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 – Primary Client

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: ____________________

Couples Therapy Release:

I, the undersigned, do authorize Kristina J. Chomick, LMFT to release and obtain information to and from my partner ______________________________ for the purposes of therapeutic continuity throughout the therapy process. I understand by signing this, that Kristina J. Chomick, LMFT may discuss topics with my partner that I have stated both in individual and joint sessions.

Client Signature: ____ Date: ____________________

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

Emergency Contact Consent Form – Primary Client

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

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Client Signature: ____ Date: ______________

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Kristina J. Chomick, LMFT

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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 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

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: ____

____

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. ______________________________ ______________________________
____
____

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

Kristina J. Chomick, LMFT

Therapy, Supervision and Consulting Services, LLC

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.

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

❑ Memory problems
❑ Menstrual problems, PMS, menopause
❑ Mood swings
❑ Motivation, laziness
❑ Nervousness, tension
❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
❑ Oversensitivity to rejection
❑ Pain, chronic
❑ Panic or anxiety attacks
❑ Parenting, child management, single parenthood
❑ Perfectionism
❑ Pessimism
❑ Procrastination, work inhibitions, laziness
❑ Relationship problems (with friends, relatives, or at work)
❑ School problems
❑ Self-centeredness
❑ Self-esteem
❑ Self-neglect, poor self-care
❑ Sexual issues, dysfunctions, conflicts, desire differences
❑ Shyness, oversensitivity to criticism
❑ Sleep problems: too much, too little, insomnia, nightmares
❑ Smoking and tobacco use
❑ Spiritual, religious, moral, ethical issues
❑ Stress management, tension
❑ Suspiciousness, distrust
❑ Suicidal thoughts
❑ Temper problems, self-control, low frustration tolerance
❑ Thought disorganization and confusion
❑ Threats, violence
❑ Trauma
❑ Weight and diet issues
❑ Withdrawal, isolating
❑ 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:

Kristina J. Chomick, LMFT

Therapy, Supervision and Consulting Services, LLC

Partner Information:

Name: ____________________ DOB: ______________ Age: ________ Gender: ______________

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

Occupation: ______________________ Employer/School: ____________________________

Highest Level of School Completed: ____

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

____

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: ________________________________

____
Are you currently on any medications: Yes No
If Yes, please describe medication, prescriber, and purpose for medication:
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Any other issues regarding weight and/or appetite/eating habits:

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____Are

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Yes No

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