ALEXANDRA CONDA, RMHCI

client intake

CLIENT DETAILS

First Name: Last Name:

Address: Date of Birth:

City: Zip Code:

Phone Number: Email Address:

Emergency Contact: Contact Number:

ALEXANDRA CONDA COUNSELING, LLC

813-461-4212 | alexcondacounseling@gmail.com | 10823 Boyette Road, Riverview, FL 33569

Please provide a brief description for seeking therapy.

By signing below, I acknowledge that I have completed this Client Intake Form to the best of my knowledge. I understand that the information provided is essential and that it will be kept confidential.

Patient or Authorized Printed Name	Date
Patient or Authorized Signature	Date
Patient or Authorized Printed Name	Date
Patient or Authorized Signature	Date

ALEXANDRA CONDA, RMHCI

informed consent

I, ... hereby consent to participate in counseling or therapy services provided by Alexandra Conda, RMHCI, a registered intern. I have received and reviewed the following information to make an informed decision about engaging in counseling or therapy.

PURPOSE OF COUNSELING

Counseling or therapy services are intended to assist individuals, couples, or families in addressing a variety of personal, emotional, psychological, or relationship-related challenges. The primary goal of counseling is to collaboratively explore and address these concerns with the therapist's guidance to improve mental and emotional well-being.

NATURE OF COUNSELING SERVICES

Counseling or therapy may encompass confidential and privileged discussions about thoughts, feelings, experiences, and behaviors. The therapist will employ various therapeutic techniques and interventions to help the client achieve their therapeutic objectives.

CONFIDENTIALITY

Confidentiality is a fundamental component of counseling, Information shared during sessions is typically kept confidential. However, there may be exceptions to confidentiality, including;

- If there is a clear and imminent risk of harm to yourself or others.
- If you disclose information about child or elder abuse or neglect.
- If the therapist is legally compelled by a court order to disclose information.
- If consultation with other mental health professionals is necessary for your care. Alexandra Conda is supervised by Jennifer Mannion, LMHC.

BENEFITS AND RISKS

I acknowledge that I have been informed about the potential benefits and risks of counseling Counseling may provide me with insights, coping skills, emotional relief, and personal growth. Nevertheless, there are no guarantees of specific outcomes, and the process may evoke strong emotions.

FEES AND PAYMENT

- My standard fee is $90 per session - unless other arrangements have been agreed upon prior to our meeting or you are using insurance. All co-pays are due at time of service. Telephone consults, reports, letters, etc. are not paid by insurance and you are responsible for these fees. Fees are standard at $90 an hour, prorated if less than one hour. Session fees and insurance co-pays are due at the time of each session.
- I understand the fee structure for counseling or therapy sessions and the accepted payment methods.
- I agree to pay for each session promptly in accordance with the agreed-upon fee schedule.

INSURANCE AND THIRD-PARTY BILLING

I understand that if I choose to use health insurance or another third-party payer for counseling services, my confidential information may be disclosed to these entities for billing and reimbursement purposes.

CANCELLATION POLICY

It is your responsibility to give a 24- hour notice for any cancellations. Failure to give proper notice, or failure to show for an appointment, will result in a $90 fee. My voicemail is available 24 hours a day for your convenience if you need to cancel or reschedule an appointment.

TERMINATION OF SERVICES

I am aware that either the counselor or I may decide to terminate counseling services at any time for any reason. The counselor will engage in a discussion with me about such a decision and provide appropriate referrals if necessary.

DURATION OF FREQUENCY OF SESSIONS

I understand that the duration and frequency of counseling sessions will be determined collaboratively with the therapist based on my individual needs and goals.

CLIENT'S CONSENT

I have read and comprehended the information provided in this informed consent form. I willingly consent to participate in counseling or therapy services with Alexandra Conda. I understand my rights and responsibilities within this therapeutic relationship.

Patient or Authorized Printed Name	Date
Patient or Authorized Signature	Date
Patient or Authorized Printed Name	Date
Patient or Authorized Signature	Date
Counselor's Signature	Date

ALEXANDRA CONDA, RMHCI

office policies

Contact: My usual business hours are 9:00AM- 7:00PM- Monday through Friday. I will reply to all emails received during business hours the day they were received and return all calls within business hours on the day they were received. My voicemail is confidential and a safe place to leave a message. Please keep emails to scheduling, billing or reference information only. Please note electronic communication is not a secure method and it is best to save interpersonal information for scheduled sessions.

Emergencies: In the event of an emergency, in which you feel immediate attention is necessary; you may contact your primary health care provider, proceed to the nearest emergency room, or call 911 or 211.

Patient or Authorized Printed Name	Date
Patient or Authorized Signature	Date
Patient or Authorized Printed Name	Date
Patient or Authorized Signature	Date

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ALEXANDRA CONDA, RMHCI

Credit/Debit Card Payment Consent Form

I, _____ authorize to pay for professional services provided by Alexandra Conda, RMHCI. I acknowledge the name listed above to use my credit/debit card to pay for these professional services. These services include, but are not limited to individual therapy, couples therapy, phone calls, evaluations, and report writing. The card will be charged at the time of billing. If the payment is declined, every effort will be made to contact the card holder to collect payment. In addition, every effort will be made to collect payment from the person(s) to whom the professional services were rendered. Further professional services will not be offered until such time a new agreement is completed or the existing card is available to be charged. By signing this consent form, you are allowing payment, at any time following the professional service, to be charged to your card.

This agreement shall be in effect for the duration of time the above named is receiving professional services or until the cardholder provides written instruction to cease using the authorized card.

By signing this Credit/Debit Card Payment Consent Form, I agree with the terms listed.

Type of Card: VISA MASTERCARD HAS/FSA OTHER

Name on Card: _____

Card Number: _____

Expiration Date: _____ CVV: _____

Card holder's billing zip code: _____

Card holder's printed name: _____

Card holder's signature: _____

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ALEXANDRA CONDA, RMHCI

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Client Name: _____

In the course of providing service to you, Alexandra Conda, RMHCI (IMH26826) creates, receives and stores health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services, and to conduct health care operations involving this office. As described, the use and disclosure of your health information is used in a confidential manner for purposes of payment and may include the submission of your personal information and/or medical information to process insurance claims.

I have read this consent and understand the terms. I consent to the use and disclosure of my confidential information for purposes of treatment, payment, and health care operations.

If I choose to file with insurance, I authorize Alexandra Conda, RMHCI (IMH26826) to release my clinical diagnosis and treatment request information acquired in the course of my treatment to my insurance carrier. I am also aware that payment is ultimately my responsibility and should my insurance fail to pay for services for any reason, I am required to pay for services.

_____ _____

Client or Authorized Signature Date

_____ _____

Client or Authorized Signature Date

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