David Flomenhaft
PSYCHOTHERAPY
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Phone/fax: 516.596.0739

INTAKE FORMS

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Name:_____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date:_____/_____/_____ Age:_____ Gender: ☐ Male ☐ Female

Marital Status:

☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please list any children and their age(s):

_____

_____

Street Address:_____

City:_____ State:_____ ZIP Code:_____

Home Phone:_____ May we leave a message? ☐ Yes ☐ No

Cell Phone:_____ May we leave a message? ☐ Yes ☐ No

Work Phone:_____ May we leave a message? ☐ Yes ☐ No

Email:_____ May we email you? ☐ Yes ☐ No

Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any):_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

☐ No ☐ Yes If yes, previous therapist/practitioner:_____

Are you currently taking any prescription medication?

☐ No ☐ Yes If yes, please list:_____

_____

Have you ever been prescribed psychiatric medication?

☐ No ☐ Yes If yes, please list and provide dates:_____

_____

General Health and Mental Health Information

1. How would you rate your current physical health?

   ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

   Please list any specific health problems you are currently experiencing:

   _____

2. How would you rate your current sleeping habits?

   ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

   Please list any specific sleep problems you are currently experiencing:

   _____

3. How many times per week do you generally exercise?_____

   What types of exercise do you participate in:_____

4. Please list any difficulties you experience with your appetite or eating patterns:

   _____

5. Are you currently experiencing overwhelming sadness, grief or depression?

   ☐ No ☐ Yes If yes, for approximately how long?_____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?

   ☐ No ☐ Yes If yes, when did you begin experiencing this?_____

7. Are you currently experiencing any chronic pain?

   ☐ No ☐ Yes If yes, please describe:_____

8. Do you drink alcohol more than once a week? ☐ No ☐ Yes

9. How often do you engage recreational drug use?

   ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

10. Are you currently in a romantic relationship? ☐ No ☐ Yes If yes, for how long?_____

    On a scale of 1 to 10, how would you rate your relationship?_____

11. What significant life changes or stressful events have you experienced recently?

    _____

    _____

    _____

    _____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Alcohol/Substance Abuse	☐ No	☐ Yes	_____
Anxiety	☐ No	☐ Yes	_____
Depression	☐ No	☐ Yes	_____
Domestic Violence	☐ No	☐ Yes	_____
Eating Disorders	☐ No	☐ Yes	_____
Obesity	☐ No	☐ Yes	_____
Obsessive Compulsive Behavior	☐ No	☐ Yes	_____
Schizophrenia	☐ No	☐ Yes	_____
Suicide Attempts	☐ No	☐ Yes	_____

Additional Information

1. Are you currently employed? ☐ No ☐ Yes

   If yes, name and address of your employer:

   _____

   _____

   Do you enjoy your work? Is there anything stressful about your current work?

   _____

   _____

2. Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes

   If yes, describe your faith or belief: _____

3. What do you consider to be some of your strengths?

   _____

   _____

4. What do you consider to be some of your weaknesses?

   _____

   _____

5. What would you like to accomplish out of your time in therapy?

   _____

   _____

Health Insurance Information

If you are using health insurance or may use it in the future, the following information is necessary in order to bill the insurance company.

Patient's Information

Patient's Full Name: _____

Patient's Street Address: _____

City: _____ State: _____ ZIP Code: _____

Patient's Telephone: _____ Patient's Date of Birth: _____

Patient's Gender: ☐ Male ☐ Female

Patients' Relationship To Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Patient's Marital Status: ☐ Single ☐ Married ☐ Other

Patient's Work Status: ☐ Employed ☐ Full-Time Student ☐ Part-Time Student

Insured's Information (The "insured" is the person who owns the policy or is the employee to whom a group policy is applicable.)

Insured's Full Name: _____

Insured's Street Address: _____

City: _____ State: _____ ZIP Code: _____

Insured's Telephone: _____ Insured's Date of Birth: _____

Insured's Social Security #: _____

Insured's Place of Employment: _____

Insurance Plan Name or Program Name: _____

Insured's Insurance ID Number: _____

Insured's Policy Group Number: _____

I authorize the release of any medical or other information necessary to process insurance claims. I further authorize the payment of medical or insurance benefits to David Flomenhaft, LCSW, PhD, and authorize David Flomenhaft, LCSW, PhD to obtain or release therapy records and treatment plans to my insurance company for the purpose of evaluation, treatment and payment.

_____ _____

Signature of insured Date

Physician Notice and Release of Information

Most insurance plans request that the therapist notify the physician that their patient is being seen in counseling. Please complete and sign. If you do not wish for your physician to have this notice in your medical files, please indicate below.

Name of MD:_____

Street Address of MD:_____

City:_____ State:_____ ZIP Code:_____

The client named below is receiving psychotherapy at this office with David Flomenhaft, LCSW, PhD. The client has indicated that you are the ☐ primary physician or ☐ psychiatrist.

The client's insurance has requested that you be notified, and the client has authorized this notice. I look forward to working with you in a team effort for the benefit of the client.

If you wish to contact me, please call (516) 596-0739.

Thank you.

David Flomenhaft, LCSW, PhD

I, _____ ☐ authorize ☐ do not authorize
Print your name

that this notice be sent to the above-named doctor and further authorize consultations between the patient's doctor and therapist relative to my medical and psychological care.

_____ _____
Signature of patient or guardian of minor Date

Statement of Fee Policy

It is important that you understand the fee policy. Please read and complete the section which states your insurance and your co-pay, sign and date. If you are a cash pay, you and your therapist will complete the section relative to fee.

David Flomenhaft, LCSW, PhD, provides psychotherapy, educational and consultation services. I am requesting that you read and sign this statement to acknowledge your understanding of my policy. Your signature does not bind you to therapy. It does make you responsible for charges incurred.

Insurance Billing: This will be handled on a case-by-case basis. You are asked to contact your insurance company relative to your benefits. This office has made every effort to be a provider for a variety of managed-care companies. As a service to you, David Flomenhaft, LCSW, PhD, may bill Client's insurance company on Client's behalf. **If for any reason a claim is denied, it is the Client's responsibility to contact the insurance company and clear up any reasons for its denial. Client is responsible for verifying insurance coverage, obtaining any necessary pre-authorization, and resolving any claim denials**. If Client fails to do so, Client will pay provider's full customary fee for all services rendered. For managed care claims and EAP referrals, we will bill as per the agreement with the managed-care company. (Example: United Behavioral, Cigna, etc.) Because David Flomenhaft, LCSW, PhD is a Licensed Clinical Social Worker, most insurance companies will accept claims.

Co-Pay: If your managed-care policy requires a co-pay, it is the individual's responsibility to bring the co-pay to each session or make other arrangements. This office does NOT send out statements for co-pay.

Deductible: Your health insurance may also have a deductible. If it is applied by your insurance company to any claim we submit, you are responsible for these amounts also. You should check with your insurance to see if a deductible applies.

Auxiliary Service: Occasionally requests are made for mental health evaluations and other reports. A fee will be charged for these reports.

Telephone Calls and Email: There is no charge for telephone calls and email unless you and the therapist have prearranged a formal session.

Cancellations: The time of your scheduled appointment is reserved for you. It is our policy to charge $50 when the appointment is canceled within three hours of the appointed time. It is our policy to charge for the entire session for a no-show. We understand that circumstances arise that make it difficult to keep an appointment. We will work with you relative to these charges.

Length of Session: A session is generally **45 minutes**. There is no extra charge for other individuals such as spouse, children, relatives or friends who may need to attend at your request.

Emergencies: I am generally available on a 24-hour basis. However, clients seen in outpatient psychotherapy are assumed to be responsible for their day-to-day functions. You may reach me at: Office 516.596.0739.

I will attempt to return your call within one hour. This is not always possible as I may be in session with another person, speaking to a group of people or traveling from one destination to another. If a life-threatening situation arises, please go immediately to the nearest hospital emergency room or contact the emergency psychiatric services in your area.

Email: You may also write to me at DrFlomenhaft@davidflomenhaft.com. If you would like a reply, please note that in your email. The reply may come in approximately 24 to 48 hours.

Fees: Please speak openly to me about my fees. It is my desire to work with you as much as possible as to payment.

Fees are payable to David Flomenhaft, LCSW, PhD.

Insurance will be billed when requested.

I give my consent and authorization to David Flomenhaft, LCSW, PhD, to bill my insurance noted above and I further acknowledge that my co-pay is _____ to be paid at the time of the session or at the time otherwise arranged. My signature also represents my understanding of the above fee policies.

Signed:_____ Date:_____