

Kristina J. Chomick, LMFT
Therapy, Supervision and Consulting Services, LLC

Hello, and welcome to my practice. I appreciate you giving me the opportunity to be a part of your therapy journey. This document contains information about my professional services and business policies, in addition to forms that I need for you to complete and bring to your initial appointment with me. Please read it and jot down any questions that you might have so that we can discuss them when you come in for your first appointment.

About my Office and Parking

My office is located at 111 Main Street in the beautiful Old Wethersfield District of Wethersfield, Connecticut. When you arrive at my building, you can park on the street – either on Garden Street or Main Street. The entrance to the office is in the back of the building. When you enter, you can go directly to the waiting room, which is on the right side, just past the kitchen. I look forward to meeting you there.

Signature and Consent

For your convenience I have made all of my practice policies and procedures available online at www.kristinachomick.com. Prior to your initial appointment, please take a moment to visit my website, review the policies and procedures and bring any questions that you may have to your initial appointment.

Consent for treatment:

I, the undersigned, do hereby agree and give my consent to Kristina J. Chomick, LMFT - Therapy, Supervision and Consulting Services, LLC to provide me with psychological/psychiatric assessment and treatment as considered necessary and proper in diagnosing or treating my condition.

Client Signature: _____ Date: _____

Benefit assignment/ release of information:

I authorize the use or disclosure of all information necessary, including patient records, to process insurance claims and secure payment. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations. Additionally, I authorize payment of medical benefits to Kristina J. Chomick, LMFT - Therapy, Supervision and Consulting Services, LLC for services performed.

Client Signature: _____ Date: _____

Financial Policy:

I have read and understand the information provided to me via www.kristinachomicklmft.com. I understand my responsibility for payment of my account (including fee for services, failed or late cancellations, additional services rendered by provider on my behalf, and late fees). I understand that payment is due at the time services are rendered (co-pays, co-insurance, deductibles, or self-pay balances and I understand that if I do not pay these fees in a timely manner I may be subject to late fees.

Client Signature: _____ Date: _____

Privacy Practices:

I acknowledge that Kristina J. Chomick, LMFT - Therapy, Supervision and Consulting Services, LLC's "Notice of Privacy Practices" has been made available to me at www.kristinachomicklmft.com. I am aware that I may obtain a copy of this policy at any time. My signature below attests to an understanding of the information that has been provided to me.

Client Signature: _____ Date: _____

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Emergency Contact Consent Form

In case of a medical emergency (either physical or behavioral) for you, I may need to contact someone inform them of the emergency. Please complete this form with you will permit for me to contact in such emergencies:

I, _____ permit Kristina J. Chomick, LMFT to contact the following person(s) in case of an emergency – either physical and/or if you are a risk to your self or others:

Name	Phone Number
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Client Signature: _____ Date: _____

Kristina J. Chomick, LMFT

Therapy, Supervision and Consulting Services, LLC

Credit Card Authorization Form

Client Name: _____ DOB: _____

Please read thoroughly and complete the following information. This form will be electronically stored securely in your clinical file and in a square account that I will set up for you and may be updated periodically. It is your responsibility to update Kristina J. Chomick, LMFT if your credit card information changes and you may accrue additional late fees if she is unable to automatically charge your account.

In instances of late cancellations, no shows, bank returned checks and/or unpaid balances beyond 60 days, your credit card will be charged as follows:

- The charge for missed appointments or appointments canceled with *less than 24 hour notice* is \$50
- In the case of returned checks, the amount of the check plus an additional \$20.00 will be assessed to cover bank charges
- Unpaid balances beyond 60 days
- Unpaid balances after therapeutic relationship has ended

Additionally, if you would prefer, I can automatically charge your credit card on file for any out of pocket payments that you are responsible for (including but not limited to full-fee payments, copays and deductibles.)

Card Type (circle one): Visa / MasterCard / Discovery / American Express/Other

Card Number: _____ Expiration Date: _____

Name as printed on the card: _____

Verification/Security code (3 digit code on the back of card or 4 digit number of front of card): _____

Billing Zip Code for the card: _____ E-mail address for invoices: _____

I, _____, authorize Kristina J. Chomick, LMFT to charge my credit card in the event that I fail to notify her of my inability to attend a scheduled therapy session, do not cancel a scheduled appointment at least 24 hours in advance, have a check returned from my bank, or maintain an unpaid balance beyond 60 days, according to the policy outlined above, and I further agree to not dispute the charges.

Signature: _____ Date: _____

I, _____, authorize Kristina J. Chomick, LMFT to automatically charge my credit card for any out of pocket payments that I am responsible for (including but not limited to full-fee payments, copays and deductibles).

Signature: _____ Date: _____

Should charges be declined by your credit card company due to a closed account, inaccurate or outdated information, Kristina J. Chomick reserves the right to utilize a collections agency to help with acquiring necessary payments.

Kristina J. Chomick, LMFT
Therapy, Supervision and Consulting Services, LLC
Adult Intake Questionnaire

Patient information:

Name: _____ Today's Date: _____

Address: _____ Cell phone: _____

_____ Additional phone: _____
 Work Home

Is it okay to leave voicemail regarding scheduling? Yes (please circle: cell # only/ all provided #s) No

Is it okay to send you text messages regarding scheduling? Yes No

Would you like to receive reminder texts regarding your appointments? Yes No

Email address: _____

Is it okay to send you e-mails regarding scheduling? Yes No

Would you like to receive e-mail reminders for your appointments: Yes No

DOB: _____ Age: _____ Gender: _____ Social Security Number: _____

Race/Ethnicity: _____ Religious Affiliation (if applicable): _____

Occupation: _____ Employer/School: _____

Highest Level of School Completed: _____

Marital Status: Single Married Divorced Widowed other _____

Insurance Information:

Insurance carrier: Anthem BC/BS Cigna Medicaid/Husky Tricare Tufts Other: _____

ID #: _____ Group #: _____

Policy holder's name (if different from patient): _____ Policy holder's DOB: _____

Policy holder's Phone Number: _____ Policy holder's employer: _____

Address of policy holder: _____

Referral Information:

What is (are) your main reason(s) for this visit? _____

Did anyone recommend or refer you to services: Yes (I was referred by _____) No

If no, where did you find information regarding Kristina Chomick's therapy services: _____

Have you been involved in treatment with another provider in the past: Yes No

If yes, with whom: _____ When: _____

Briefly describe reason for past treatment: _____

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Medical Information:

Medical Provider Release of Information

Who is your primary care provider: _____

Would you like for me to speak with your primary care provider regarding your mental health treatment? Yes
No

Are you under the care of any other medical providers? Yes No

Would you like for me to speak with your providers(s) regarding your mental health treatment? Yes No

If Yes, Please write the name of the doctor in addition to their phone number and sign here authorizing Kristina J. Chomick, LMFT ability to obtain from and release information to your doctor(s) for the purpose of coordination of medical care.

Name/Phone Number/Specialty of Doctor:

Signature/Date:

1. _____

2. _____

3. _____

4. _____

Kristina J. Chomick, LMFT
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Are you currently on any medications: Yes No

If Yes, please describe medication, prescriber, and purpose for medication:

Please briefly explain any current or previous medical treatment/operations that you have had:

Have you gained/lost over ten pounds in the past year? Yes (please circle: gained/lost) No

If yes, was this weight change intentional? Yes No

Do you have a history of: Binging Purging Restricting

Any other issues regarding weight and/or appetite/eating habits:

Are you having any issues with your sleeping patterns: Yes N if yes, please explain:

Trouble falling asleep Trouble staying asleep Nightmares Oversleeping/sleeping too much

Any other issues regarding sleep:

Please check all substances you have used in the last 5 years:

Caffeine Tobacco Marijuana/THC Cocaine/crack (circle: snorted/injected/smoked)
 Alcohol Opioids (circle: snorted/injected/smoked/swallowed) Inhalants/"huffing" LSD/hallucinogens
 Ecstasy Prescription pills (specify: _____) Other (specify: _____)

Which is your primary drug of choice: _____

When was the last time you used this drug? _____ How often do you use? _____

Have you ever felt that you ought to cut down on your drinking or drug use? Yes No

Have people annoyed you by criticized your drinking or drug use? Yes No

Have you ever felt bad or guilty about your drinking or drug use? Yes No

Have you ever had to drink or use drugs first thing in the morning to steady your nerves or to get rid of a hangover?

Yes No

Do you gamble? Yes No If yes, has your gambling caused significant financial or relational stress? Yes N

Have you ever utilized shopping/spending money as a coping mechanism? Yes No

If yes, has your shopping ever lead to any significant issues with relationships, debt or affected any other aspects of your life negatively? Yes No

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Checklist of Concerns

Please check off all of the items below that apply, and feel free to add any others at the bottom under “Any other concerns or issues.” You may add a note or details in the space next to the concerns checked.

<input type="checkbox"/> I have no problem or concern bringing me here
<input type="checkbox"/> Abuse—physical, sexual, emotional, neglect
<input type="checkbox"/> Aggression, violence
<input type="checkbox"/> Alcohol use
<input type="checkbox"/> Anger, hostility, arguing, irritability
<input type="checkbox"/> Anxiety, nervousness
<input type="checkbox"/> Attention, concentration, distractibility
<input type="checkbox"/> Career concerns, goals, and choices
<input type="checkbox"/> Childhood issues (your own childhood)
<input type="checkbox"/> Codependence
<input type="checkbox"/> Confusion
<input type="checkbox"/> Compulsions
<input type="checkbox"/> Decision making, indecision, mixed feelings, putting off decisions
<input type="checkbox"/> Delusions (false ideas)
<input type="checkbox"/> Dependence
<input type="checkbox"/> Depression, low mood, sadness, crying
<input type="checkbox"/> Divorce, separation
<input type="checkbox"/> Drug use: prescription medications, street drugs
<input type="checkbox"/> Eating problems: over eating, under eating, purging
<input type="checkbox"/> Emptiness
<input type="checkbox"/> Failure
<input type="checkbox"/> Fatigue, tiredness, low energy
<input type="checkbox"/> Fears, phobias
<input type="checkbox"/> Financial or money troubles, debt, impulsive spending
<input type="checkbox"/> Friendships
<input type="checkbox"/> Gambling
<input type="checkbox"/> Grieving, mourning, deaths, losses, divorce
<input type="checkbox"/> Guilt
<input type="checkbox"/> Headaches, other kinds of pains
<input type="checkbox"/> Health, illness, medical concerns, physical problems
<input type="checkbox"/> Inferiority feelings
<input type="checkbox"/> Infertility or Reproductive Difficulties or Stress
<input type="checkbox"/> Interpersonal conflicts
<input type="checkbox"/> Impulsiveness, loss of control, outbursts
<input type="checkbox"/> Irresponsibility
<input type="checkbox"/> Legal matters, charges, suits
<input type="checkbox"/> Loneliness
<input type="checkbox"/> Marital conflict, infidelity/affairs, remarriage, different expectations

<input type="checkbox"/> Memory problems
<input type="checkbox"/> Menstrual problems, PMS, menopause
<input type="checkbox"/> Mood swings
<input type="checkbox"/> Motivation, laziness
<input type="checkbox"/> Nervousness, tension
<input type="checkbox"/> Obsessions, compulsions (thoughts or actions that repeat themselves)
<input type="checkbox"/> Oversensitivity to rejection
<input type="checkbox"/> Pain, chronic
<input type="checkbox"/> Panic or anxiety attacks
<input type="checkbox"/> Parenting, child management, single parenthood
<input type="checkbox"/> Perfectionism
<input type="checkbox"/> Pessimism
<input type="checkbox"/> Procrastination, work inhibitions, laziness
<input type="checkbox"/> Relationship problems (with friends, relatives, or at work)
<input type="checkbox"/> School problems
<input type="checkbox"/> Self-centeredness
<input type="checkbox"/> Self-esteem
<input type="checkbox"/> Self-neglect, poor self-care
<input type="checkbox"/> Sexual issues, dysfunctions, conflicts, desire differences
<input type="checkbox"/> Shyness, oversensitivity to criticism
<input type="checkbox"/> Sleep problems: too much, too little, insomnia, nightmares
<input type="checkbox"/> Smoking and tobacco use
<input type="checkbox"/> Spiritual, religious, moral, ethical issues
<input type="checkbox"/> Stress management, tension
<input type="checkbox"/> Suspiciousness, distrust
<input type="checkbox"/> Suicidal thoughts
<input type="checkbox"/> Temper problems, self-control, low frustration tolerance
<input type="checkbox"/> Thought disorganization and confusion
<input type="checkbox"/> Threats, violence
<input type="checkbox"/> Trauma
<input type="checkbox"/> Weight and diet issues
<input type="checkbox"/> Withdrawal, isolating
<input type="checkbox"/> Work problems, can't keep a job, dissatisfaction, ambition

Please use this space to further explain anything checked off above and/or any other information that you have not yet shared that you believe would be important for me to know: