Daniel Schonbuch, LMFT

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**INDIVIDUAL INTAKE FORM**

Welcome to Daniel Schonbuch, LMFT. We look forward to providing you with excellent and efficient counseling services. Please take a few minutes to fill out this form. The information will help us to better understand your situation as well as potential solutions in helping you get your life back on track. Please note, this information is confidential, for our use only, and will not be released to anyone without your written permission.

**Personal Information**

Client Name: Date of Birth: Age: SSN: Street Address:

City/State: Zip Code: Sex: Female Male

Home Phone Is it okay to leave a message? Yes No Work Phone Is it okay to leave a message? Yes No Cell Phone Is it okay to leave a message? Yes No Email Address: May we e-mail you? Yes No

In an emergency, who do we call? Contact Name: Contact Phone:

Employer: Length of Employment: Occupation:

Do you have children? If so, please provide names and ages:

If you have listed children, with whom do they live? List any other individuals living in your home (other than you and any children

listed above):

**Medical and Mental Health History / Information**

Are you currently being treated by a physician for any medical conditions? If so, please describe:

Are you currently taking prescription, over-the-counter or herbal medication? No Yes; Medication name/dose:

Have you ever seen a Psychiatrist or other mental health provider? No Yes; If yes, when?

What was the focus of treatment? Was it helpful? Yes No

**Counseling Concerns**

What are the issues for which you are currently seeking assistance? Please be as specific as possible.

1. 3.

2. 4.

What have you previously tried in order to resolve these issues (e.g. religious counseling, talking with family/ friends)? Has anything been helpful?

What are some of your coping strategies?

What do you consider to be your strengths?

**Counseling Goals**

Goals are very important in counseling. They provide us with a focus and direction that will help us to help you. Please list the goal(s) that you hope to address and achieve in counseling. Please be as specific as possible. 1. 2.

3. 4.

**Risk Assessment**

Is there any family history of mental illness or substance abuse? If so, please list relationship & diagnosis:

Please list family, friends, support groups and community groups which are helpful to you:

List any personal history of emotional, physical, and/or sexual abuse:

Has a family member or close friend ever committed suicide? No Yes, (who) Have you been having any thoughts of harming yourself or others?

Yes No Self Other(s)

Are there any guns or weapons in your house (specify whose & what type) Have you ever been involved in any significant legal actions, currently or in the past (e.g.: lawsuit, probation, parole)? If so, please state who and under what circumstances:

**TREATMENT:**

I understand that I must be committed to attend sessions on a consistent basis in order to receive the greatest benefit from therapy. Although I may stop therapy at any time, I agree to inform my therapist of my decision **prior** to my last visit. If my therapist believes that I can receive more effective treatment elsewhere, I will be given referrals. I understand that I may not attend a session if I am under the influence of alcohol or drugs, or if I am in possession of a dangerous weapon. My signature below indicates my desire and consent to receive mental health services from Daniel Schonbuch, LMFT

**PAYMENT & INSURANCE REIMBURSEMENT:**

I understand that I (the client) am fully responsible for the payment of all fees for services provided regardless of any insurance coverage I may have. I understand that it is ’s policy that the fee for any session is payable at the beginning of the session.accepts cash, checks as forms of payment.

I understand that if I have insurance, I will either file the claim on my behalf or will provide me with the necessary in- formation so that I can file the claim. I understand that I am ultimately responsible for any therapy fee(s) not covered by my insurance carrier. Co-pays and non-covered services are payable at time of service unless other arrangements have been made. In the event that insurance is billed on my (the client) behalf, I authorize payment of mental health benefits to Daniel Schonbuch, LMFT or the name of the therapist as indicated above (please check name of attending therapist).

My signature below indicates that I have read, understand, and agree to the statements made above regarding Treat- ment, Payment & Insurance Reimbursement, and Cancellations and Missed Appointment Policy.

Client (or responsible party’s) signature: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INFORMED CONSENT FORM**

**THE COUNSELING PROCESS:** The counseling process is a partnership between you and a Daniel Schonbuch, LMFT clinician (“clinician”) to work on areas of dissatisfaction in your lie or assist you with life goals. For counseling to be most effective, it is important that you take an active role in the process. This involves keeping scheduled appointments, listening to the clinician, being honest with the clinician, discussing the counseling process with the clinician, and completing outside assignments agreed upon with the clinician. Counseling can have both benefits and risks. While counseling can be of benefit to most people, the counseling process is not always helpful. The counseling process also can evoke strong feelings and sometimes produce unanticipated changes in one’s behavior. It is important that you discuss with a clinician any questions or discomfort you have regarding the counseling process or any behavioral changes you may be experiencing. Your clinician may be able to help you understand the experience and/or use different methods or techniques that may be more satisfying.

**COUNSELING:** is a confidential process designed to help you address your concerns, come to a greater under- standing of yourself, and learn effective personal and interpersonal coping strategies. It involves a relationship between you and a trained therapist who has the desire and willingness to help you accomplish your individual goals. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. During the course of counseling, there may be periods of increased anxiety or confusion. The outcome of counseling is often positive; however, the level of satisfaction for any individual is not predictable. Your therapist is available to support you throughout the counseling process.

**CONFIDENTIALITY:** Daniel Schonbuch, LMFT recognizes that confidentiality is essential to effective counseling. We believe that for counseling to work best, you must feel safe about sharing personal information about yourself with your clinician. When you share information about yourself with your clinician, he or she will respect the importance of that information. Counseling records are destroyed 7 years after your last contact with us in a way that protects your privacy. Under most circumstances, all information about you obtained in the counseling process (including your identity as a client) is confidential and will be related to other parties only with your expressed written consent. However, it is because of the strength of our belief in the importance of you feeling safe about sharing information about yourself with your clinician that we want to inform you about the circumstances in which we may share information about you without your consent.

* If you are under 18, your parents or legal guardian(s) may have access to your records and may autho- rize their release to other parties.
* If you are reasonably suspected to be in imminent danger of harming yourself or someone else.
* If you disclose abuse or neglect of children, the elderly, or disabled persons.
* If you disclose sexual misconduct by a therapist.
* To qualified personal for certain kinds of program audits or evaluations.
* In criminal proceedings.
* In legal or regulatory actions against a professional.
* Upon the issuance of a court order or lawfully issued subpoena
* Where otherwise legally required

The above is considered to be only a summary. If you have questions about specific situations or any aspect of the confidentiality of records, please ask a member of the counseling staff.

# \*All interactions with Daniel Schonbuch, LMFT, , including scheduling of or attendance at appointments, content of your sessions, progress in counseling, and your records are confidential. No record of counseling is contained in any academic, educational, or job placement file. You may request in writing that the counseling staff release specific information about your counseling to persons you designate.

**CONSULTATION**: When appropriate, therapists consult with a psychiatrist regarding any medication concerns discussed on behalf of the client or to gain psycho-education regarding medications.

**COUNSELING RECORDS**: Counseling records are stored in locked files and/or electronically on a secure server that is only accessible by our staff. Upon request, you may review your counseling records. In order to ensure the information contained is clearly understood, you will be asked to arrange an appointment with your therapist or another member of the counseling staff to go over the information. Appropriate fees will be charged for making copies of client records.

**COUNSELING DECISIONS:** Frequency of sessions, number of sessions, goals, type of counseling and any alternative counseling methods will be discussed and negotiated between you and your therapist. You are encouraged to regularly discuss your progress and review your goals with your therapist. If you have questions about recommendations or the approached used by therapist, please discuss your questions or concerns with the therapist. If you feel these recommendations are not appropriate, you may refuse to accept them. If you feel you are not making satisfactory progress toward your goals, please discuss this with your therapist, if you are able to resolve questions or concerns you have about the progress of counseling, the process of referring to another provider will be implemented.

**ACCESS TO SERVICES**: Counseling services are generally available during normal business hours (Monday thru Friday until 5pm) throughout the year (including breaks between semesters) except on designated holidays. Please call Daniel Schonbuch, LMFT at 646-428-4723 for current information. An individual in crisis can come to the office location at any time during office hours and be worked into a schedule for a brief evaluation. If it is after office hours and you are in imminent crisis, please call 911 or visit your local emergency room.

**ELECTRONIC COMMUNICATION**: Daniel Schonbuch, LMFT seeks at all times to maintain and respect the confidentiality of each client, including not only the details of any services rendered, but also the fact that an individual may in contact with Daniel Schonbuch . With this in mind, I wish to remind each person that electronic communication (e.g., email, texts, faxes) is not a secure form of communication. Because confidentiality cannot be assured, the use of electronic communication is discouraged in regard to communications with me . When necessary, electronic communication may be used for scheduling appointments but should not be used for counseling purposes or major forms of communication. The suitability of any clinical consultations or recommendations can only be determined through counseling sessions. electronic communication is not appropriate for emergency or time-critical situations. The fastest way to contact is by phone. Please call your clinician or the office directly (646 428 4723) if your message is time-critical. If it is after office hours and you are in imminent crisis, please call 911 or visit one of your nearest emergency rooms.

**COUNSELING APPOINTMENTS**: The therapist can be expected to respect you as an individual and to con- vey this respect by keeping appointments or contacting you if a change in times is necessary, by giving you his/ her complete attention during sessions, and by avoiding interruptions during sessions. On rare occasions how- ever, sessions may be interrupted if the clinician is called to respond to a crisis. It is also expected that you will be prompt for appointments, and that you will call in advance if you will be more than a few minutes late or have to miss an appointment.

**NO-SHOW/LATE CANCELLATION CHARGE**: We appreciate prompt arrival for appointments. Please notify us at 646 428 4723 for any late arrivals. **IF** a client does not provide notice within 24 hours of his/her scheduled appointment, the full fee will be charged to the client’s account and will be asked to pay this balance prior to scheduling his/her next appointment. Clients may leave a message on Daniel Schonbuch, LMFT voicemail to cancel an appointment; however this message must be left at least 24 hours before the scheduled appointment.

# Consent:

I certify that I have read, understand and agree to abide by the information, terms and conditions contained in this Informed Consent for counseling services form. I have had the opportunity to discuss any questions about the information contained in this form, or any other aspect of Daniel Schonbuch, LMFT, . I hereby give my consent to Daniel Schonbuch, LMFT, to evaluate, provide counseling services and/or refer me to others as needed.

*Signature of Client Signature of Therapist*

*Signature of Client's Guardian (if applicable)*

*Date*

**AUTHORIZATION FORM (HIPAA) (2 pages)**

Authorization for Disclosure of Protected Health Information

Name of Patient:

1. I authorize the healthcare practitioner Daniel Schonbuch, LMFT (the ‘Practitioner”) and/or the administrative and clinical staff of the Practitioner to disclose my (or my child’s or my ward’s) protected health information, as specified below, to **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

2. I am hereby authorizing the disclosure of the following protected health information: Mental Health Information

**[Specifically describe the protected health information to be disclosed such as date of service, type of service, and level of detail to be released.]**

3. This protected health information is being used or disclosed for the following purposes: At the request of the individual

**["At the request of the individual" is acceptable if the request is made by the patient, the parent of a minor patient, or the legal guardian of a patient, and they do not want to state a specific purpose.]**

4. I specifically authorize the disclosure by the healtare practitioner of the following types of protected health information by placing my initials where appropriate below, my initials serving as my signature release for each type of specially protected health information:

\_\_\_\_\_\_\_\_\_Psychotherapy Notes (as defined by HIPAA)1

\_\_\_\_\_\_\_\_\_Confidential HIV Related Information 2

\_\_\_\_\_\_\_\_\_Alcohol/Substance Abuse Treatment Information 3

5. This authorization shall be in force and effect until one (1) year after the date below at which time this authorization to disclose protected health information shall expire.

6. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Practitioner at the address above. I understand that a revocation is not effective to the extent that the Practitioner has relied on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by HIPAA or any other federal or state law, provided however, that Confidential HIV Related Information and Alcohol/Substance Abuse Treatment Information may not be disclosed without my authorization unless permission to re-disclose such information is granted by federal or state law.

8. The Practitioner will not condition my treatment on whether I provide an authorization for disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

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Signature of Patient, or Parent of Minor Patient, Date

or Personal Representative of Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Print Name of Patient, Parent of Minor Patient

or Personal Representative of Patient (If a Personal

Representative, also state relationship to patient.)

1. HIPAA defines psychotherapy notes as “ Notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual’s medical record. “ Psychotherapy notes do not include information contained elsewhere in the medical record or information regarding:

medication prescription and monitoring; counseling session start and stop times; modalities and frequencies of treatment furnished; results of clinical tests; and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.

2. HIV is the Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person’s contacts, including HIV test results. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights. Although I am authorizing this release of HIV-related to the recipient, the recipient is prohibited from re-disclosing such information without my authorization unless specifically permitted to do so under federal or state law.

3. Although I am authorizing this release of Alcohol/Substance Abuse treatment information to the recipient, the recipient is prohibited from re-disclosing such information without my authorization unless specifically permitted to do so under federal or state law.