Mark Milazzo, LCPC, Ltd
Intake Form

Name of Client _____
Last First Middle

_____
Last First Middle

Address _____

City _____ State_____ Zip Code_____

Name of Parent/Legal Guardian _____
(if under 18)

Home Phone _____D.O.B. _____Occupation _____

Email Address: _____

Place of Employment/School _____

How did you find out about me?_____

Single/Coupled/Married/Separated/Divorced/Re-Married (Circle One)

Work Phone _____ Age_____

In Case of Emergency Please Contact _____

Relationship _____ Phone _____

I understand that all fees/charges incurred are my responsibility or the responsibility of my parent/legal guardian. I/we agree to pay all fees and charges regardless of whether or not I/we choose to utilize insurance benefits. I consent for Mark Milazzo, MA, LCPC to call and/or send a card to thank whoever referred me.

Clients Name (please print) _____

Signature of Responsible Party _____ Date_____

Witness _____Date_____

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 medication?

□ Yes

□ No

Please list: _____

_____

Have you ever been prescribed psychiatric medication?

□ Yes

□ No

Please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in: _____

4. Please list any difficulties you experience with your appetite or eating patterns.

_____

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 any 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 recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

_____

_____

_____

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 (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	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 to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

_____

4. What do you consider to be some of your weakness?

_____

_____

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

_____

_____

Mark Milazzo LCPC Ltd

Informed Consent

Consent To Treatment

Welcome to therapy! This form is designed to help explain some aspects of our work together so that we may have a mutual understanding regarding the process of therapy. Therapy is just that, a process. Since we will likely work together for weeks, months, or even years, I encourage you to ask questions about any aspect of therapy that concerns you at any point during the treatment process. The goals of treatment and methods used to achieve those goals are open to discussion and evaluation at any time.

While we will work to achieve maximum benefit from this treatment, there is no way to guarantee such benefits or particular outcomes. To be effective, the process of therapy may entail exploring difficult and often painful issues. As a result, you may experience emotional strain, and at times you may feel even worse during treatment as these painful issues are explored. Regular attendance will produce the maximum benefit in this work, and allow us maximum ability to address these issues, however, you are free to discontinue treatment at any time. Although a number of professionals work in this suite, Mark Milazzo LCPC Ltd works independently and is a separate entity.

Messages & Emergencies

A voicemail system answers my phone when I am not available, and I check messages regularly. Hours during which you may expect a return phone call are between 10:00am and 9:00pm. Monday-Friday. I will return your call as quickly as I can. **I do not regularly check for messages during the weekend**. In case of an emergency requiring immediate therapeutic assistance you may call The Crisis Line at (630) 482-9696. If I am unable to get back to you as quickly as you require, or if you feel the emergency is beyond the scope of what might be able to be handled by phone, please get to the nearest emergency room or call 911 for assistance. When I am out of town, emergency phone calls will be covered by a licensed therapist (contact info will be provided). If a client regularly texts or calls me outside of scheduled appointments, they will immediately be assessed for a higher level of care, such as a PHP program or multiple sessions per week. This is to ensure the work of therapy can be held to the therapy hour and allow for safe, effective treatment.

Confidentiality

Conversations between us will almost always be kept confidential. Please be aware that to most effectively help you I may need outside consultation from another trained therapist. I work diligently to protect your identity by **never** sharing your name or other identifying information that might compromise confidentiality. There are times where these principles will not apply.

- If you choose to use insurance benefits, you need to be aware that all insurance policies require a diagnosis. Some companies require information about our work together (content, issues being worked on), and dates of sessions.
- **By law** I am required to report actual or suspected child or elder abuse to the appropriate authorities.
- I am legally bound to protect anyone whom you threaten with violence or to cause physical harm or other dangerous actions; including yourself.

If such incidents arise, I will need to break the confidentiality of our communications. Whenever possible, I will make reasonable efforts to resolve these situations before breaking confidentiality.

Technology Risks

I use a secure email to communicate with clients, psychiatrists, & insurance companies. The nature of this type of communication is that it can be never be guaranteed 100% safe and protected. Signing this form indicates your taking on the risk associated with these types of communications. If video or phone therapy should take place (agreed upon by therapist and client beforehand) every effort will be made to use a HIPPA-compliant platform (Doxy). If this platform becomes unavailable or fails, Skype or Facetime may be utilized. No recording of sessions is allowed by either party. My credit card system follows current PCI compliance regulations.

Appointments & Cancellations

I will make every attempt to reserve a regularly scheduled appointment time for you. I will also make **every** attempt to not miss appointments. I ask that you please do the same. If you need to miss a session I ask that you: give me **24 hours notice** so that I may attempt to fill your time. If this doesn't happen, you will be responsible for paying for the missed session. Payment in full for missed sessions is expected at the time of our next scheduled appointment. Please be advised that many insurance companies do not reimburse for missed sessions.

No Surprises Act: Good Faith Estimate (GFE)

CPT Code	*Description*	
90791	Intake Evaluation	$175.00
90837	Psychotherapy Session	$175.00
90847	Family Session	$175.00
90899	Missed Session	$175.00

The GFE is only an estimate and the actual items, services, or charges may differ from what is included in it. Individuals may challenge a bill from a provider through a patient-provider dispute resolution (PPDR) process if the billed charges substantially exceed the expected charges in the GFE. To initiate PPDR process, visit www.cms.gov/nosurprises/consumers or call 1-800-985-3059. PPDR process must be started within 120 calendar days of the date on the original bill. Initiating a PPDR will not adversely affect the quality of services rendered. The GFE has

been provided to you both verbally and in writing. The provider may recommend additional services that are not in the GFE. These estimates may change as the treatment progresses or if emergences/clinical situations arise and are not a guarantee of treatment frequency, length, or cost. Your signature does not require you to receive psychotherapy services from me.

Payment

To minimize administrative costs, I request that you pay me at the time of service. If you are using insurance, your co-pay or co-insurance will be due at the time of service. If for **whatever** reason your insurance company will not reimburse me for the completed sessions, you will be responsible for the balance accrued. Every effort will be made to work with your insurance company before this occurs. Your signature below assumes you have read, understand, and agree to abide by the above. It also assumes that you give your consent for me to provide you with psychotherapeutic services.

My preferred method of payment is via Zelle (mark.milazzo.13@gmail.com) or Venmo (@mark-milazzo-13). If either of these methods are not feasible, credit payments are accepted online through my website (www.markmilazzotherapy.com/make-a-payment) and will incur a 3% processing fee not listed on your original invoice. By electing to pay with credit using this link, you are consenting to this added transaction fee.

_____ _____

Client Signature Date

_____ _____

Mark Milazzo, MA., LCPC Date