MADRIGAL
CONSULTING & COUNSELING, LLP

(630) 474-3900
(630) 474-3903 fax
Email: info@madrigalconsultingandcounseling.com

Student's Name: _____

Classroom Number: _____

School Counselor: _____

Please assist us in assuring the following have been completed and signed prior to sending to Madrigal Consulting and Counseling, LLP:

- ❑ Client Intake Questionnaire
- ❑ Insurance Authorization Form & Financial Policy
- ❑ Credit Card Authorization Form
- ❑ Consent for Treatment and Limits of Liability
- ❑ Authorization for Use and Disclosure of PHI & Education Records
- ❑ Copy of insurance card

Please send completed Madrigal Consulting and Counseling, LLP intake forms to:

info@madrigalconsultingandcounseling.com -or- fax (630) 474-3903

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Client Intake Questionnaire

Please complete this form and bring it with you to your first session.
Please note: information provided on this form is protected as confidential information.

Personal Information

Name:_____ Date:_____
Parent/Legal Guardian (if under 18): _____
Address:_____ City:_____ Zip Code:_____
Home Phone:_____ May we leave a message? ___Yes ___No
Cell/Work/Other Phone:_____ May we text/leave a message? ___Yes ___No
Email:_____ May we email? ___Yes ___No
Cell Phone (for client under 18):_____ May we text/leave a message? ___Yes ___No
Email (for client under 18):_____ May we email? ___Yes ___No

DOB:_____ Age:_____ Gender:_____ Race:_____

Marital Status
___Never Married ___Domestic Partnership ___Married
___Separated ___Divorced ___Widowed

How did you hear about our practice?_____

Primary Care Physician Name:_____ Address:_____ Phone:_____
Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
___No ___Yes, previous therapist/practitioner:_____
Are you currently taking any prescription medications? ___No ___Yes
If Yes, please list the medications, the reason for the prescriptions, and the dates:
_____

General and Mental Health Information

1. How would you rate your current physical health? (please circle one)
   Poor Unsatisfactory Satisfactory Good Very Good
   Please list any specific health problems you are currently experiencing:_____
   _____
2. How would you rate your current sleep habits? (please circle one)
   Poor Unsatisfactory Satisfactory Good Very Good
   Please list any specific health problems you are currently experiencing:_____
   _____
3. How many times per week do you generally exercise?_____
   What type of exercise do you participate in?_____

4. Please list any difficulties you experience with your appetite, or eating problems:_____
_____
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 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 in recreational drug use? ___Daily ___Weekly ___Monthly ___Never
10. Are you currently in a romantic relationship? ___No ___Yes
On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship? ____
11. Are you/spouse/child/mother/father in active duty/military veteran? ___No ___Yes
Explain:_____

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 (e.g. father, grandmother, uncle, etc.):

History Of	Please Circle One	List Family Member
Alcohol/Substance Abuse	yes/no	_____
Anxiety	yes/no	_____
Depression	yes/no	_____
Domestic Violence	yes/no	_____
Eating Disorder	yes/no	_____
Obesity	yes/no	_____
Obsessive Compulsive Behavior	yes/no	_____
Schizophrenia	yes/no	_____
Suicide Attempts	yes/no	_____

Additional Information

1. Are you currently employed? ___No ___Yes
If Yes, what is your current employment situation?_____
_____
Do you enjoy your work? Is there anything stressful about your current work?_____
_____
2. Do you consider yourself spiritual or religious? ____No ____Yes
If Yes, describe your faith or belief:_____
_____
3. What do you consider some of your strengths?_____
_____
_____
4. What do you consider some of your weaknesses? _____
_____
_____
5. What would you like to accomplish out of your time in therapy?_____
_____
_____
6. What are you looking for from your therapist that will assist you with progress? _____
_____

Madrigal Consulting and Counseling, LLP
Consent for Treatment & Limits of Liability

Limits of Services and Assumption of Risks:
Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Limits of Confidentiality:
What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect
If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threaten or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults
If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

Prenatal Exposure to Controlled Substances
Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers
Insurance companies and other third-party payers are given information that they request regarding services to the clients. In order for your insurer or third-party payer to pay for our services, such insurance companies and other third-party payers are given (upon their request) information re: our services rendered to clients.

Clinical Counseling Interns
Madrigal Consulting and Counseling works in partnership with University's graduate social work and psychology programs to support the proper training and supervision of graduate students who are studying in the field to be licensed clinicians. As a result, you may be asked to consent to allow the graduate clinical interns to observe or support in your session. At any time you can decline consent.

Teletherapy Services
Madrigal has access to HIPAA compliant video/phone therapy that is available based on need and insurance coverage.

The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.

_____ _____
Client Signature (12+ years of age) Date

_____ _____
Parent/Guardian (if client under age 18) Date

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The COVID-19 virus is a serious and highly contagious disease which has required state and local health officials to provide guidelines in order to manage the spread of the virus. The staff at Madrigal have used these guidelines as the minimum standards for in person counseling services. For your safety and the safety of our staff and community, you must comply with all measures and protocols in order to receive in person services at Madrigal. These protocols are subject to change based on the best information we have from those health officials.

- ❑ All clients and guests must wear a mask when in the common spaces.
- ❑ All clients must wear a mask in the therapist office.
- ❑ All clients must wash or disinfect their hands upon entering the building, after they use the restrooms, and anytime they touch their face.
- ❑ All clients must maintain 6 feet of distance from anyone in the building, unless they are from the same household.
- ❑ All clients must wait to enter the office until the start time of their session. Please wait outside or in your car until your therapist notifies you that they are ready. Currently, our waiting room is closed.
- ❑ Only clients are allowed in the office. For children under 18, one parent/guardian may accompany client. Children and family members who are not clients of Madrigal are not permitted into the office.
- ❑ All clients understand they will be asked COVID-19 screening questions about any symptoms they have. Madrigal staff have the right to ask you to reschedule using telehealth if you say "Yes" to any questions.
- ❑ All clients understand that they will have their temperature checked upon entering the office. Clients with a temperature above 100.4 will not be able to attend their therapy session in-person, and will be asked to engage in telehealth for two weeks or until cleared by a doctor.
- ❑ All clients will be required to sanitize their hands upon entering the office.
- ❑ Clients who identify as a member of the vulnerable/high risk population must continue teletherapy until further notice. All clients who attend in person therapy sessions agree that they are not a member of the vulnerable or high risk population.
- ❑ Clients who tested positive for COVID and have attended an in-person therapy session in the past 2 weeks must notify their therapist immediately. If you should

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test positive for COVID, in-person services will be paused and telehealth will resume for the duration of two weeks or until you are cleared by a doctor.

- ❑ person visits may not be available for every therapist of Madrigal, due to their personal needs.
- ❑ We reserve the right to require telehealth appointments of any or all clients versus in person appointments if we feel it is necessary to maintain the safety of Madrigal staff and our clients.

Due to the long incubation period of the COVID-19 virus, as well as the reality that an individual may be a carrier of the virus without any symptoms or awareness, face to face contact with any other member of the community increases risk of transmission of the virus.

Madrigal will continue to provide individual, couples and family therapy via a telehealth platform. **We strongly suggest that clients continue to use telehealth for therapy services and that in person sessions be used for clients with whom telehealth is not possible or suggested, such as clients with privacy or safety issues, clients who receive therapy by certain modalities that are not conductive to telehealth, and clients who need a higher level of care.** By choosing in person sessions over telehealth, you recognize the increased risk of contracting the virus in the office and accept that risk.

Patient/Client Acknowledgement

I confirm that I have read the Notice above and understand and accept that there is an increased risk of contracting the COVID-19 virus in coming to this office and being in this office for in person sessions. I understand and accept the additional risk of contracting COVID-19 from contact at this office. I also acknowledge that I could contract the COVID-19 virus from a multitude of sources outside the office and unrelated to my visit here. I acknowledge it would be very difficult for anyone to prove from whom or where they contracted COVID-19. I assume the risk of being in this office and proceeding with services at Madrigal.

Name Signature Date

Revised 8-7-20

Madrigal Consulting and Counseling, LLP

Insurance Authorization Form & Financial Policy

Name:_____ Today's Date:_____

Home Address:_____

City:_____ State:_____ Zip Code:_____

Telephone:_____ Birth Date:_____ Age:_____

Email Address:_____ May we email? Yes No

Occupation:_____

Employer:_____ Years There:_____

Employer Address:_____

City:_____ State:_____ Zip Code:_____

Work Phone:_____ May we contact you at work? Yes No

Primary Insurance

Name of Insurance Company:_____

Insured's Name:_____

Member ID Number:_____ Group Number:_____

Secondary Insurance

Name of Insurance Company:_____

Insured's Name:_____

Policy ID Number:_____ Group Number:_____

Name of Spouse:_____ Birthdate:_____ Age:____

Occupation:_____

Employer:_____ Years There:_____

Employer Address:_____

City:_____ State:_____ Zip Code:_____

Work Phone:_____

In Case of Emergency:

Contact:_____Relationship:_____

Phone:_____Alternative Number:_____

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all copays, deductibles, coinsurances, and non-covered service amounts. By signing this document you understand that you are held financially responsible for all services provided by Madrigal Consulting and Counseling, LLP, with or without insurance coverage.

I authorize the release of any medical information necessary to process my claim.

Signature of Patient or Responsible Party:_____ Date:_____

I authorize payment of medical benefits to Madrigal Consulting and Counseling, LLP.

Signature of Patient or Responsible Party: _____ Date:_____

Any balance that is unpaid 90 days after services are rendered will be considered delinquent. A late payment charge of *1.5% per month* will be added to your account. The late payment charge will be billed each month until the delinquent balance is paid.

In the event that this account goes into default and our office turns it over to our outside collections agency/attorney, it is accepted and agreed that *30% of the principal amount* of the balance due will be added as collections agency/attorney fees.

Signature of Patient or Responsible Party:_____ Date:_____

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Authorization for Use and Disclosure of Protected Health Information & Education Records

Patient's Name: _____ **Date of Birth:** _____

I hereby authorize Madrigal Consulting and Counseling, LLP clinician:_____
Phone number:_____ Email:_____

To disclose protected health information and/or educational records to (patient's provider):
Name: Regional Office Safe School Program Phone: _____ Fax:_____
X Check here if authorization is given for the parties above to mutually exchange the information described below.
Description:
The health information to be disclosed consists of (check all that apply):
__ Any and all records in possession of _____ including mental health, HIV, and/or substance abuse records. (Cross out any items that you do not authorize to be released.)
__ Records regarding treatment for the following condition or injury: _____
__ Records covering the period of time between _____ and _____
__ Other (be specific, including dates): _____
The education information to be disclosed consists of (check all that apply):
__ Any and all educational records, including permanent, temporary, and special education records
__ Records covering the period of time between _____ and _____
X Other: Coordination of supports – Academic performance (grades)
*Parents have the right to limit consent to specific records or portions of records and can use this section to do so.
Purpose:
This information is to be disclosed at the individual's request and will be used for the following purpose(s) (check all that apply):
__ Educational evaluation and program planning
__ Health assessment/planning for health care services in school or medical treatment
X Other: Coordination of supports + service

This authorization is valid for one calendar year and will expire on _____.
I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I understand that my revocation of this authorization will not be effective for actions taken by the school district or health care provider in reliance upon my authorization and prior notice of my revocation. I understand that failing to authorize disclosure of records may adversely impact the educational programming and/or medical treatment for my child. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care. I also understand that I have the right to inspect and copy educational records and to challenge their contents. I understand that a photocopy of this document is valid as the original.

_____	_____
Parent Signature	**Date**
_____	_____
***Patient Signature**	**Date**
_____	_____
Witness Signature	**Date**

*Patient signature required 12+ years of age; this authorization is for the release of mental health records