Connie Hornyak

1000 Quail Suite 242
Newport Beach 92660
Phone: (714) 785-3407
FAX: (714)-202-3715
conniehornyak@icloud.com

# Adult intake form

Name

Address

Home Phone number

Fax number (if applicable)

Mobile Phone number

Date of birth

Work Phone number

Marital status

Email address (if applicable)

Date of separation (if applicable)

Date of marriage

Date widowed (if applicable)

Date of divorce (if applicable)

Occupation

Place of employment and address

## Whom may we thank for referring you?

Name

Address

Phone number

Fax number (if applicable)

Email address (if applicable)

Family Information:

| Name | DOB | RELATIONSHIP (e.g., spouse, child, step-child) | CURRENTLY LIVING (in or out of home) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Medical Information:

Name of physician

Physician's address

Physician's Phone Number

What is your present health condition?

Do you smoke? Yes No If so, how much

and how often

Date of most recent physical examination:

Please list your medications below, beginning with current medication, and working backward:

| Dates | Names of Medication | Amount (EX 10mg) | Taken When: | Prescribed by: | Your Reaction |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

SOCIAL ADJUSTMENTS:

How would you describe your interpersonal relationships?

With spouse/partner

With mother

With father

With brother(s)

With sister(s)

With peers

With employer

With others (specify)

PRESENTING PROBLEMS:

Please describe in detail the issues which have brought you to counseling:

Medical History

List any current/past illnesses/injuries that have impacted you or your family:

Marital History

Describe your current marriage, including both positive and negative qualities (e.g., intimacy, communication, problem-solving, togetherness).

Briefly list and describe any previous marriages.

THERAPEUTIC CONTRACT

**PART 1: PATIENT RIGHTS**

1. You have the right to a confidential relationship with me. Within certain legal limits (see #4 below), information revealed by you during the course of therapy will be kept completely confidential and will not be revealed to any agency or other person without your written permission.
2. You have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances.
3. If you ask for it, any part of your records on file with me can be released to any agency or person you specify. I will inform you at the time of your request whether or not I think releasing that information to that agency or person might be harmful to you in any way.
4. Under certain legally defined situations, I am required to reveal information given during the course of therapy, including E mail and text message communication, to other agencies or persons without your written consent. I am not, however, required to inform you of my actions if this occurs.

    a) If you reveal information to me about child abuse, or neglect or physical abuse of a dependent adult or an elderly person, I am required by law to report this to the appropriate authority. I will direct you to report spousal abuse.
    b) If you threaten bodily harm or death to another person I am required by law to warn the intended victim and notify the appropriate law enforcement agencies.
    c) If you threaten bodily harm or death to yourself, I am required by law to refer you immediately to an inpatient psychiatric program.
    d) If you are in therapy or being tested by order of a Court of law, the results of the treatment or tests ordered must be revealed to that Court.
    e) If a Court of law issues a legitimate subpoena, I am required by law to provide the information specifically described in the subpoena.

5. You have the right to ask questions about any of the procedures used in the course of therapy. If you ask, I will explain my customary approach and methods to you.
6. You have the right to choose not to receive therapy from me. If you choose this, I will provide you with names of the other qualified professionals whose services you might prefer.
7. You have the right to terminate therapy with me at any time without any financial, legal or moral obligations other than those you have already incurred.

**PART II: THE THERAPY PROCESS**

Participation in therapy can result in a number of benefits to you, including a better understanding of your personal goals and values, improved interpersonal relation ships, and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part and may result in your experiencing considerable discomfort.

Remembering and resolving unpleasant events through therapy can bring on strong feelings of anger, depression, fear, etc. Attempting to resolve issues between marital partners, family members, and other individuals can also lead to discomfort and may result in changes that were not originally intended.

**PART III: LENGTH OF THERAPY**

1. I agree to enter therapy with Connie Hornyak, LCSW.
2. I understand that I can leave therapy at any time.

_____ _____

Client's Signature(s) Date

_____

Address

_____ _____

Phone Number: Home Phone Number: Work

_____ _____

Date of Birth Social Security Number

_____

Therapist's Signature



1000 Quail Suite 242 Newport Beach 92660 Phone: (714) 785-3407 FAX: (714)-202-3715 conniehornyak@icloud.com

Connie Hornyak

1000 Quail Suite 242
Newport Beach 92660
Phone: (714) 785-3407
FAX: (714) 202-3715
conniehornyak@icloud.com

# Fee Agreement

I (We), _____ agree to pay for the

treatment of _____ by Connie Hornyak, LCSW.

I (We) agree to be responsible for payment to Connie Hornyak, LCSW, for all services rendered. I (We) understand that Connie Hornyak, LCSW, will assist me (us) in collecting insurance reimbursement, but that I am (we are) ultimately responsible for obtaining this reimbursement. Costs of sessions are as follows:

## PSYCHOTHERAPY FEES

| | |
|---|---|
| Individual or Family Psychotherapy, 100 minutes | $350.00 |
| Individual or Family Psychotherapy, 75 minutes | $265.00 |
| Individual or Family Psychotherapy, 50 minutes | $175.00 |
| Individual or Family Psychotherapy, 25 minutes | $ 90.00 |
| Individual or Family Psychotherapy, 15 minutes | $ 45.00 |
| Three-session assessment (75 min. each session ) | $800.00 |
| Three-session assessment with report | $1065.00 |
| Court reports, time spent in the Courtroom or waiting outside, preparation, being on call, and travel per hour | $400.00 |

There is a four-hour minimum charge for Court related matters, payable one week in advance, by cashier's check or credit card only.

Check or cash payments receive a $5 discount per 50 minutes of services.

PAYMENTS & INSURANCE REIMBURSEMENT:

Clients are expected to pay their fee at the end of each session unless other arrangements have been made. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, and travel time will be charged at the same rate. Please notify your therapist if any problem arises during the course of therapy regarding your ability make timely payments. Health insurance is a contract between you and your insurance company. Patients who carry insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. You will be provided with a "superbill" that you can submit to your insurance company for reimbursement.

CANCELLATION:

Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours (1 day) notice is required for re-scheduling or canceling an appointment. The full fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions.

I have read the above Fee Agreement. I understand and agree to comply with it.

| | | | |
|---|---|---|---|
| Signature | Name (print) | Date | Relationship to client: |
| Signature | Name (print) | Date | Relationship to client: |
| Therapist's signature | | Date | |



1000 Quail Suite 242 Newport Beach 92660 Phone: (714) 785-3407 FAX: (714)-202-3715 conniehornyak@icloud.com