Dreamline
Counseling & Therapy

CONFIDENTIAL CLIENT INTAKE FORM

CLIENT DEMOGRAPHICS **Date:** _________________________

Client's Full Name____________________________________ Preferred Name: _________________________

Client's DOB: _______________ Age: __________ Sex: ( ) Male ( ) Female

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed

Street Address:____Apt/Suite #: ___________

City: __________________________________ State: ___________ Zip Code: _________________

Home Phone: _____________________________________ May we leave a message here: ( ) Yes ( ) No

Mobile Phone: ____________________________________ May we leave a message here: ( ) Yes ( ) No

Work Phone: _____________________________________ May we leave a message here: ( ) Yes ( ) No

Email Address: ___________________________________ May we send a message here: ( ) Yes ( ) No

Referred by: ____

PRIMARY CARE PROVIDER

If a minor, Parent or Guardian Name: ____

If referred by a PSYCHIATRIST, please provide information:

Psychiatrist's Name: ____ Office phone #: ____________________

Street address: ____

City: ________________________________ State: _______________ Zip: _______________

EMERGENCY CONTACT INFORMATION

Name: ____ Relationship: ____________________

Home Phone: ________________________________ Cell Phone: ____________________________________

RESPONSIBLE PARTY AGREEMENT

I certify that the above information is true and correct. I agree to take responsibility for the any amounts not covered by insurance, including copayments and deductibles which are due for any and all services rendered by ***Dreamline Counseling & Therapy Services, LLC. Cancelled or missed sessions are subject to a $30 charge, unless 24hrs notice is given.***

Client/Parent/Guardian/Guarantor Signature___________________________________ Date _______________

Client Name (Print) ________________________________

Client Consent Form

I hereby authorize Digna L.Montañez and her colleagues to provide, directly or through consultation, mental health counseling, to me now or at a later date. I realize that these services do not guarantee improvement or cure of any mental disorder or distress.

In connection with the foregoing, I understand that any information asked of me now or in the future shall be kept in my records and/or files. Any information in these records or files will be used to provide me with counseling and will not be made available to individuals or agencies without my written consent. I also understand that Digna L. Montañez and her colleagues are required to keep all information related to my case completely confidential.

Information necessary to carry out the official responsibilities of a grand jury, or other court, law enforcement agency or Legislative Investigation Committee will be released when requested by subpoena or court order, after consultation with a legal advisor.

I agree to pay for or make arrangements for payment of services. I realize that treatment may be discontinued if my account is delinquent by an excess of three sessions.

____________________________________ ______________________________
CLIENT'S SIGNATURE DATE

LIMITS OF CONFIDENTIALITY

Information discussed in the therapy setting is held confidential and will not be disclosed without written permission except under the following conditions:

- The client threatens suicide.
- The client threatens to bring harm to another person(s), including murder, assault, or other physical harm.
- The client reports suspected child abuse, including but not limited to physical beatings and sexual abuse.
- The client reports suspected abuse or exploitation of an aged person or disabled adult.
- Records are requested through court order and signed by a judge.

Florida State law mandates that mental health professionals must report these situations to the appropriate persons and/or agencies.

Communications between the clinician and client will otherwise be deemed confidential as stated under the laws of the State of Florida.

Having read and understood the above, I agree to these limits of confidentiality.

____________________________________ ______________________________
CLIENT'S SIGNATURE DATE

1417 N. Semoran Blvd. Suite 115 Orlando, FL 32807 (407) 749 – 3416 FAX: (407) 520-5408
https:\\www.dreamlinecounseling.com email: dlmmsw1@gmail.com