sleeping.			
I have a normal appetite.			
When I am sad or upset I drink alcohol to feel better.			
When I am sad or upset, I take pills to relax me.			
I have thought about ending my life recently.			
I have tried to end my life in the past.			
My mood changes often/daily.			
I tend to think about the same thing over and over again.			
I am generally a happy person.			
I feel sad or unhappy most days.			
I have either lost a lot or gained a lot of weight recently.			
I am easily agitated or "grumpy".			
I have energy and rarely feel tired.			

INTAKE CHECKLIST

Please initial each item to acknowledge that the intake counselor has thoroughly explained the below items during the intake session.

_____ I understand that Jonathan Kruger is a licensed marriage and family therapist in the State of California.

_____ I understand that Jonathan Kruger is a general practice counseling agency and not a crisis or urgent care behavioral health entity.

_____ I understand that if my treatment plan requires a higher level of care that what can be offered by Jonathan Kruger, I may be referred to an organization or private practice therapist who could better treat my presenting issue(s) and diagnosis.

_____ I understand that Jonathan Kruger has a 24-hour cancellation policy, and I am responsible for any fees accrued due to a cancellation less than 24 hours before my appointment.

_____ I am aware that Jonathan Kruger's telephone number is 310 729-9062 where I may leave my counselor messages in case of a cancellation of appointment or an emergency.

_____ I understand that my fee based on my ability to pay is \$200 unless otherwise discussed and entered.

_____ I understand that Jonathan Kruger has an annual fee reevaluation and my fee may change depending on my ability to pay.

_____ I understand the California law regarding client confidentiality and the limits to confidentiality in the event of harm to self or others, child or elder/dependent abuse.

_____ I understand my appointments are weekly for a 50 minute session at an agreed upon day and time.

_____ I understand that there will be a nominal fee for all progress and attendance letters and/or copies of medical records.

_____ JKC Policies and General Information Agreement page explains in writing what has been verbally explained regarding the terms on this checklist.

Client Signature: _____ Date: ____/____/____

Counselor Signature: _____ Date: ____/____/____