JENNIFER VALLI, MSW, LCSW, AASECT CERTIFIED - REGISTRATION

DATE OF FIRST VISIT: _____

PATIENT'S NAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

ADDRESS: _____

CITY:_____ STATE:_____ ZIP:_____

CELL PHONE #: (_____)_____HOME PHONE #: (_____)_____

EMAIL: _____

EMERGENCY PERSON: _____EMERGENCY PERSON'S PHONE #: (_____)_____

INSURANCE COMPANY FOR MENTAL HEALTH:_____
(please see information under financial agreement regarding insurance).

MARITAL STATUS (circle as many as apply):

MARRIED

SINGLE

DIVORCED

WIDOW

MONOGAMOUS WITH SIGNFICANT OTHER

POLYAMOROUS WITH MORE THAN ONE SIGNIFICANT OTHER

IF CLIENT IS A MINOR, NAME AND PHONE OF PARENTS

PARENT_____ PHONE_____

PARENT_____ PHONE_____

PARENT_____ PHONE_____

Jennifer Valli, MSW, LCSW, AASECT Certified - Consent for Evaluation and Treatment

Clear and direct communication is important for effective therapeutic services. This handout is to provide you with clear information regarding practice polices. It is important that you understand this information so please ask questions if you do not understand as it will constitute a binding agreement between us, as well as serve as your consent to begin therapy.

CONFIDENTIALITY: Information regarding treatment is controlled by the patient. There are exceptions to this rule:
1) By law therapists are to take whatever actions seem necessary to protect people from harm.
2) Therapists are required to contact the Department of Human Services if there is a reason to believe that someone is abusing or neglecting children, or a dependant adult.
3) If you have been referred to a therapist by court, you can assume that the court wishes to receive a report of the evaluation. In such instances, you have a right to tell the therapist only what you want me to know and be aware of the information that may be requested.
4) If you are involved in legal actions of any kind and inform the court of services that you receive from a therapist, you will be making your mental health an issue before the court. You may be waiving your right to keep your records confidential. You may wish to consult with your attorney regarding such matters before you disclose that you have received mental health treatment.
5) Most insurance companies, other payers, or manage care companies require the provider to release information regarding diagnosis, type and place of service, date of service, treatment plan, or other confidential information.
* Jennifer L. Valli requires a formal, written, release form to be completed to release any information, verbal or written, unless required by law, or the release is needed to coordinate treatment with another healthcare professional, or for payment purposes, or for general health care operations. For more information, see Notice of Privacy Practices.

BENEFIT AND RISK OF THERAPY: Therapy is an interactive process between the patient and therapist. It is meant to promote change and understanding. This process is very fulfilling but sometimes can be emotionally difficult. You will be expected to contribute to decisions regarding interventions. You have the right to refuse or alter any intervention. You are encouraged to question the rationale of treatment if it is unclear to you. While I have every expectation of helping you determine and achieve personal therapeutic goals, any specific outcome cannot be guaranteed.

AFTER HOURS POLICY: In the event of an emergency, patients should call 911, or go to the closest emergency room. In cases of urgent care, you may call (901) 299-3224. Routine questions, appointments and other non-emergency matters can be handled during your appointment. If you feel you cannot wait until our appointment time, you may call me at this number, (901) 299-3224. These phone calls will within 24 hours.

TELEPHONE CALLS/EMAILS/TEXTS: I do not interrupt sessions for incoming calls. We will use sessions to discuss clinical information. While email or text is not a method to conduct therapy, coordinating appointment times, sending appointment reminders along with links to pertinent articles are offered to you by email/text. Your signature below indicates you understand information exchanged via email cannot be guaranteed confidential.

BY SIGNING MY NAME BELOW I SHOW THAT I HAVE READ THE ABOVE INFORMATION AND IF NEEDED IT HAS BEEN EXPLAINED TO MY SATISFACTION. I HAVE HAD ALL MY QUESTIONS ABOUT FEES, CONFIDENTIALITY, INSURANCE OR OTHER MATTERS ANSWERED, AND HAVE MADE A COPY OF THIS CONTRACT IF DESIRED.

I,_____, HEREBY CONSENT TO EVALUATION AND TREATMENT.

Signature:_____Date:_____

Jennifer Valli, MSW, LCSW, AASECT Certified – Financial Agreement

Payment

Cash, checks and credit cards are accepted. If you are paying by credit card, a 3% convenience fee will added to each session. Payment is due at the time of services. We ask that you pay at beginning of the session and have checks written out in advance as to not take up our session time to do this. Fees may be periodically adjusted for inflation and fair market value of the services provided however any increases will be communicated well in advance of the effective date.

There may be charges for questionnaires or letters that are not normally required for billing or treatment purposes, phone consults that exceed 15 minutes, and medical record requests. If a check is returned by your bank for insufficient funds, there will be a charge of $25 to cover the cost to my bank. For any required legal depositions, there will be a prepaid, non-refundable charge of $300 per hour, with a minimum of 3 hours.

Insurance

I do not accept insurance but will generate a superbill that clients can submit to insurance companies directly if they would like to file themselves. Not every plan offers an out-of-network benefit. While sexual health is not typically covered, some services for other mental health issues may be covered in part. Each insurance company varies so please check with them directly to know first if you have an out-of-network benefit and the specifics of your particular plan. If you wish to file yourself as part of an out-of-network benefit, please let me know at the time of the session.

Cancellation Policy

If you are unable to keep an appointment, please notify us at (901) 299-3224 as soon as possible. This will enable us to accommodate other patients and those on a waiting list. If you have not notified me at least 24 hours in advance, you will be charged half of the fee of the session. If this occurs subsequently, you will be billed for the session as it is your reserved time and I will be unable to fill this time slot without advanced notice.

Keeping your balance current

We ask that every effort will be made to keep your account current financially as this is part of mutually respectful relationship. In the event that the account becomes delinquent, the responsible party agrees to pay for attorney and/or collection fees that might occur. The account will become delinquent after it has matured to 121 days from the date of service. If the account goes to collections, there will be an added 33% to the account balance. The office of Jennifer L. Valli will determine the collection agency.

By signing below you have agreed to all the terms in this financial agreement.

PATIENT/RESPONSIBLE PARTY **DATE**

1. VERIFICATION OF NOTICE OF PRIVACY POLICY

I, _____ have read Jennifer L. Valli's Notice of Privacy Practices and have asked questions if they were not clear to me.

_____

Patient Signature of Guarantor Date

*If signature was not given, please provide efforts in attempting to obtain signature.

*********Complete this part of the form only if the patient is a minor or an adult dependant**********

2. AUTHORIZATION FOR EVALUATION AND TREATMENT OF MINORS AND ADULT DEPENDANTS

I certify that I am the parent or legal custodial guardian of _____ who is a minor or adult dependant.

_____

(Signature) (Date)

I authorize Jennifer L. Valli, LCSW, to conduct an evaluation and treatment of _____. Such an evaluation may include, but is not limited to personal interviews, review of treatment records, and other generally accepted practices in the field of mental health. Such treatment may include, but is not limited to individual psychotherapy, group treatment, family therapy, or specialized therapeutic procedures, which are generally accepted in the field of mental health.

_____

(Signature) (Date)

CONFIDENTIAL CLIENT QUESTIONNAIRE

Please circle areas of concern

Worry	Depression	Fear
Drug or Alcohol	Friends	Finances
Anger	Self-Control	Unhappiness
Lack of Energy	Stress	Work/Career Stress
Mood Swings	Appetite or Eating Related	Trauma
Inability to Feel Calm	Thoughts of Harming Self	Thoughts of Harming Others
Legal Matters	Memory	Making Decisions
Loss	Insomnia or Feeling Exhausted	Feelings of Inferiority
Health Problems	Loneliness	My Children or Being a Parent
Poor Concentration	Social Anxiety	Infertility
Lower Sexual Desire	My Thoughts	No Intimacy in my Relationship
Poor Body Image	Relationship Issues	Hypersexual Behaviors
Menopause Related	Painful Intercourse	Gay, Lesbian, Bisexual Concerns
Transgender	Concerns related to Sexuality	Sexually Transmitted Disease
Concerns related to Porn	Concerns related to Infidelity	Erectile Dysfunction
Bothersome Sexual Fetishes	Premature Ejaculation	Sexual-Related Performance Anxiety
Change in Sexual Functioning	Surviving after Unwanted or Negative Past Sexual Experience	

Briefly describe your reason for seeking help and your goals for treatment:

_____

_____

_____

Who suggested you seek treatment? _____

If you were ever been under the care of a psychiatrist to follow medicines for a mental health issue, please state condition for which you were / are being treated (for example, Bipolar Disorder, Generalized Anxiety Disorder, etc.).

Have you seen a therapist or counselor in the past? ___No
___Yes; Please list name of professional
_____

Have you ever been admitted to a psychiatric hospital? If yes: list reason for and date of the admission/s.

_____

_____

Do you have any medical problems? Please explain, and list doctor's name and phone number:

_____

_____

Allergies: _____ ____ None Are you pregnant ___yes ___no

Do you smoke? __Yes __No If yes, how much?_____ For long?_____

Do you consume caffeine? __yes __no If yes, how much?_____

Please list any medications you take regularly.

Name of Medication	Dose	Frequency	Reason for Medication

_____

_____

_____

_____

_____

Your Occupation: _____ Highest degree completed:_____

Leisure interests_____ Languages Spoken_____

Who do you live with_____

Describe your support system:_____

Do you attend a church or synagogue regularly please list: _____

Physician Communication Form

Communication between behavioral health providers and other doctors is important to help ensure all patients receive comprehensive and quality health care. This information is not released without the patient's consent. Know that information relating to sexual health is shared with very limited details. Many times a communication form is sent, simply letting the other provider know that you have decided to enter therapy. Below please find the consent or refusal to release information to coordinate care. The patient may revoke this consent in writing at any point.

Please check off one of the following 2 options.

___I will initial here & I do not want to release any information.

OR

___I will initial each & authorize Jennifer Valli, MSW, LCSW to exchange and release information with the following people (initial here and below):

___My Primary Care Physician's Name, City & Phone number is:

_____

_____

___My Psychiatrist's Name, City & Phone number:

_____

_____

___My OB- GYN's Name, City & Phone number:

_____

_____

___My Urologist's Name, City & Phone Number:

_____

_____

****SIGNATURE OF PATIENT:_____ date: _____