INSTRUCTIONS:

You may print this form out and fill it in by hand or you may fill out the form using Adobe Acrobat Reader's (it's free) fill and sign function or an equivalent program

When completed you may return it to me via Email: info@lifescriptcounseling.com

Alternatively, you may print it out, fill it in by hand and bring it with you to our first session, or FAX: 585-787-7478.

Thank You!

INTAKE FORM

PERSONAL DATA

Date: _____

Name: _____

Street: _____

City: _____

State: _____ Zip: _____

Birth City: _____

Birth State: _____

Age: _____ Birth Date: _____

Home Phone #: _____

Mobile #: _____

E-Mail: _____

EMPLOYMENT DATA

Employer: _____

Street: _____

City: _____

State: _____ Zip: _____

Job Title: _____

Years Employed: _____

Work Phone #: _____

EMERGENCY CONTACT INFORMATION

Name of person to contact: _____ Phone #: _____

Relationship to you: _____

If you live outside of Monroe county—What County: _____

If you live outside of Monroe County:

Police or Emergency Services # for your area (Not 911): _____

EDUCATIONAL DATA

Highest Grade Completed: ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ AAS ☐ BA/BS ☐ MASTERS ☐ PhD

Degrees:_____

IF YOU ARE CURRENTLY A STUDENT:

School Name: _____

Street: _____

City:_____

State: _____ Zip: _____

Insurance (Does not apply to Medicaid/Medicare):

Does your insurance plan have out of network coverage? ☐ Yes ☐ No ☐ Not Sure

If you are not certain about the coverage, please find out and let me know. If you have out of network coverage I will provide a super bill that you can submit to your insurance company so they may reimburse you.

MARTIAL STATUS:

☐ Single/Not Married

☐ Never Married

☐ Married — How Long:_____ Partner's Name_____ Age:____

☐ Single w/Partner — How Long?_____ Partner's Name_____ Age:____

☐ Separated — How Long:_____ Ex-spouse's Name_____

☐ Divorced — How Long:_____ Ex-spouse's Name_____

CHILDREN (First Name Only)

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

MEDICAL

Primary Care Physician (PCP)

Name:_____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Date of last physical: _____ May I contact Your PCP? ☐ Yes ☐ No Initials: _____

List names of any other physicians you are currently seeing, and the condition they are treating you for

Name:_____ Address: _____

Condition:_____

Name:_____ Address: _____

Condition:_____

Are you taking any prescription drugs at this time? ☐ Yes ☐ No

If **YES**, please list name of medication and condition prescribed for:

Medication:_____ Dosage: _____ Condition_____

Medication:_____ Dosage: _____ Condition_____

Medication:_____ Dosage: _____ Condition_____

Medication:_____ Dosage: _____ Condition_____

Do you have any food allergies? ☐ NO ☐ YES

Do you have hay fever, mold, or tree/grass/weed pollen allergies? ☐ NO ☐ YES

Do you have any other allergies? ☐ NO ☐ YES

Would you like to minimize or possibly eliminate these allergies? ☐ NO ☐ YES

FAMILY HISTORY

The following information will help me understand you and your relationship(s) to your family. Please fill out those which apply to you .

Father:_____ Age:_____

Year Deceased:_____ Cause of death:_____

Mother:_____ Age:_____

Year Deceased:_____ Cause of death:_____

Step mother:_____ Age:_____

Year Deceased:_____ Cause of death:_____

Step father:_____ Age:_____

Year Deceased:_____ Cause of death:_____

Describe your childhood experience of your father/step father:

Describe your childhood experience of your mother/step mother:

Number of **Brothers:**_____ Name:_____ Age:_____

Name:_____ Age:_____ Name:_____ Age:_____

Name:_____ Age:_____ Name:_____ Age:_____

Number of **Sisters:**_____ Name:_____ Age:_____

Name:_____ Age:_____ Name:_____ Age:_____

Name:_____ Age:_____ Name:_____ Age:_____

What type of relationship do you have with your siblings?

Details

Have any of your brothers or sisters attended counseling before? ☐ NO ☐ YES ☐ ???

Details

Have any of your parents or stepparents attended counseling before? ☐ NO ☐ YES ☐ ???

Details

Any history of drug or alcohol abuse in your father's family, including your father? ☐ NO ☐ YES ☐ ???

Details

Any history of drug or alcohol abuse in your mother's family, including your mother? ☐ NO ☐ YES ☐ ???

Details

Any history of drug or alcohol abuse with you? ☐ NO ☐ YES

Details

If yes, what made you use or continue to use?

Details

Any history of drug or alcohol abuse with your spouse/partner? ☐ NO ☐ YES ☐ N/A ☐ ???

Details

Any history of traumatic events experienced by your father or his parents? ☐ NO ☐ YES ☐ ???

Details

Any history of traumatic events experienced by your mother or her parents? ☐ NO ☐ YES ☐ ???

Details

What Religion were you raised in? _____

What spiritual practices do you indulge yourself in? (ex. meditation, yoga, music, art, etc.)

Details

Have you either witnessed or been the victim of any of the following: ☐ NO ☐ YES
If ***YES*** then check all that apply

☐ Sexual abuse or rape? Who was the perpetrator? _____
☐ Physical abuse Who was the perpetrator? _____
☐ Emotional or mental abuse? Who was the perpetrator? _____
☐ Financial Abuse? Who was the perpetrator? _____
☐ Spiritual or religious Abuse? Who was the perpetrator? _____
☐ Cult or Ritual Abuse? Who was the perpetrator? _____

Did other family members witness any of the abuses checked above? ☐ NO ☐ YES ☐ N/A ☐ ???

Details

Were any other family members victims of the abuses checked above? ☐ NO ☐ YES ☐ N/A ☐ ???

Details

Were drugs or alcohol involved in the abuse? ☐ NO ☐ YES ☐ N/A ☐ ???

Details

How has this experience affected your life?

Details

Any history of physical abuse to your spouse/partner? ☐ NO ☐ YES ☐ N/A ☐ ???

Details

Any physical problems that you feel has affected your life? ☐ NO ☐ YES ☐ N/A

Details

Any history of sexual abuse to your spouse/partner? ☐ NO ☐ YES ☐ N/A ☐ ???

Details

Have you ever experienced any sexual difficulties? ☐ NO ☐ YES ☐ N/A

Details

Do you ever feel like someone or something has taken over your body or mind? ☐ NO ☐ YES

If ***YES***, what percentage of the time? _____

Have you ever had counseling before? ☐ NO ☐ YES How Long:_____

When:_____ Where:_____

Facilitator(s)/Details: _____

Has your spouse/partner ever had counseling before? ☐ NO ☐ YES How Long:_____

When:_____ Where:_____

Facilitator(s)/Details: _____

Have you ever been a member of a self-help group? ☐ NO ☐ YES How Long:_____

When:_____ Where:_____

Facilitator(s)/Details: _____

Have you ever suffered a significant loss, such as a:

Job ☐ NO ☐ YES_____

Family member or other loved one ☐ NO ☐ YES_____

Abortion ☐ NO ☐ YES _____

Miscarriage ☐ NO ☐ YES_____

Have you ever had major surgery? ☐ NO ☐ YES..._____

Have you ever been in the military/police/fire/EMT/First Responders? ☐ NO ☐ YES Branch:_____

If **YES**, did you witness or were you a part of any traumatic events in the line of duty?: ☐ NO ☐ YES

Details

Have you ever been in a serious car accident or other disaster? ☐ NO ☐ YES

Details

Any particular fears, phobias or anxieties I should be aware of? ☐ NO ☐ YES

Details

Do you: Smoke? ☐ NO ☐ YES How many packs a day? _____

Use Alcohol? ☐ NO ☐ YES How many drinks per day? _____

Use Illegal drugs? ☐ NO ☐ YES What type? _____

How much/often? _____

If Yes to any of the above: Do you want to quit? ☐ NO ☐ YES

List three goals that you want to accomplish in your counseling & growth:

1. _____
2. _____
3. _____

List your last three employers:

1. _____ From:_____ To:_____

Reason For Leaving the above Job: _____

2. _____ From:_____ To:_____

Reason For Leaving the above Job: _____

3. _____ From:_____ To:_____

Reason For Leaving the above Job: _____

ACE (Adverse Childhood Experience) Score

Place an X in the Yes or No box for each question

QUESTION:	**YES**	**NO**
Did a parent or other adult in the household **often or very often** swear at you, insult you, humiliate you, or put you down, ***OR*** act in a way that made you afraid that you might be physically hurt?	☐	☐
Did a parent or other adult in the household **often** or **very often** push, grab, slap, or throw something at you ***OR*** ever hit you so hard that you had marks or were injured?	☐	☐
Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way, ***OR*** attempt to have anal, oral or vaginal intercourse with you?	☐	☐
Did you **often or very often** feel that no one in your family loved you or thought you were important or special ***OR*** that your family did not look out for each other or support each other?	☐	☐
Did you **often or very often** feel that you didn't have enough to eat, had to wear dirty clothes, and Had no one to protect you, ***OR*** your parents were too drunk or too high to take care of you ***OR*** take you to a doctor if you needed it?	☐	☐
Were your parents ever separated or divorced?	☐	☐
Was your mother or stepmother **often or very often** pushed, grabbed, slapped or had something thrown at her, ***OR***, sometimes, often or very often kicked, bitten, or hit with a fist or hit with some thing hard, ***OR***, ever repeatedly hit at least a few minutes or threatened with a gun or a knife?	☐	☐
Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	☐	☐
Was a household member depressed or mentally ill, ***OR*** did a household member commit suicide?	☐	☐
Did a household member go to prison?	☐	☐
For office use only:		

Candida

If your answer to a statement is ***yes*** or ***true***, circle the number after the statement.

Have you taken antibiotics (penicillin, amoxicillin, etc) short term or long term?	4	☐
Do you feel "sick all over," yet the cause hasn't been found?	3	☐
Are you bothered by hormone disturbances, including PMS, menstrual irregularities, sexual dysfunction, sugar craving, low body temperature or fatigue?	2	☐
Are you unusually sensitive to tobacco smoke, perfumes, colognes and other chemical odors?	2	☐
Are you bothered by memory or concentration problems or do you sometimes feel "spaced out"?	2	☐
Have you taken prolonged courses of Prednisone or other steroids; or have you taken "the pill" for more than 3 years?	2	☐
Do some foods disagree with you or trigger your symptoms?	1	☐
Do you suffer with constipation, diarrhea, bloating, or abdominal pain?	1	☐
Does your skin itch, tingle or burn; or is it unusually dry; or are you bothered by rashes?	1	☐
	Total Score	

Scoring for women:	9 or greater	Probably;	12 or greater	most certainly
Scoring for men:	7 or greater	Probably;	10 or greater	most certainly

Depression Screening: PHQ-9

Answer each of the following questions with regard to how you have felt over the last two weeks.

Circle the number that represents the amount of time you experience the symptom or topic

Symptom or Topic	*Not at all*	*Several Days*	*More than half the days*	*Nearly every day*
Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
Feeling down, depressed, or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
Trouble falling or staying asleep, or sleeping to much	0 ☐	1 ☐	2 ☐	3 ☐
Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐
Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐
Feeling bad about your self, that you are a failure	0 ☐	1 ☐	2 ☐	3 ☐
Trouble concentrating on tasks or activities like reading or watching TV	0 ☐	1 ☐	2 ☐	3 ☐
Moving or speaking slowly, or being fidgety & restless	0 ☐	1 ☐	2 ☐	3 ☐
Thoughts that you would be better off dead or of hurting yourself or someone	0 ☐	1 ☐	2 ☐	3 ☐
For office use only:				
How difficult have these problems made it for you to work, take care of things at home or get along with others?	Not Difficult	Some-what Difficult	Very Difficult	Extreme Difficulty

*These questions are to ask about things you may have felt most days in the **past six months**.*

Most days I feel very nervous.	YES ☐	NO ☐
Most days I worry about lots of things.	YES ☐	NO ☐
Most days I cannot stop worrying	YES ☐	NO ☐
Most days my worry is hard to control.	YES ☐	NO ☐
I feel restless, keyed up or on edge.	YES ☐	NO ☐
I get tired easily.	YES ☐	NO ☐
I have trouble concentrating	YES ☐	NO ☐
I am easily annoyed or irritated.	YES ☐	NO ☐
My muscles are tense and tight.	YES ☐	NO ☐
I have trouble sleeping.	YES ☐	NO ☐
Did the things you noted above affect your daily life (at home, work or leisure) or cause you a lot of distress?	YES ☐	NO ☐
Were the things you noted above bad enough that you thought about getting help for them?	YES ☐	NO ☐

Post Traumatic Stress Disorder Check List

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Use the below scoring to indicate how much you have been bothered by the experience.

1 = Not at all ***2 = A little bit*** ***3 = Moderately*** ***4 = Quite a bit*** ***5 = Extremely***

1.	Repeated, disturbing memories, thoughts or images of a stressful military OR civilian experience.	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
2.	Repeated, disturbing dreams of a stressful military OR civilian experience.	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
3.	Suddenly acting or feeling as if a stressful military OR civilian experience were happening again, as if you were reliving it.	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
4.	Feeling very upset when something reminded you of a stressful military OR civilian experience	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
5.	Having physical reactions (e.g: heart pounding, trouble breathing, sweating) when something reminded you of a stressful military OR civilian experience.	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
6.	Avoiding thinking about or talking about a stressful military OR civilian experience or avoiding having feelings related to it.	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
7.	Avoiding activities or situations because they remind you of a stressful military OR civilian experiences	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
8.	Trouble remembering important parts of a stressful military OR civilian experience.	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
9.	Loss of interest in activities that you used enjoy.	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
10.	Feeling distant or cut off from other people.	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
11.	Feeling emotionally numb or being unable to have loving feelings towards those close to you.	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
12.	Feeling as if your future will somehow be cut short	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
13.	Trouble falling or staying asleep	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
14.	Feeling irritable or having angry outbursts	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
15.	Having difficulty concentrating	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
16.	Being "super-alert" or watchful or on guard	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐
17.	Feeling jumpy or easily startled	1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

For office use only: ☐ ☐ ☐ ☐ ☐

Scoring: 17 —- None: Less than 22 – Questionable; 22 – 44 Sub Clinical; Greater than 50 — Clinical

Total ☐

Moral Injury Events Scale (MIES)

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Use the below scoring to indicate how much you have been bothered by the experience.

1 = Strongly Disagree 2 = Moderately Disagree 3 = Slightly Disagree
4 = Slightly Agree 5 = Moderately Agree 6 = Strongly Agree

1.	I saw things that were morally wrong.	☐1	☐2	☐3	☐4	☐5	☐6
2.	I am troubled by having witnessed others' immoral acts	☐1	☐2	☐3	☐4	☐5	☐6
3	I acted in ways that violated my own moral code or values	☐1	☐2	☐3	☐4	☐5	☐6
4.	I am troubled by having acted in ways that violated my own morals or values	☐1	☐2	☐3	☐4	☐5	☐6
5.	I violated my own morals by failing to do something that I felt I should have done	☐1	☐2	☐3	☐4	☐5	☐6
6.	I am troubled because I violated my morals by failing to do something I felt I should have done	☐1	☐2	☐3	☐4	☐5	☐6
7.	I feel betrayed by leaders who I once trusted	☐1	☐2	☐3	☐4	☐5	☐6
8.	***Veterans Only***: I feel betrayed by fellow service members who I once trusted	☐1	☐2	☐3	☐4	☐5	☐6
9.	***Veterans Only***: I feel betrayed by others outside the U.S. military who I once trusted	☐1	☐2	☐3	☐4	☐5	☐6

For Office Use Only:

Scoring:
9 or less — None: 10 to 22 — Some; 27 to 36 — moderate; 36 or above — severe

Total

Anger Evaluation

1	Are you habitually impatient?	Yes ☐	No ☐
2	Are you often frustrated?	Yes ☐	No ☐
3	Do others seem to constantly be "in your way?	Yes ☐	No ☐
4	Are you usually on your guard against being cheated?	Yes ☐	No ☐
5	Do you feel a more or less constant pressure to prove yourself?	Yes ☐	No ☐
6	Are you habitually fearful of somehow being "caught"?	Yes ☐	No ☐
7	Does it seem (or feel) that someone is always watching you ?	Yes ☐	No ☐
8	Do you secretly resent others' success, feeling that yours is never recognized?	Yes ☐	No ☐
9	Are the negative things in your life more obvious to you than the positive?	Yes ☐	No ☐
10	Do you habitually find a lot to complain about ?	Yes ☐	No ☐
11	Do you often feel insecure, believing that others are superior to you	Yes ☐	No ☐
12	Are you afraid you will end up with less than you need?	Yes ☐	No ☐
13	Do you habitually expect bad things to happen?	Yes ☐	No ☐
14	Is it hard for you to "go with the flow" ?	Yes ☐	No ☐
15	Is it often difficult for you to stand up for yourself?	Yes ☐	No ☐
16	Do you secretly believe that your feelings are not important?	Yes ☐	No ☐
17	Do you usually keep your preferences to yourself, often deferring to what others want?	Yes ☐	No ☐
18	Do you feel your needs are often minimized or ignored altogether?	Yes ☐	No ☐
19	Do you have temper tantrums ?	Yes ☐	No ☐
20	Do you regularly tend to overreact?	Yes ☐	No ☐
21	Is it hard for you to accept that others care about and love you?	Yes ☐	No ☐
22	Are you frequently afraid that somehow you are "missing out" on what counts?	Yes ☐	No ☐
23	Are you often disrespectful to those with less power than yourself ?	Yes ☐	No ☐
24	Does the intimacy of others somehow make you uncomfortable?	Yes ☐	No ☐

For office use only:		

How did you find out about me?

☐ Personal Referral

Who Referred you? _____

May I send this person a thank you card? ☐ NO ☐ YES

If ***YES:*** Their Address: _____

City: _____ State: _____ Zip: _____

☐ Google Search

☐ Psychology Today Web Site

☐ HelpPro Web Site

☐ ThumbTack

☐ Good Therapy

☐ ACEP Web Site

☐ EFT Universe Web Site

☐ The Tapping Solution/Tapping International Web Site

☐ Veteran's Stress Project

☐ Legends 102.7/WLGZ/Save Our Soldiers

Other Web Site: _____

Some other method: _____

Did you visit my web site before calling me? ☐ NO ☐ YES

Was my web site helpful in your decision? ☐ NO ☐ YES

Life Script Mental Health Counseling Services PLLC

"Helping YOU Reclaim Your Life"

Tom Porpiglia, MS, LMHC, DCEP, EFT-ADV, EAS-C,

585-704-0376 ❖ info@lifescriptcounseling.com

www.lifescriptcounseling.com

Directions/Instructions:

You will need Adobe Acrobat Reader DC or an equivalent program to open and fill in this document. You may also print it out and fill it in by hand.

Please Read and initial each section carefully. If you have any questions, please let me know.

Be sure to sign and date the last page – Both Sides.

Once you have filled in the appropriate information, please save a copy for your file and return entire packet/document to me via email to me at info@lifescriptcounseling.com or fax to 585-787-7478.

Thank You.

INFORMATION & CONSENT

Please read each section carefully and initial each section. By initialing each section, you are stating that you have read, understand, and agree to the content in each section. Signing this document constitutes both a receipt of my office policies, and consent to do therapy. If you have any questions or concerns, please ask me.

Thank you for choosing me as your counselor/therapist. This document is designed to inform you about my background and to ensure that you understand our professional relationship.

I have a Bachelor of Science degree in Human Development and a Master of Science in Counseling Psychology. I use a wide variety of traditional and alternative tools to help you attain the healing you desire. I am only a guide. This is your work and you have the answers inside of you. It is my job to help you discover the answers. I am also certified as a Diplomate of Comprehensive Energy Psychology and an Employee Assistance Specialist – Clinician as well as several levels of training in Energy Psychology Techniques.

All of the techniques I use have plenty of clinical evidence and support, are highly effective, and some are novel falling under the heading of Energy Psychology (EP); the use of the body's energy systems to release issues of any type and create healing. My primary EP technique is Emotional Freedom Techniques, also known as EFT tapping or tapping. I also use other psycho energetic protocols like Tapas Acupressure Technique (TAT), Eden Energy Medicine (EEM), and Allergy Antidotes. Strong emotions may arise when clearing your energy field when using any of these techniques. It is wise to drink plenty of water after a session to help flush out toxins that are released into your system. Failure to do so may result in you feeling ill or unpleasant. These techniques may involve me having safe, respectful, physical contact on safe areas of your body with your permission.

Initial: _____

Our First Session:

During our first session I will answer any questions about this consent form, our sessions and we will review your intake form. I may ask more questions about your intake information to gather more information. I will either explain EFT tapping to you or show you a short video to help you understand how we will be proceeding during sessions.

Initial: _____

Duration of Therapy:

The duration of therapy varies, based on the individual and the presenting issues. Individual results will vary. You may terminate at any time you feel you have achieved your goals. If you are an EAP referral, that may be when you have used up your allocated number of sessions and you have the option of continuing on with me or being referred to someone else. If you are a long term client, (greater than 6 months) I ask that when the time comes to end our relationship you terminate our relationship formally and cleanly. To do so leaves the door open for the future and gives us a chance to clean up any unfinished business.
Appropriate and acceptable termination is to give two sessions if you are a weekly client, or two weeks' notice of you are a weekly client, of your intent to terminate our relationship. This gives us both time to reflect on

what each of us needs to say or do to bring the relationship to a close. Failure to honor this agreement will result in your receiving a bill for the remaining sessions. I reserve the right to terminate this agreement without notice in the event of abusive, dangerous, unhealthy, disrespectful or irresolvable situations.

Initial: _____

Confidentiality/Disclosure:

Confidentiality in therapy is a must; therefore, I will not divulge anything you tell me without written consent, except under the following circumstances:

- I am ordered by a court to disclose information.
- My need to discuss your case with my supervisor.
- You give me to permission tell someone else, via signed release.
- I determine that you are a danger to yourself or others.
- You reveal that you are abusing a child (Federal Law mandates this be reported).
- You may review or get a copy of your PHI, Personal Health Information/Intake Form by providing me a written request. This does not include case notes which are excluded by HIPPA.

Initial: _____

Client Agrees to:

- Arrive on time. You are responsible for showing up for your appointment. I do not call or text reminders.
- Respect my right to privacy.
    - You only have a right to be on the premise if you have an appointment with me.
    - You may ask personal questions and I have a right to not answer them based on my judgement of unnecessary or inappropriate disclosure
- If you are paying by check, please have checks written when you arrive for session.
- Be as open, honest and vulnerable as possible.
- Pay for missed or inappropriately canceled sessions.
- Pay for additional letter writing at the rate of $25/hour: Minimum Charge: $25
- Be willing to stretch and take risks when appropriate.
- Pay bounced check fees imposed by the bank plus $15.00.
- Be responsible for all fees incurred in the collection of outstanding debts (any debt 90 days past due)
- Provide 24-hour advanced notification to cancel a scheduled appointment. Failure to do so will result in your account being charged the full amount and no further appointments will be provided until the debt is settled.
- **Stay home if you are ill. No penalty if you reschedule within 7 business days.**
- Give two sessions or two weeks' notice of intent to terminate our relationship. (See Duration of Therapy)
- Not give me expensive gifts, invite me to social functions or expect social connection. (See Dual Relationships)
- Let me know if you need a statement for insurance purposes.
- **Provide local police/sheriff phone number (not 911) if outside of Monroe County, NYS**

Initial: _____

Counselor Agrees to:

- Maintain confidentiality.
- Provide 30-day notice of fee increases.
- Provide you with a high standard of service.
- Guide you in identifying and resolving issues.
- Support you in taking healthy stretches and risks.
- Help you gain awareness and insight about yourself.
- Make referrals to other professionals where appropriate.
- Believe in you and your ability to grow, change and heal.
- Abide by the Ethical Standards of organizations I belong to.
- Be supportive, helpful, honest, respectful, compassionate & empathetic.
- Provide, upon request, copies of the Ethical Standards and Codes of Conduct by which I abide.
- Work toward a viable resolution of any complaints or concerns you have about my services or conduct.
- Provide services in 60-minute sessions, unless you are late for your appointment. Extended sessions will be billed accordingly.
- Provide, upon request, phone numbers of the organizations I belong to in the event that you feel it necessary to file a grievance.
- Send you a monthly statement, usually via Email, should you request one for insurance purposes. Otherwise, I do not send them out.

Initial: _____

Dual Relationships:

Professional Ethics Standards prohibit Dual Relationships. This refers to a relationship that exists outside of our Counseling Relationship. I will not enter into any business or other social relationship with you. Should we run into each other in public, a simple acknowledgment of each other is appropriate if you choose to acknowledge me. I will take my cue from you and If you do not acknowledge me, I will not acknowledge you or take offence. This remains in effect after the termination of the therapeutic relationship.

Initial: _____

Perfumes & Colognes:

Please do not wear perfumes or colognes to session as I am allergic to many of them. This includes deodorants and antiperspirants that have a noticeable odor to them

Initial: _____

Footwear:

Please remove your shoes and/or boots when you arrive, regardless of the season. Feel free to bring slippers or socks to wear during session.

Initial: _____

Scheduling or Changing Appointments/Communicating w/Me:

- Appointments may be scheduled or changed via telephone/voicemail, or email or text.

- My voice mail is confidential and secure; email and texting are not secure.
- You may request a schedule change via text; however, I will send that info to you via email. It's just easier for me to use a regular keyboard
- Email has limited security, so keep your data/information to a minimum.
- Communicating with me via Facebook is not an option nor is it advised as it is not a secure form of communication.

Initial: _____

Organizational Memberships:

- ACEP Association for Comprehensive Energy Psychology
- NYMHCA New York Mental Health Counselors Association
- EAPA Employee Assistance Professionals Association
- Irondequoit Chamber of Commerce

Initial: _____

Insurance:

I do not accept insurance of any type. This is a benefit to you since you will not be limited to the number of visits you can have during the year and preserves your confidentiality. These expenses are also a legitimate medical expense and tax deductions, as is your mileage to and from your appointments.

Some insurance policies offer out-of-network coverage (OONC). You will need to check with your provider. If you have OONC, I will supply you with a super bill that will include insurance codes and procedure codes so you can submit it for reimbursement.

NYS No Fault will require pre-authorization from your insurance provider.

Currently, NYS Licensed Mental Health Counselors cannot accept Worker's Compensation, Medicaid or Medicare.

Worker's Compensation Cases (WCB): It is against the law for you to pay out of pocket for any services related to your case. If I accepted your case without WCB approval I could lose my license, and I am not willing to do that. However, you may attempt to get the WCB to approve treatment by me.

Initial: _____

Telehealth Video Sessions/Distance Counseling

I offer telehealth sessions over the internet for clients not in the immediate Rochester area or who are unable to travel to my office. This option is also available and valuable during inclement weather as it allows us to keep appointments and not have to travel. The program I use is VSee which is HIPPA compliant, offers better quality, reliability and security than Skype. It is a free program and I will send you an invitation to download and install it if you choose this option. While this platform is secure, there is no 100% guarantee that information disclosed during sessions is safe. Head phones or ear buds with a microphone are recommended for security reasons and to cut down on background noise. It is also recommended that you have a private place away from other family members to conduct your sessions in. Please have Skype installed as a backup program.

Initial: _____

Your Appreciation of My Services, Time & Skills:

I accept cash, checks, (payable to Tom Porpiglia) Visa, MasterCard, Discover Card, American Express and FSA/HSA cards. You must pre-authorize the use of your credit card(s) if you wish to use it to pay for services at any time. There is a form later in this document for you to fill out. *Please have checks or cash ready and available at the beginning of each session. All accounts past due 90 days will be submitted for collection.*

All sessions are 60 Minutes in Duration:

	Standard	Pre-Pay 3 Save 10%	Pre-Pay 6 Save 12.5%
Individual	$110.00	$297.00	$577.50
Couples	$125.00	$337.50	$656.25
Veterans with PTSD	6 Free Sessions.	See next row	See next row
Veterans –reasons other than PTSD And Students	$85.00	$229.50	$446.25
Veteran Couples	$100.00	$270.00	$525.00
Open Path Collective	You must be an Open Path Collective Member		
Letter Writing/SSD Forms, etc.	$25/hr minimum.		
Reading long emails (longer than 5 minutes)	$25/quarter hour.		

Pre-Pay Refund Policy:

The discount is based on the usage of all sessions that you pre-paid for. If you do not use all of the sessions you have 2 options:

1. Leave the balance on account for future sessions.
2. Request a refund in writing within 30 days of your last visit. The amount of your refund will be pro-rated based on number of sessions used vs. paid for. Requests for refunds beyond 30 days will not be honored.
3. Missed Sessions are charged at the full rate. I reserve the right to make adjustments in the fee schedule based on unusual or extraordinary circumstances. 30-day written notice of fee increases will be given. Other terms subject to change without notice.

Initial: _____

Consent & Agreement:

I agree to honor the terms and conditions set forth in this document. I promise to pay the current, appropriate, agreed upon session fee. I also agree to be responsible for all bank fees, collection agency fees or legal fees incurred in the collection of outstanding debts. In addition, I acknowledge and agree to appropriate safe, physical contact during the course of treatment with EFT, TAT or Allergy Antidotes, when necessary

I also authorize Tom Porpiglia of *Life Script Mental Health Counseling Services PLLC*, to keep my credit card number and signature on file and to charge my Visa, MasterCard American Express, Discover, FSA/HSA card for recurring session charges in accordance with the agreed upon session price and corresponding charges determined by the table on the previous page. Missed sessions will be charged at the maximum rate defined in the table on the previous page.

If I am paying by other means (check or cash), I agree to have my card charged in the event that I fail to attend a scheduled session, or return phone message, emails or text messages about the missed session and fail to reschedule

I understand this form is valid until termination of services. I promise not to dispute charges ("charge back") for sessions I have received or that I have not cancelled 24 hours prior to a scheduled session. I further authorize Tom Porpiglia of *Life Script Mental Health Counseling Services PLLC* to disclose information about my attendance/cancellation to my credit card issuer if I dispute a charge.

I also agree that in the event of an emergency Tom Porpiglia of *Life Script Mental Health Counseling Services PLLC* may contact my emergency contact person or emergency services and disclose necessary information.

Client Signature: _____ Date: _____

If couples counseling:

Partner's Signature: _____

If client is a minor:

Parent or Guardian: _____

Credit Card Pre-Authorization:

1. *Required regardless of your chosen method of payment*
2. *Required even if you are an EAP referral*
3. Credit Card information is stored in a very safe and secure manner.
4. ***If you are returning this document via email, please give me your CC number during our first session and note that in place of your card number. Please do sign and date.***

Card Number: _____ Exp. Date: _____

Cardholder Signature: _____ Date: _____

If different from information on intake form:

Cardholder Name: _____

Billing Address: _____

City: _____ State: _____ Zip: _____