Intake Information

Please complete the following questionnaire. This information will be discussed more thoroughly in session and used to determine goals for counseling.

Name: _____ Date of Birth:_____

Address: _____

City, State, Zip: _____

Telephone number(s): Home: (____) _____ Work: (____) _____

Cell: (____) _____ Where can I leave messages? ☐ Home ☐ Work ☐ Cell

Can I contact you by email? ☐ No ☐ Yes Email address: _____

Do I have your permission to email you my monthly newsletter? ☐ Yes ☐ No

Occupation: _____

Employer: _____

Highest level of education: _____

How satisfied are you with your job? _____

Briefly describe your reason(s) for seeking help at this time: _____

_____

_____

_____

_____

When did the problem/symptoms start?:_____

What do you wish to accomplish through the process of therapy: _____

_____

_____

_____

_____

Marital/Relationship Status (check all that apply):

☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Remarried

☐ Single ☐ Long term relationship ☐ Cohabitating ☐ Other: _____

Current partner's name: _____

Partner's occupation: _____

Partner's Date of Birth: _____

Length of relationship: _____

How satisfied are you with this relationship and why?_____
_____

Do you have any children (biological, adopted, foster, step, etc.)? ☐ Yes ☐ No

If yes, please list names and ages from oldest to youngest:
_____

_____

_____

Do your children currently live with you? ☐ Yes ☐ No
If yes, which ones live with you?
If no, where do they live? _____

How often do you see them? _____

If you have been previously married, please complete the following:

1st marriage: Date married: _____ Date ended: _____

Children: ☐ Yes ☐ No Ex-spouse's name: _____

Reason for divorce: _____

2nd marriage: Date married: _____ Date ended: _____

Children: ☐ Yes ☐ No Ex-spouse's name: _____

Reason for divorce: _____

Have you ever been in therapy/counseling before? ☐ Yes ☐ No

If yes, briefly describe the reason(s), dates(s) and length of treatment: _____

_____

_____

_____

Was it a positive experience? ☐ Yes ☐ No

What was helpful about it? _____

_____

Have your ever attempted suicide? ☐ Yes ☐ No

If yes, please describe: _____

_____

Have you ever seriously contemplated suicide? ☐ Yes ☐ No

Are you currently having suicidal thoughts? ☐ Yes ☐ No

Are you presently taking any medication? ☐ Yes ☐ No
When did you start taking them and why?_____
If yes, please describe: _____

_____

What do you enjoy doing in your spare time? _____

Are there things that you used to do, or would like to do, but currently don't? _____

_____

How would you describe your spiritual or religious beliefs? _____

_____

Is there anything else you think would be important for me to know about you or your family?

_____

Did someone refer you? ☐ Yes ☐ No If yes, who? _____

May I contact him or her to thank them for referring you? ☐ Yes ☐ No

If you were not referred by someone, how did you find my practice? _____

Please circle any of the following that presently cause you difficulty:
Please put an * by the items that are causing you the MOST difficulty

Assertiveness	Health Problems	Career choices	Stomach problems
Parenting	Alcohol use	Legal matters	Self-concept
Bowels	Sexual problems	Marriage	Religion
Nightmares	Loneliness	Concentration	Separation
Energy	Ulcers	My thoughts	Suicidal thoughts
Nervousness	Sleep difficulties	Infertility	Decision making
Physical abuse	Children	Parents	Sexual orientation
Education	Divorce	Relaxation	Infidelity
Temper	Depression	Sexual abuse	Shyness
Stress	Inferiority	Friends	Dating
Memory	Drug use	Headaches	Tiredness
Finances	Appetite	Anxiety	Unhappiness
Fears	Worry	Work	Confusion
Premarital	Food	Relationships	Self-control
Sadness	Grief/loss	In-laws	My past
Guilt	Eating disorder	Lack of self-confidence	Other:

Treatment Agreement

This document is intended to clarify in writing some of the issues we may have already discussed verbally that need to be brought to your attention regarding our professional relationship. In my work I have found that it is best to specify as well as possible the form and content of our relationship by making a mutual agreement that you may receive the service you desire. It is my assurance that I am well aware and respectful of your basic rights as a consumer and that I will respond to your needs in the most highly ethical manner, according to the standards of care for my profession, mental health and marriage/family counseling. By clarifying the services I have to offer, as the person to be treated, you may best judge whether you desire or are satisfied with them. I remain personally and professionally committed to providing you with the highest quality of service.

Client Rights

As a client of Julie Ingber, MEd., LMHC, NBCC you have certain rights which are:

1. To participate voluntarily in treatment with your therapist and to terminate at any time without penalty.
2. To understand that "treatment" could include individual or conjoint therapy for up to 50-60 minutes (a therapy hour) or group therapy for 90 to 120 minutes conducted by your licensed therapist with no absolute guarantee of your desired results by your therapist.
3. To participate with your therapist in exploring your goals as a client and developing a Treatment Plan, this will include the benefits and risks associated with the particular approach to therapy.
4. To have reasonable access to your therapist by telephone in case of emergency.
5. To have information available to you regarding your therapist's professional license and credentials as well as access to the ethical guidelines or "Standards of Practice" in Mental Health Counseling or Marriage and Family Therapy. Your counselor is licensed under Florida Statute 491 of the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling of the Agency for Health Care Administration in Tallahassee, Florida.
6. To understand that, under certain conditions, your therapist may choose to seek supervision from other qualified clinicians. If yours is one of the cases, you will be notified as to whom and given a release form to sign prior to the supervision.
7. To understand that, in keeping with generally accepted standards of practice, your therapist may confidentially consult with other mental health professionals regarding case management. The purpose of the consultation is to assure quality care, and every effort is made to protect the identity of clients.
8. To have all records and other information concerning to your involvement with this office held in strict confidence and all communication with your therapist privileged, which means that no information is ever to be released to a third party without your written permission. Certain exceptions are: if you are in clear and imminent danger to yourself and others, in child abuse and neglect cases, therapist's subpoena or court order, if you carry and infectious or communicable disease (e.g. AIDS), or if there is a medical emergency.

I hereby commit to offering you these rights and providing these services.

Therapist's Signature: _____

Date: _____

Client Responsibilities

As a client/consumer, I have carefully read over and signed all of the policies regarding financial responsibilities, making, keeping and cancelling appointments with this therapist and this agreement.

Consent and Authorization for Treatment

I consent to and authorize the assessment and/or treatment I will receive as a client of Julie Ingber, MEd., LMHC, NBCC. I have read the policies of this office and received a copy of them. I understand these rules and policies and agree to follow them.

_____ _____

Signature of Client Date

Financial Responsibility Agreement
Late Cancellation/No Show Policy

As the financially responsible person for the account, I understand that my initial appointment will be 50 - 60 minutes, posted and charged at a fee of $175.00 for couples and $140.00 for individuals.

I understand that I will be financially responsible for any charges. I acknowledge that I understand, and accept the terms of the services allowed for mental health treatment.

I understand that I will be charged and am required to pay for phone consults with the therapist which last over 10 minutes, fees based on the 50-minute psychotherapy allowable amount.

I understand that I shall keep all scheduled appointments and shall give at least 24 hours notice of my intention to cancel any appointments.

I understand that if I do not cancel my one hour appointment at least **24 hours** in advance or 2-hour appointment **72 hours** in advance (LATE CANCELLATIONS), or fail to show up for my scheduled appointment (NO SHOW), I will be charged in full and insurance companies do not cover missed or late cancellation fees. I understand that I will be required to pay for the therapist's full charge for this missed session.

I understand that if my check is returned for insufficient funds (NSF) or other bank reasons, I will be required to pay for this check in cash in addition to a service charge of $30. I also understand that my payments after this will be on a cash or charge only basis.

I understand and agree that I am ultimately financially responsible for all fees described in this agreement.

_____ _____

Date Client

Julie Ingber, MEd., LMHC, NBCC
Jacksonville, FL 32216
(904) 599-3099

Julie Ingber, MEd., LMHC, NBCC

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:_____

Date of Birth: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the "Notice of Privacy Practices" of Julie Ingber, MEd., LMHC, NBCC. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact.

_____

Signature of Patient/Client Date

☐ Patient/Client Refuses to Acknowledge Receipt

Life History Questionnaire

The purpose of this questionnaire is to obtain a comprehensive picture of your background. If you do not desire to answer any questions, merely write "Do not care to answer". Feel free to write on the back of the page. We can go over in our first session together. This is provided to save time and be as efficient as possible with time in therapy.

Personal Data

Date of Birth_____ Place of Birth_____

Mother's condition during pregnancy (as far as you know)_____

Circle any of the following that apply during your childhood:

Night Terrors	Bedwetting	Sleepwalking	Thumb sucking
Nail Biting	Stammering	Fears	Happy childhood
Unhappy childhood			

Health during childhood?_____ List Illnesses: _____

_____

Health during adolescence?_____ List Illnesses: _____

_____

What is your height?_____ Weight_____ Any accidents: _____

What are your five main fears?

1._____

2._____

3. _____

4. _____

5. _____

Present interests, hobbies, and activities:_____

_____

How is most of your free time occupied?: _____

_____

What is the last grade of school you completed? _____

Scholastic abilities, strengths and weaknesses:_____

_____

Were you ever bullied or severely teased?_____

Did you make friends easily?_____ Do you keep them?_____

If you use alcohol or drugs please answer the following:

Do you use the following and if so, please state how often (be specific-daily, weekly, monthly, more/less)

Marijuana_____ Nicotine_____ Cocaine_____

LSD_____ Alcohol_____ Prescription Drugs_____

Other_____

How much do you use?_____

Have you ever been arrested for driving while intoxicated?_____

If Yes, When (Date/s)?_____

Has your drug/alcohol use been pointed out by anyone in or outside of the family as a problem? If so, please explain: _____

_____

_____

_____

Does your personality change when you use?_____ How: _____

_____

Has your behavior become more hostile and caused conflict with anyone else when you've been under the influence of drugs/alcohol?_____ With Whom?___

_____

Have you ever had periods of time that you cannot remember the next day after you have been influence of drugs/alcohol?_____ How often does this occur and when is the last time?

_____

Does or has anyone in your family abused drugs or alcohol? _____ Who and to what extent?

_____

_____

Occupational Data

What sort of work are you doing now?

_____

What sort of jobs have you held in the past?

_____

_____

Does your present work satisfy you? _____ If not, what ways are you dissatisfied?

_____

_____

Sex Information

Parental attitudes toward sex (e.g was there sexual instruction or discussion at home?)_____

_____

When and how did you derive your first knowledge of sex? _____

_____

When did you first become aware of your own sexual impulses? _____

_____

Did you ever experience and anxiety or guilt feelings arising out of sex or masturbation? If yes, please explain:

_____

_____

Any relevant details regarding your first or subsequent sexual experience?_____

_____

Is your present sex life satisfactory?_____ If not, please explain: _____

_____

Have you ever experienced any sexual abuse? (*This could include fondling, inappropriate remarks, witnessing adults display sexual behavior, lack of privacy in home, coercion by adults to participate in sexual games, being "checked out" by parents to see if you are developing "properly" or having sex, intrusive touching etc):*

_____ If yes, please state the circumstances and people involved:

_____

_____

Please state what you did about it: _____

_____

Family Data

Husband/wife/partner's age_____

Occupation of husband/wife/partner_____

Personality of husband/wife/partner in your own words: _____

_____

_____

In what areas is there compatibility? _____

_____

_____

In what areas is there incompatibility? _____

_____

_____

How do you get along with your in-laws (This includes brothers and/or sisters-in-law)

_____

_____

_____

How many children do you have?_____ Please list their sex and ages: _____

Do any of your children present special problems?_____ What?_____ _____

_____

Any relevant details regarding miscarriages or abortions? _____

Comments about any previous marriage(s) and brief details: _____

_____

Has there been any physical violence between you and your spouse/partner or child(ren): _____

If so, please explain the circumstances and the action as well as when this occurred: _____

_____

_____

Has there been any verbal violence or abuse in your family?_____ If so, please explain:

_____

_____

How do you and your partner resolve conflicts or differences? _____

_____

_____

_____

Family of Origin Data

Father

Living or deceased? _____ If deceased, your age at the time of his death: _____

Cause of death? _____ If alive, father's present age?_____

Occupation: _____ Health: _____

Mother

Living or deceased? _____ If deceased, your age at the time of her death: _____

Cause of death? _____ If alive, mother's present age?_____

Occupation: _____ Health: _____

Siblings

Number of brothers:_____ Ages: _____

Number of sisters:_____ Ages: _____

Relationship with brothers and sisters:

Past: _____

Present: _____

Give description of your father's personality with his attitude toward you (past and present):

_____

_____

_____

Give description of your mother's personality with her attitude toward you (past and present):

_____

_____

_____

In what ways were you punished by your parents as a child?

_____

_____

Give an impression of your home atmosphere (i.e the home in which you grew up. Mention state of compatibility between parents and between parents and children): _____

_____

_____

_____

Were you able to confide in your parents? _____ Did your parents understand you? _____

Basically, did you feel loved and respected by your parents? _____

If you have a step parent, give your age when parent remarried: _____

Give an outline of your religious training: _____

_____

If you were not brought up by your parents, who did bring you up, and between what years?

_____

Has anyone (parents, relatives, friends) ever interfered in your marriage, occupation, etc?

_____

Who are the most important people in your life? _____

_____

Does any member of your family suffer from alcoholism, epilepsy, or anything which can be considered a "mental disorder"? _____

_____

What was your greatest challenge or difficulty growing up in your family? _____

_____

_____

Goals

List the benefits you hope to derive from this therapy: _____

_____

_____

_____

_____

_____

List any situations which make you feel calm or relaxed: _____

_____

_____

_____

_____

Please add any information not tapped by this questionnaire that may aid me in understanding and helping you:

_____

_____

_____

_____

_____

_____

Julie Ingber, MEd., LMHC, NBCC
8833 Perimeter Park Blvd., Suite 701
Jacksonville, FL 32216
904.599.3099

Patient Name_____ Date of Birth_____

Address_____

City_____ State_____ Zip Code_____

Home Phone_____ Cell Phone_____ Work Phone_____

Responsible Party_____ Relationship to Patient_____

Email_____

Driver's License #_____

Referred by_____ May I thank this person for their referral? Yes / No

---

Insurance Company_____ Policy#_____ Group #_____

Social Security #_____

Name of Policy Holder_____ Policy Holder's Date of Birth_____

Relationship to Patient_____ May we contact the policy holder?_____

Address and Phone # (if different)_____

Fees are as follows:
50-minute Individual session = $140.00
60-minute Couple's session = $175.00
90-minute Individual session = $195.00
120-minute Individual session = $280.00
Deposition/legal testimony fee per hour = $375.00
Any additional documentations or letters that need to be created by the therapist is billed at rate of $1.00 per minute. Payment is due at the time of service.

Payment is due at the time of service.

My signature below indicates that I have consented to evaluation and treatment by Julie Ingber, LMHC, NBCC. I certify that I understand the financial and billing policies for this provider and acknowledge that all of my questions have been answered to my satisfaction. I further understand and agree that I am responsible for all professional services rendered.

_____ _____
Client Signature Date

_____ _____
Therapist Signature Date

Diagnosis Code_____

Julie Ingber, MEd., LMHC, NBCC
8833 Perimeter Park Blvd., Suite 701
Jacksonville, FL 32216
Office 904.599.3099
Fax 904-713-2967

AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION

_____ _____ _____
Client Name Birth Date Social Security #

I hereby request and authorize the office of Julie Ingber, MEd., LMHC, NBCC to:
Obtain information _____
Release information _____
Exchange information_____

From or To: _____
_____
_____

The following types of information:_____
_____
For the purpose of facilitating treatment.

I hereby release and exonerate Julie R. Ingber, MEd., LMHC, NBCC from any and all liability of every nature and kind growing out or in anywise pertaining to the inspection of such documents, records, medical and psychiatric information, and hereby waive absolutely any privilege existing between client and physician under the laws of the state of Florida with reference to the information furnished by Julie Ingber, MEd., LMHC, NBCC pursuant to the Information and Authorization and Release. I understand that unless otherwise limited by the state or federal regulation, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time.

_____ _____
Client Signature Date

_____ _____
Witness Signature/ Date Client/Authorized Signature
Representative & Relationship

Use this space only if the client withdraws consent

_____ _____
Date this Consent is revoked by client Client Signature

_____Witness Signature