Family Guidance Center, PLLC
Client Intake Form

Name: _____ Date of Birth: _____ SS#: _____

Marital Status: _____ Spouse's Name (if applicable): _____ Referred By: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Is it okay to leave a message? ☐ Yes ☐ No

Cell Phone: _____ Is it okay to leave a message? ☐ Yes ☐ No

Parent/Guardian Information:

Parent/Guardian Name: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Parent/Guardian 2 Name: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact - <u>this person will be contacted in the case of an emergency</u>

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Primary Care Physician

Name/Practice: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Do we have your permission to coordinate care with your Primary Care Physician? ☐ Yes ☐ No

Client Employer

Employer Name: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Information

Primary Insurance Company: _____ Policy #: _____

Policy Holder: _____ Relationship: _____

Secondary Insurance Company: _____ Policy #: _____

Policy Holder: _____ Relationship: _____

Emailed Invoices (optional)

Billing invoices are available by email. Please be aware that although unlikely, communications via email may be lost, delayed, intercepted, delivered to the wrong address, or arrive incomplete or corrupted. If you understand and accept responsibility for these risks please provide your signature and email address below.

Email: _____ Client or Parent/Guardian Signature: _____

Family Guidance Center, PLLC

Informed Consent for Treatment Page 1 of 2

The decision to enter into counseling is personal and can lead to solutions to specific problems and reductions in feelings of distress. Counseling begins with an understanding of what to expect as a client as well as what your rights are. Informa□on is given here that should be reviewed with your therapist prior to beginning therapy. Additionally, as required by law, a copy of the mental health bill of rights is posted in the waiting area.

Confidentiality: Under New Hampshire law, communications between a client and a licensed psychotherapist are privileged and may not be disclosed without the written authorization of client except under specific, limited circumstances. Among the exceptions to confidentiality are New Hampshire reporting laws which require licensed psychotherapists to report to the appropriate authorities in the case of physical or sexual abuse, neglect or endangerment of a minor or incapacitated adult. Psychotherapists are also required to warn the police or a specifically named victim of an intended act of physical violence. Confidentiality will also be suspended in the event of suicidality. If any of these circumstances occur, ac□on will not be taken without discussion as to whom will be notified, why and what to expect.

Recordkeeping: Records are kept and securely maintained for seven years for each client, couple or family. Such records include a billing file and a clinical file which will contain assessment notes, diagnosis, the date of each session, a brief summary of clinical content, treatment recommendations and a discharge summary. Clinical records are securely stored by the therapist and contain a copy of this agreement, any releases signed, any additional diagnosis reports, summaries of other written information received by the client as well as documentation of communication requested with additional par□es. Records may be requested and/or reviewed upon request. Ideally, discussion should take place with your therapist as to why this request is being made to further protect privacy.

Treatment Planning: Over the course of your or your child's treatment, you will be informed. participant as well as a collaborator in this process. You will be aware of your/their diagnosis, the direction of your/their therapy, recommendation, rationale and expected outcomes. Your therapist will also discuss insurance limitations to number of sessions.

Treatment of Couples and Families: Treatment notes from couple or family sessions contain information about each person. All parties should be aware that records may be requested and released to any party, unless an agreement is made in advance that records will only be released by joint consent. In the event of a legal disagreement, records will not be released without a court order. This ma□er should be discussed in a thorough manner with your therapist.

Treatment of Minors: The treatment of minors must be authorized by a parent or guardian, except in some limited cases where minors have the right to confidential treatment. In the case of divorce/separation, both parents must give permission unless there is a compelling reason why this contact should not take place. Parents will be appropriately involved in their child's treatment and despite minors not being granted full confidentiality by law, should respect their child's privacy. This ma□er shall be thoroughly discussed with both the parents and in an age-appropriate manner to the minor. Minors should be aware that guarantees cannot be made about release of records and other information to their parents. However, every effort will be made to advocate for a minor's privacy.

Availability: Each therapist has a direct phone extension and schedules their own appointments. Phone messages are checked frequently, are heard only by your therapist, and will be returned as soon as schedule allows. Each therapist will discuss emergency contact information with you directly. In a significant clinical emergency please go to the nearest hospital emergency room for help

FLIP OVER FOR SIGNATURE

Family Guidance Center, PLLC

Informed Consent for Treatment Page 2 of 2

Cost of Services: Fees for services are expected at the ⍰me they are rendered and are billed at ***$130 per 60 minute session.*** If you have insurance coverage, we will submit claims for you. However, you will be responsible for copayments and/or plan deductible. This payment is expected at each visit. ***A $75 charge will be made for missed sessions or same day cancellations (within 24 hours). Insurance does not cover this charge. If additional professional services are required such as writing letters, reports, meetings or telephone calls on your behalf, or court appearances, fees will be charged at the rate of $130 per hour. Insurance does not cover this charge.***

Statements of Understanding: I give consent for evaluation and treatment to be provided for myself/my child at the Family Guidance Center of Milford.
I am aware that the practice of psychotherapy is not an exact science and that results cannot be guaranteed. No promises have been made to me about the results of treatment.
The risks, benefits, side effects, and alternatives of treatment as well as the consequences of non-compliance with treatment have been discussed with me and I have had the opportunity to ask questions.
I understand that I will need to provide accurate information about myself to my therapist so that I will receive effective treatment. I also agree to play an active role in my treatment process.
I understand that I may terminate treatment at any ⍰me.
If insurance is billed for services, I authorize the release of the necessary information to obtain authorization and process my claim. Informa⍰on required by insurance companies includes a diagnosis, symptoms and when necessary a treatment plan to request additional sessions.
I understand that all insurance information is pending final authorization and not guaranteed. I am financially responsible for the full amount billed for services, including copayments, deductibles, and charges for missed appointments.
I understand I may discuss concerns about treatment, privacy, billing, or any other practices with my therapist. If I feel these concerns are not addressed to my satisfaction, I may contact the Agency Director, Anna Girard, at 978-403-0950.
My signature below shows that I understand and agree with all of the above statements. I have had the opportunity to ask questions about the treatment process. If the client is a minor or has a legal guardian appointed by the court, the client's parent or legal guardian must sign this consent.

_____ _____
Signature of Client or Parent/Guardian Date

_____ _____
Printed Name Relationship to Client

_____ _____
Therapist Signature Date

Family Guidance Center, PLLC
TELEHEALTH INFORMED CONSENT

I hereby consent to participate in telehealth with Family Guidance Center, PLLC. I understand that telehealth is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. This agreement supplements the general informed consent which was completed at the start of therapy. I understand the following with respect to telehealth:

1. I have the right to withdraw consent at any time without affecting my right to future care or services to which I would otherwise be entitled.

2. There are risks, benefits, and consequences associated with telehealth, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3. There will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4. The privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telehealth unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5. If I am experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate, and a higher level of care is required.

6. During a telehealth session, we could encounter technical difficulties resulting in service interruptions, which may result in rescheduling or canceling the appointment.

7. I agree to inform my therapist of my current location at the beginning of each session.

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____ _____
Signature of Client or Parent/Guardian — Date

_____ _____
Printed Name — Relationship to Client

_____ _____
If Applicable: Signature of Spouse/Significant Other — Date

_____ _____
If Applicable: Spouse/Significant Other Printed Name — Relationship to Client

_____ _____
Therapist Signature — Date

Family Guidance Center, PLLC

Please complete a card of file for co-pays, deductibles, no shows and late cancellations.

CREDIT CARD AUTHORIZATION FOR

After each appointment, your credit/debit/HRA/FSA card will be charged your copay, coinsurance, or deductible amount, unless you provide another form of payment. A credit/debit card on file is required for any no-shows or late cancellations.

If your coinsurance or deductible amount has not yet been determined, an estimate based upon your individual insurance benefit will be charged. Any overpayments will be credited to future appointments, or refunded.

If you have an outstanding balance at the end of treatment your credit card will be charged.

I,_____, authorize Family Guidance Center of Milford, Inc., to charge my credit card for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Please fill out credit card information Below

_____ _____
Cardholder Signature Date

_____ _____
Client Name Client Date of Birth

Client Name: _____ Date of Birth: _____

Cardholder Name (as shown on card): _____

Cardholder Billing Zip Code: _____

Card Type: ☐ American Express ☐ MasterCard ☐ Visa ☐ Other: _____

Card Number: _____

Expiration Date (MM/YY): _____ Security Code: _____

THIS SLIP WILL BE STORED IN OUR SECURE FILES

Family Guidance Center, PLLC
ADULT INFORMATION SHEET

Client Name: _____ **Date of Birth:** _____ **Age:** _____
Gender: _____ **Preferred Pronouns:** _____

CLIENT & FAMILY HISTORY:

Reason(s) for seeking treatment: _____
_____
_____

Briefly describe your therapy goals: _____
_____
_____

Marital Status: • Married • Never married • Separated • Divorced • Widowed

Household Members:

Name: _____ Age: ___ Relationship: _____ Occupation/School: _____
Name: _____ Age: ___ Relationship: _____ Occupation/School: _____
Name: _____ Age: ___ Relationship: _____ Occupation/School: _____
Name: _____ Age: ___ Relationship: _____ Occupation/School: _____
Name: _____ Age: ___ Relationship: _____ Occupation/School: _____
Name: _____ Age: ___ Relationship: _____ Occupation/School: _____

Any past or present difficulties with legal matters? • No • Yes *(specify)*: _____
Is treatment court-ordered? • No • Yes: _____
Highest Grade Completed: • High School • GED • College • Graduate School
Employment History: • Unemployed • Employed • Retired • Disabled
If Employed: Employer name: _____ • Full time • Part time
How long have you worked there? _____ Are you satisfied with your job? • Yes • No
Military History: • No • Yes *(branch)*: _____ Honorable discharge? • Yes • No
Do you have a religious preference? • No • Yes *(specify)*: _____

MEDICAL HISTORY:

Primary Care Provider: _____ **Psychiatrist:** _____
List current medications *(including over-the counter, vitamins, supplements)*: • Check here if none

Medication: _____ Strength/Dosage: _____
Medication: _____ Strength/Dosage: _____
Medication: _____ Strength/Dosage: _____
Medication: _____ Strength/Dosage: _____
Medication: _____ Strength/Dosage: _____

Food or drug allergies: • Check here if none

Allergen: _____ Reaction: _____
Allergen: _____ Reaction: _____
Allergen: _____ Reaction: _____
Allergen: _____ Reaction: _____
Allergen: _____ Reaction: _____

List any current or past medical conditions: _____
_____
List any previous hospitalizations, surgeries, or major injuries, including dates: _____
_____
List any family history of mental illness or substance abuse *(ex: depression, alcoholism, etc)*: _____
_____
_____

Have you received previous treatment for alcohol or drug abuse? • No • Yes
If yes, please list provider, reason for treatment, and dates: _____
_____

Do you drink alcohol? • No • Yes *(how much/how often)*: _____
Do you use drugs, including Nicotine? • No • Yes *(type(s), how much/how often)*: _____
Have you ever thought about cutting down on your drinking or drug use? • No • Yes
Has anyone asked you to cut down on your drinking or drug use? • No • Yes
Do you get annoyed when people ask you about your drinking or drug use? • No • Yes

TRAUMA HISTORY:

Recent major changes/losses:

- Divorce/separation • Change/loss of job • Move/relocation • Abuse
- Childbirth/adoption • Death of loved one • Health issues • Other: _____

Current Symptoms *(check all that apply)*:

- Anxiousness
- Tearfulness
- Irritability
- Sleeplessness
- Appetite changes
- Hopelessness
- Panic attacks
- Suicidal thoughts
- Decreased energy
- Hyperactivity
- Withdrawal
- Depressed mood
- Difficulty concentrating
- Mood swings
- Lack of interest in sex
- Loss of interest in usual activities
- Changes in sleep patterns
- Difficulty resolving conflict/anger
- Difficulty making decisions
- Other: _____

Have you received any previous mental health treatment? • No • Yes
If yes, please list provider, reason for treatment, and dates: _____
_____

Abuse history including physical, emotional, sexual and/or exposure to domestic violence, past and present:
_____
_____
_____
_____

Have you been abusive to others? • No • Yes *(specify)*: _____
Do you have any suicidal history? • No • Yes *(specify)*: _____

Please add any further information you feel the therapist should know: _____
_____
_____
_____
_____
_____

If you are interested in corresponding with your therapist by email concerning appointment scheduling ONLY, please provide your email address: _____

_____ _____ _____
Client Name PRINTED SIGNATURE DATE

Family Guidance Center, PLLC

Consent for the Release of Information to Coordinate Care with Primary Care Physicians

Client Information

Name: _____ Date of Birth: _____

Phone: _____ Parent/Guardian Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Therapist Information

Provider Name: _____, Family Guidance Center PLLC

Address: 16 Elm Street Milford, NH 03055 Phone: (603) 672-5005 Fax: (603) 672-6501

Primary Care Physician Information

Provider Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

The undersigned authorizes the provider and primary physician to release/obtain the following medical records and information concerning the client. The purpose of such release is to allow for coordination of care, which enhances quality, and reduces the risk of duplication of tests and medication interactions. Refusal to provide consent could impair effective coordination of care.

- ☐ Current medication/treatment plans
- ☐ Substance dependence assessments
- ☐ Assessment/evaluation report
- ☐ Discharge reports/summaries
- ☐ Laboratory/diagnostic test results
- ☐ Medical History
- ☐ Other (*specify*):_____
  _____

I understand that this authorization includes written, electronic, verbal and/or telephone communication and will remain in effect for the duration of my treatment. I may revoke this authorization at any time by written request. A photocopy of this release will be accepted as comparable to the original.

I further understand that federal law prohibits disclosure of matters concerning regulated substances (such as illicit drugs and/or alcohol) without explicit written consent regarding such matters. HIV-related information and drug and/or alcohol information will be released under this consent unless indicated here: ☐ Do Not Release

_____ _____

Signature of Client or Parent/Guardian Date

_____ _____

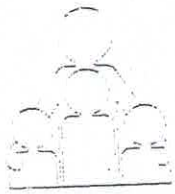
Printed Name Relationship to Client

_____ _____

Witness Signature Date

Declination: ☐ Client declines consent for information to be shared with Primary Care Provider

☐ Client is not currently receiving services from a Primary Care Provider



Family Guidance Center, PLLC

Thank you for selecting Family Guidance Center, PLLC. As a group, we have been very busy with a long list of clients waiting to get in, sometimes waiting months for an opening. When clients fail to show up for scheduled appointments. that time is lost not only to them, but also their fellow community members who are looking for help.

Because of the high demand for services, this letter is to inform you that Family Guidance Center will be adhering to no show and late cancellation fees of $75 per missed session, effective 1/1/2026. This fee is not covered by insurance.

We understand there are occasions when clients must miss appointments due to unforeseen problems. In this event, we ask that you contact your therapist directly to cancel or reschedule within 24 hours of your scheduled visit. This courtesy allows us to schedule another client who is in need. If at any point you feel there were circumstances outside of your control leading to a missed appointment, we are happy to discuss waiving the fee.

Thank you for your respect toward our policies and allowing us to best serve you and the community. We are here to help you, so please feel free to talk to us if you have any questions.

Sincerely,

Family Guidance Center, PLLC

Laurene Allen, LICSW

Nancy Loddengaard, LICSW

Mary Brady, LCMHC

Barbara O'Brien, MA

Kelley Purselley, LCMHC

Jessie Foltz, LCMHC

Kathryn Stack, LCMHC

Anna Girard, LCMHC

Colleen Zarrella, LICSW

Ashlee Dionne, LICSW

Jeanette Carey, MFT

_____ _____

Signature Date