Center for Family Counseling

John Croner, MA, MSW, LCSW

Initial Therapy Intake Form

Welcome and thanks so much for choosing me to begin or continue your talk therapy. I look forward to beginning the process of getting to know you and beginning to define and refine your goals towards growth, healing and self-discovery. I approach therapy as a jointly explorative journey in which through the building of empathetic trust you may begin to feel safe and comfortable in making our shared space a place where we can discuss your hopes, worries, struggles, concerns and aspirations.

In beginning to do so I would appreciate if you could take some time to fill out the following paperwork, as developed by and excerpted from my colleague Beatrice Kerr's, LCSW, own intake forms. The information below will help me to understand your background, so that I can offer any compassionately neutral insights in regard to your history to help you reach your goals for therapy. If you are uncomfortable at this time in answering any of the non-basic demographically specific information below, please just leave the space blank and we can perhaps discuss in the future closer to the right time as defined by our ongoing discussions.

In addition you will find some explanations of what you may expect and experience thorough-out the process of therapy, your privacy rights under federal law, the clinician's role and responsibilities as a mandated reporter, billing and other expectations and consents in regard to treatment. Please sign below and bring this paperwork with you to your first session. Again, thanks for taking the time to complete this information and I look forward to meeting you.

- John

Client Name:		Age:		Birth Date:	
Address:					
City:		State:		Zip:	
Home Phone:		Work (optional):			
Cell Phone:		Email:			

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Occupation:		Employer:	

If client is a minor, name of responsible adult:

Emergency Contact:				Phone:	
Address:					
City:		State:		Zip:	
Relationship of emergency contact:					

May we say who we are if we phone you? at:			May we leave a message?	
Home:	Yes ☐	No ☐	Yes ☐	No ☐
Work:	Yes ☐	No ☐	Yes ☐	No ☐
Cell Phone:	Yes ☐	No ☐	Yes ☐	No ☐

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REASON FOR COMING TO THERAPY

Please describe the problem(s) that you want help with:	
How has this problem affected your life in the following areas?	
Family:	
Work/School:	
Social:	
Health:	
How long have you had this problem?	
Have you had counseling/therapy in the past? ☐ Yes ☐ No If so, where/when/duration?	
What was helpful about the counseling?	
What was not helpful about the counseling?	

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CURRENT FAMILY SITUATION

Who raised you?	
If there were changes, please list and indicate the age you were when these changes occurred:	
# of siblings_____ # brothers_____ # sisters_____	In rank order from oldest to youngest, what is your place in the order?
Which members of your family are you close to?	
Are there any family members who are a problem for you?	
Please indicate other people in your life that provide support for you:	
Please list any problems that family members have/have had and indicate relationship:	
Arrests/convictions	
Alcoholism	

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Depression	
Violence	
Other mental/emotional problems	

Who currently lives in your home?

Current marital status:

Current family stressors:

FAMILY HISTORY

Check any of the following that apply to your childhood/adolescence:

☐ Happy childhood ☐ Unhappy childhood ☐ School problems ☐ Medical problems

☐ Family problems ☐ Alcohol use ☐ Drug use ☐ Arrests/convictions

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EDUCATIONAL HISTORY:

Yrs. Completed:
Problems:
Strengths:

WORK HISTORY:

Usual occupation:
Are you currently employed: ☐ Yes ☐ No Length of time:
If you have changed jobs during the last five years, give duration of employment and reason for leaving job:

PHYSICAL AND MENTAL HEALTH:

How would you rate your current health? Very poor 1 2 3 4 5 6 7 8 9 10 Very good
List current health/emotional problems for which you are receiving treatment:

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List medical/emotional problems you have experienced in the past

Physicians currently receiving treatment from:

Name	Phone number	Fax number	Reason for Treatment

List any medications currently prescribed:

Current Medications/Dosages	Prescribing Doctor	Reason

Past medications/effectiveness:

Indicate any of the following that apply to you:

	Current	Past		Current	Past
Thoughts of suicide	☐	☐	Hurting yourself deliberately	☐	☐
Plan for suicide	☐	☐	Thoughts of hurting someone else	☐	☐
Suicide attempt	☐	☐	Plan for hurting someone else	☐	☐

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What is your current use of alcohol/drugs?
Have you had problems with alcohol use in the past? ☐ Yes ☐ No
Do you have a history of drug use? ☐ Yes ☐ No If yes, please detail type/usage/frequency:
Have you been arrested for alcohol/drug related offenses? ☐ Yes ☐ No
Have you had treatment for drug abuse/dependency? ☐ Yes ☐ No Where/When?

SOCIAL OUTLETS/ACTIVITIES/SUPPORTS

Exercise
Religion/Spiritual Affiliation
Social Activities/Interests

(note specifics, frequencies, increases /decreases in involvement)

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Check any of the following that may apply to you (client):

	Depression		Inferiority Feelings		Traumatic event
	Anxiety		Feeling “blue”		Avoidance of associations with traumatic event
	Troubling thoughts		Unable to relax		Afraid of people
	Under-eating		Fears and phobias		Panic Attacks
	Over-eating		Obsessions		Self-harm behaviors
	Bowel disturbances		Suicidal thoughts		Racing thoughts
	Stomach trouble		Isolation		Hyper vigilance
	Always tired		Alcohol problem		Problems concentrating
	Difficulties sleeping		Drug problem		Flashbacks
	Legal problems		Loved one alcohol or drug problem		Nightmares
	Financial problems		spiritual distress		Heightened Startle Response
	Health problems		Grief/loss		Difficulties with intimacy/sex relations
	Work problems		Anger management/rage		Sexual abuse/assault Survivor
	School problems		Feelings of guilt/shame		Other:
	Marital stressors		Conflict with parent/child		Other:

What do you wish to achieve through the process of therapy?

How were you referred to John Croner?

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Upon my signature below, I hereby attest that all the information furnished is true and correct. By signing, I agree to be responsible for all fees that my insurance does not cover. I agree to receive therapy services from John Croner, LCSW.

Signature Date

(For minors:) John Croner, LCSW, has my permission to provide services to the above-named child. I will attend sessions with and for my child as requested.

Signature Date

John Croner's Qualifications

B.A. in political science, University of Cincinnati (UC/CCM), graduated cum laude in 2002. M.A. in political science/urban policy, Brooklyn College (CUNY), graduated 2005. M.S.W. in social work, New York University (NYU), graduated 2009 (L.M.S.W. through New York State soon after). Since 2004: Extensive experience in social services and advocacy in Ohio, India, New York City and Virginia. Multiple social work positions throughout NYC, NY, including psychotherapist (with partial analytical training) at the National Institute for the Psychotherapies. L.S.W., Commonwealth of Virginia, converted/awarded 06/05/2015. L.C.S.W. awarded by same 11/12/2019. Since 04/2016 to currently: Full-time medical social worker with Mary Washington Hospice at Mary Washington Hospital in Fredericksburg, VA. Center for the Advancement of Palliative Care (CAPC) multiple-course designations in *Best Practices in Dementia Care and Caregiver Support, Communication Skills, Symptom Management* and *Social Work Serious Illness* 2018-2020. Current work towards receiving credentialing in neurobiologically-informed CBT for anxiety, anger management specialist and telehealth.

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Informed Consent to Psychotherapy and Office Policies:

(Please read the following below carefully and ask John Croner for specifications about any element you do not fully understand.)

Process, Benefits, and Risks of Psychotherapy

Participating in therapy can provide a number of benefits to you. These benefits include reducing or eliminating psychological symptoms, improving interpersonal relationships, as well as resolving the specific concerns that led you to seek therapy.

Benefits may also include increased comfort in social, work and family settings, increased capacity for intimacy, decreased negative ideation, decreased self-defeating behaviors and improved abilities to become goal oriented. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your active involvement, honesty and openness in order to change your thoughts, feelings and/or behaviors. Much of the value of therapy comes from using the skills, ideas, tasks and suggestions discussed during the sessions in your everyday life. I will ask you for your feedback and views on your therapy and will expect you to respond openly and honestly. During the therapeutic process discomfort may be experienced by remembering or talking about unpleasant events, feelings or thoughts. These discussions may evoke strong feelings of anger, sadness, worry, fear, etc or you may experience an increase in symptoms associated with anxiety, depression or insomnia.

I may challenge some of your assumptions and perceptions or propose different ways of viewing, thinking about or handling situations. These challenges may evoke feelings of anger, upset, hurt, disappointment or resentment. Attempting to resolve the issues that prompted you to seek therapy may result in changes that were not originally intended. Psychotherapy may initiate decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a decision that is positive for one family member is viewed negatively by another family member. During the course of psychotherapy things can get better or worse. Often they will get worse before they get better. Change can be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results.

During the course of therapy, I am likely to draw on various theoretical approaches according to the problem presented and my assessment of what will be most beneficial to you. I consider my approach to talk therapy to be one mainly consisting of trusting empathetic alliance building, using a mix of cognitive behavior therapy, client/person-centered talk therapy, internal-family systems/parts work, object relations, ego-psychology, narrative-work and harm reduction approaches. If you have any questions about the procedures employed during the course of your treatment (i.e. their risks, my expertise in using them, or the treatment plan) please ask and I will answer you to the best of my ability. You also have the right to know about other treatments for

you condition. If you could benefit from any treatment that I do not provide, I will assist you in obtaining those treatments through appropriate referrals.

If at any time you wish to seek another professional's opinion or wish to consult with another therapist, I will assist you in finding someone qualified. With your written consent, I will provide him/her with the information needed for proper assessment/ evaluation. You have the right to terminate therapy at any time. If you choose to end treatment, I will offer to provide you with the names of other professionals who are qualified to work with your issues. Therapy never involves sexual or business relationships or any dual relationship that impairs my objectivity, clinical judgment or therapeutic effectiveness.

Confidentiality

The laws and standards of the Social Work profession require that I keep treatment records. All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where law requires disclosure. Law, in the following circumstances, may require disclosure:

1. Where there is reasonable suspicion of child or elder abuse or neglect
2. Where a client presents a danger to him/herself or to another person
3. A client is gravely disabled

The intent of such requirements is that a therapist has a legal and ethical responsibility to take action to protect endangered individuals from harm when the therapist's judgment indicates that danger exists. It is my policy to fully disclose these matters with my clients before any action is taken unless there is a compelling reason not to do so. Regarding the above circumstances, only information necessary to expedite the resolution of the emergency is revealed. Therefore, if there is an emergency during our work together or the possibility of you injuring yourself or someone else, I am obligated to do whatever I can within the limits of the law to assure your safety and the safety of others. For this purpose, I may contact the person you have listed as an emergency contact on the intake sheet, notify the potential victim, contact the police or seek hospitalization when necessary.

Disclosure may also 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 my testimony. If you are involved in legal proceedings, lawyers from either side can subpoena your records or a judge may order my testimony if it is determined that the issues demand it. In family therapy or when different family members are seen individually, confidentiality may not apply among family members. I will use my clinical judgment about revealing information.

Disclosure of confidential information may be required by your health insurance carrier for HMO/PPO/ MCO/EAP in order to process your claims. Only the minimum necessary information will be provided to your insurance as permitted by law. This information is called

the Protected Health Information (PHI) as determined by the HIPAA Privacy Rule. It includes the psychotherapy session start and stop times, their dates, the modalities and frequencies of treatment provided, results of clinical tests, and any summary of diagnosis, symptoms, functional status, treatment plan, prognosis, and progress to date. I have no control or knowledge over what insurance companies do with the PHI information I submit. Upon request, I will provide you with a copy of the information submitted. The confidential nature of your personal information provided through electronic means cannot be guaranteed, therefore, you can request that the information be sent through the mail.

Client Rights:

HIPAA provides you with several rights regarding your PHI record and disclosures of protected health information. These rights include:

1. The right to request that I amend your record
2. The right to request restrictions on what information from your PHI record is disclosed to others
3. The right to request an accounting of most disclosures of PHI that you have neither consented to nor authorized
4. The right to determine the location to which protected information disclosures are sent
5. The right to have any complaints you make about my policies and procedures documented in your record
6. The right to a paper copy of this agreement, the attached Notice form and my privacy policies and procedures.
7. The right to revoke your consent to send information to your insurance company effective on the date I receive the revocation in writing.

I am happy to discuss any of these rights with you.

As a client, you have the right to review or receive a summary of your psychotherapy record at any time, except in limited legal or emergency circumstances. In such circumstances, I may provide you with a summary of your records and will be available to review them with you to provide clarification and support. Per your written request, I also will provide the records or its summary to an appropriate professional of your choice. You will be charged an appropriate fee for any professional time spent in responding to an information request regarding you or your treatment.

Availability and Emergency Procedures

If you need to contact me between sessions, please leave a message on my voice mail at 540-361-1556. I check my messages daily and will return your call as soon as I am available.

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If you need to talk to someone right away, you can call Emergency Services at 540-373-6876, Snowden at 540-741-3900, the police at 911 or go to the nearest emergency room. If an emergency situation arises in which you are being harmed or are in danger of harming yourself or someone else, please call 911.

I will be away from the office at various times throughout the year. During these times, if you would need to see a mental health professional, I will provide you with the name of a qualified therapist that you can contact.

Please be aware that electronic communications including texts and e-mail are not HIPAA compliant. Please limit this form of communication to appointment scheduling.

Payments and Insurance Reimbursement:

I am currently working on obtaining paneling authorization to be directly reimbursed through a variety of health insurance companies. While I work through that process, I am able to accept out of pocket session fees for which I can provide you with written receipts that may or may not be able to be reimbursed at a level deemed appropriate by your insurance provider. I cannot guarantee that your insurance company will provide you with reimbursement and your consent for treatment is also in acknowledgement of that fact.

I currently bill a fee of $85 for the initial 60-minute intake session and $75 per each 45-minute follow-up session unless other arrangements have been made (in certain instances I may be willing to discuss a sliding scale based on your income and circumstances, but there is no guarantee that one will be available). Payment is due the day/evening of session.

It is your responsibility to obtain the appropriate reimbursement from your insurance company that I do not contract with if you choose to do so. Insurance companies do not reimburse all issues/conditions/problems that are the focus of treatment. It is your responsibility to verify the specifics of your coverage. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, release of records, longer sessions, travel time, etc. will be charged at the rate of $75 per 45-minutes unless indicated and agreed otherwise. In the event that I am subpoenaed to court, my rates are $150 per hour including travel time. The fees will be billed to the person on whose behalf I am summoned.

Please notify me if any problem arises during the course of therapy regarding your ability to make timely payments. It is important to evaluate your financial resources in terms of covering treatment fees. If you should encounter financial difficulties that interfere with your ability to pay for services rendered, it is important to notify me as soon as possible. I will provide you with a few sessions to focus on terminating our therapeutic work together and will make reasonable efforts to find a referral whose fees are more affordable to you. There will be a $30 fee for returned checks from the bank. Please be aware that if you choose to pay me by check, your

confidentiality may be compromised as the bank teller handling the transaction may see my name on the check.

Cancellation

Since the scheduling of an appointment involves the reservation of time especially for you, a fee of $50 will be charged for sessions missed without 24-business hour notice of cancellation. Insurance companies do not reimburse for missed appointments. I value the importance of keeping scheduled appointments in order to maintain the movement of the therapeutic process. Therefore, if I need to cancel an appointment with you, I will only do so when it is important and will do my best to reschedule it within the same week.

I have reviewed the information in this agreement and I fully understand it, I accept it and I agree to abide by its terms during our professional relationship. I have had my questions answered to my satisfaction. Based on the terms of this agreement, I consent to participate in an evaluation and treatment with John Croner, LCSW. I understand that this agreement can be withdrawn at any time.

YOUR SIGNATURE BELOW ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Client signature _____Date _____

I authorize permission for John Croner, LCSW, to contact my insurance company, as necessary to pursue and/or inquire regarding said services. I authorize the release of any medical or other information necessary to process claims for insurance payment. I also authorize payment of benefits to the supplier of services accepting assignment of benefits.

Client signature _____Date _____