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

Hello and welcome to my practice. I appreciate you giving me the opportunity to help you and your child on your therapeutic journey. This document contains information about my professional services and business policies. 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 Information

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.

Signatures and Consent

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

Patient/Guardian: _____ 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.

Patient/Guardian: _____ Date: _____

Financial Policy:

I have read and understand the information provided to me on 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.

Patient/Guardian: _____ 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. 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.

Patient/Guardian: _____ 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
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Parent/Guardian Signature: _____ Date: _____

A note for parents or guardians:

Often family involvement is important to the success of minor's treatment; however, at times issues are best addressed individually before involving others. Clients under 18 years of age (who are no emancipated) and their parents/guardians should be aware that the law allows parents/guardians to examine their child's records. Because privacy in psychotherapy is often crucial to successful treatment, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records if I meet with the client individually. If the parent/guardian agrees, during treatment, I will typically provide only general information about the progress of treatment, and the client's attendance at scheduled sessions. Before giving parents information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have. Additionally, I encourage parents or guardians to schedule individual appointments with me to discuss any concerns regarding their child or treatment. Please be assured that if I feel your child is in danger or is a danger to someone else, I will notify you of my concerns as soon as possible.

Please be aware that unless an order of protection or proof of termination of parental rights is provided, both biological parents have equal access to records and rights to be involved in their child's treatment.

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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 l*ess 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

Child and Adolescent Intake Questionnaire

Patient Information:

Name: _____ Today's Date: _____

Address: _____ Cell phone: _____

_____

Is it okay to leave voicemail regarding scheduling? □ Yes □ No
Would you like to receive text messages regarding scheduling? □ Yes □ No
Would you like to receive reminder texts regarding your appointments? □ Yes □ No

Email address: _____
Would you like to receive 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): _____

School: _____ Highest Level of School Completed: _____

Current School Activities/Clubs/Sports: _____

Parent/Guardian Information:

Name: _____ E-mail address: _____

Address: _____ Cell Phone phone: _____

_____ Additional Phone: _____
□Work □Home

Is it okay to leave voicemail regarding scheduling? □ Yes (please circle: primary # only/ all provided #s) □ No
Is it okay to text you regarding scheduling? □ Yes □ No
Would you like reminder texts for appointments? □ Yes □ No
Is it okay to e-mail you regarding scheduling? □ Yes □ No
Would you like to receive reminder e-mails for appointments? □ Yes □ No

Name: _____ E-mail address: _____

Address: _____ Cell Phone: _____

_____ Additional Phone: _____
□Work □Home

Is it okay to leave voicemail regarding scheduling? □ Yes (please circle: primary # only/ all provided #s) □ No
Is it okay to text you regarding scheduling? □ Yes □ No
Would you like reminder texts for appointments? □ Yes □ No
Is it okay to e-mail you regarding scheduling? □ Yes □ No
Would you like to receive reminder e-mails for appointments? □ Yes □ No
Please list the names and phone numbers of any additional parents and/our caretakers of your child:

_____

_____

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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:

_____
Has your child been involved in treatment with another provider in the past: ☐ Yes ☐ No
If yes, with whom: _____ When: _____
Briefly describe reason for past treatment:

_____

Insurance Information:
Insurance carrier: ☐ Anthem BC/BS ☐ Cigna ☐ Medicaid ☐ Tricare/MHN ☐Other: _____

ID #: _____ Group #: _____

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

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

Address of policy holder (please include Zip Code): _____

_____

Developmental and Family History:

Who currently lives in the home with your child:

_____

_____

Are there any recent changes in family dynamics or relationships that may be impacting child's functioning:

_____

_____

List any significant concerns/experiences related to child's development (prenatal, developmental milestones, trauma):

_____

_____

Please list some of your client's strengths:

_____

Medical Information:
Who is your child's primary care doctor? _____ Phone #: _____
Is your child currently under treatment with any other medical providers? □Yes □No
If Yes, please list other doctors and the current issues that they are providing treatment for:
_____
_____
_____

Would you like for me to speak with any above doctor regarding your child's mental health treatment? □Yes □No
If Yes, Please sign here authorizing Kristina J. Chomick, LMFT ability to obtain from and release to information from your child's doctor.
Name/Phone number of Doctor: Signature:

_____ _____
_____ _____
_____ _____

Is your child currently on any medication: □Yes □No
If yes, please list your child's medications and the current prescriber:
_____
_____

Please list any history of physical illness or operations:
_____
_____

Has your child gained/lost over ten pounds in the past year? □ Yes (please circle: gained/lost) □ No
If yes, was this weight change intentional? □ Yes □ No
Does your have a history of: □ Binging □ Purging □ Restricting
Any other issues regarding weight and/or appetite/eating habits:
_____
_____

Is your child having any issues with their sleeping patterns:

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

Does your child have a history of substance use issues: □ Yes □ No

If Yes, please explain:

_____
_____

Is there a history of mental health and/or substance abuse in your child's family: □ Yes □ No

If Yes, please explain:

_____
_____

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Checklist of Concerns and Behaviors

Please mark all of the concerns below that apply to your child, and feel free to add any others at the bottom of the list. You may add a note or details in the space next to the concerns checked. After you have completed this, please circle the concerns that you would like to be a focus as we begin our therapy sessions together.

☐ I have no problems or concerns regarding my child
☐ Abuse/neglect – physical, sexual, or emotional
☐ Aggression or violence
☐ Anger, hostility, arguing or irritability
☐ Anxiety, nervousness, excessive worry
☐ Appetite changes
☐ Argues, "talks back," smart-alecky, defiant
☐ Attention, issues with concentration, distractibility
☐ Bullies/intimidates, teases, inflicts pain, bossy
☐ Chronic pain
☐ Confusion
☐ Compulsions
☐ Cruel to animals
☐ Conflicts with parents
☐ Complains
☐ Cries easily, feelings are easily hurt
☐ Career/school concerns
☐ Dawdles, procrastinates, wastes time
☐ Decision making, indecision, mixed feelings, putting off decisions
☐ Delusions/hallucinations
☐ Dependence/immaturity
☐ Depression, low mood, sadness, crying
☐ Developmental delays
☐ Difficulties with changes in family dynamics
☐ Disobedient, uncooperative, noncompliant
☐ Distractible, inattentive, poor concentration
☐ Divorce/separation in family
☐ Drug or alcohol use
☐ Eating problems (over eating, under eating, purging, restricting)
☐ Emptiness
☐ Excessive exercise
☐ Failure in school, dropped/dropping out of school
☐ Fatigue, tiredness, low energy
☐ Fighting, violent, aggressive, hostile, destructive
☐ Fears, phobias
☐ Financial or money problems, debt, impulsive spending
☐ Fire setting
☐ Friendship issues/peer issues
☐ Gambling
☐ Grieving, mourning, losses
☐ Guilt
☐ Headaches

- ☐ Health, illness, medical concerns, physical problems
- ☐ Hygiene issues
- ☐ Hypochondriac, always complains of feeling sick Immature, has only younger friends
- ☐ Inferiority feelings
- ☐ Interpersonal conflicts
- ☐ Impulsiveness, loss of control, outbursts
- ☐ Irresponsibility
- ☐ Lacks organization, unprepared
- ☐ Lacks respect for authority, provokes, manipulates
- ☐ Learning disability:_____
- ☐ Legal difficulties: _____
- ☐ Loneliness
- ☐ Lying
- ☐ Memory problems
- ☐ Menstrual problems, PMS
- ☐ Mood swings/moodiness
- ☐ Motivation, laziness
- ☐ Mute, refuses to speak
- ☐ Nervousness, tension
- ☐ Nightmares/night terrors
- ☐ Obesity
- ☐ Obsessions, compulsions
- ☐ Overactive, restless, hyperactive, fidgety
- ☐ Oppositional, refuses, does not comply with rules
- ☐ Pain, chronic pain
- ☐ Panic or anxiety attacks
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Prejudiced, bigoted, insulting, intolerant
- ☐ Recent move, new school, loss of friends
- ☐ Relationship problems – family or friends
- ☐ Repetitive movements
- ☐ Running away, threatening to run away
- ☐ Self-harm behaviors: picking, head banging, cutting
- ☐ Shy, timid
- ☐ Speech difficulties
- ☐ Stubborn
- ☐ Suicide talk or attempt
- ☐ Self-centeredness
- ☐ Self-esteem issues
- ☐ Self-neglect, poor self-care
- ☐ Sexual issues – dysfunctions, conflicts, behaviors, preoccupation
- ☐ Shyness, oversensitivity to criticism
- ☐ Sleep issues
- ☐ Smoking and tobacco use
- ☐ Spiritual, religious, moral or ethical issues
- ☐ Stress management
- ☐ Suspiciousness/mistrust
- ☐ Temper tantrums, rages
- ☐ Thought disorganization

☐	Tics—involuntary rapid movements, noises, or word
☐	Teased, picked on, victimized, bullied
☐	Truant, school avoiding
☐	Uncoordinated, accident-prone
☐	Wetting or soiling the bed or clothes
☐	Weight and diet issues
☐	Withdrawal/isolation, likes to be alone
☐	Work issues – cannot keep a job, lack of 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: