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Client Information Intake

Instructions: Complete this form and return to Dr. Romeika. To minimize the risk to your confidentiality, please return the completed form in person. Unless you are sending emails and attachments via an end-to-end encryption account, confidentiality of your documents via email cannot be guaranteed.

A. Demographic Information (you, the client)

Name (first name / given name): ______________________________________

Name (last name / family name): ______________________________________

Suffix (if applicable): __________________________

Preferred Pronouns: ____

Birth Date (DD/MM/YYYY): _____/_____/_________

Age (as of today): _____________________________

Home Address: ____

____

City, ZIP: ____

Home Phone: (_____) _____ - _______
Check if this is a preferred number to reach you at: _______
May we leave a message at this number? (circle one) Yes / No

Mobile Phone: (_____) _____ - _______
Check if this is a preferred number to reach you at: _______
May we leave a message at this number? (circle one) Yes / No

Email Address: ______________________________ @ ________________

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B. Billing Information (responsible party; complete this section if different from you)

Bill to (name): ____

Billing Address: ____

____

City, ZIP: ____

Home Phone: (______) ______ - ________
May we leave a message at this number? (circle one) Yes No

Mobile Phone: (______) ______ - ________
May we leave a message at this number? (circle one) Yes No

Email Address: _________________________________ @ _________________

C. In case of emergency, who may we contact?

Name: ____

Home Phone: (______) ______ - ________

Mobile Phone: (______) ______ - ________

Email Address: _________________________________ @ _________________

Relationship to you: ____

D. Presenting Problem / Working Goals

Briefly describe your goals for working together. What would you like to address or change? What prompts you to seek consultation now?

____

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CONFIDENTIAL

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Statement of Confidentiality

As a psychologist, I seek to provide the quality of services required by the standards of professional psychologists. In keeping with those standards, strict confidentiality of all records of contact is maintained. It is policy not to release personally identifiable information concerning the use of services without prior permission of the person receiving the services. Legally and ethically, confidentiality cannot be maintained when: (1) there is a clear and present danger that someone's life is at risk; (2) in the apparent abuse of a minor; and (3) subpoenaed in a criminal (not civil) judicial proceeding. We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials. By law we cannot reveal when we have disclosed such information to the government. If you are concerned about or have questions regarding confidentiality, please discuss with me.

Your signature below indicates that you have read and understood the above **Statement of Confidentiality** and that you have read and understood the **Notice of Privacy Practices**.

Client Signature: ______________________________________ Date: __________

Parent/Guardian Signature: _____________________________ Date: __________

Therapist Signature: ___________________________________ Date: __________

For Office Use Only

_____ Documentation of Informed Consent for Treatment
_____ Documentation of Informed Consent for Telepsychology*
_____ Documentation of Notice of Privacy Practices
_____ Documentation of Pennsylvania Notice Form
_____ Documentation of Authorization to Release Information*

*if applicable

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