

New Reflection's Clinical Services

Please fill out the following information as completely as possible.

Date: _____

Full Legal Name: _____

Address: _____

City: _____ State _____ Zip _____

Phone: Home _____ Work: _____

Date of Birth: ___/___/___ Social Security # of client ____ - ____ - ____

Date of Birth of insured : ___/___/___ Security of insured ____ - ____ - ____

Marital Status: Single ___ Engaged ___ Married ___ Separated ___ Divorced ___
Widowed ___

If married, spouse's name: _____ Age _____

Spouse's occupation and place of employment _____

Number of years married _____

If you have children, please list their names and ages

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Place of Employment:

Job Title:

Number of years at current job: _____

What is your religious affiliation? (optional) _____

Attendance: Regularly ___ Sometimes ___ Never ___

How were you referred to New Reflections Clinical Services?

Insurance Co. ___ Physician ___ School ___ Church ___ Friend ___ Other ___

The following questions are designed to help me understand your background. Please complete them as they apply to you. Thank you.

Parents' names: (F) _____ Age _____ Deceased _____

(M) _____ Age _____ Deceased _____

Married ___ Separated ___ Divorced ___ Widowed ___

Number of brothers _____ sisters _____

Has anyone in your family of origin had counseling? Yes ___ No ___ If so, for what?

Is there any history of drug or alcohol abuse in either of your parents' families?

Yes ___ No ___ If yes, please describe.

Was there any physical, sexual, or emotional abuse done to you or your siblings?

Yes ___ No ___ If yes, please describe. _____

Are you in any way fearful of your current partner? Yes ___ No ___

Does your partner have angry outbursts or temper tantrums? Yes ___ No ___

Has your partner ever pushed, grabbed, slapped or hit you? Yes ___ No ___

Please list any specific medical conditions that you have _____

Are you taking any prescription medications* at this time? Yes ___ No ___

If yes, what are they? _____

How long have you been taking this? _____ Who prescribed it for you? _____

What is your daily or weekly alcohol intake? _____

Do you have a past or current history of other drug abuse? Yes, current ___ Yes, past ___
No ___

If yes, please list _____

Have you been in therapy in the past? Yes ___ No ___

If yes, when, for what, how long, and with whom _____

Was the therapy helpful? _____

What are your goals for therapy? _____

Is there anything else that you feel is important to this therapy session? _____

Please fill out the authorization of benefits page if you plan to use your insurance for payment. In addition, please fill out the checklist and return this form to your therapist. I look forward to working with you.

Francoise Mastroianni, MS., LCPC., CADC., CEDA., CCSAS.

Name _____ Date- _____

Please check any of the following that apply to you at present.
If checked please explain.

- Suicidal thoughts _____
- Always tired _____
- Poor appetite _____
- Trouble sleeping _____
- Loss of weight _____
- Weight gain _____
- Fast heart beat _____
- Frequent sweating _____
- Dizziness _____
- Shaky hands _____
- Stomach trouble _____
- Feeling tense _____
- Cold feet/Cold hands _____
- Diarrhea _____
- Constipation _____
- Muscle twitching _____
- Nausea or vomiting _____
- Headaches _____
- Fainting spells _____
- Chronic illness _____
- Full of energy _____
- Financial problems _____
- Difficulties at work _____
- Excessive drinking _____
- Excessive use of drugs _____
- Excessive spending of money _____
- Pornography use _____
- Problems with parents _____
- Fighting and quarreling often _____
- Overly ambitious _____
- Difficulties at school _____
- Confused about personal religious practice _____
- Recent loss of someone close to me _____
- Crying spells _____
- Unable to have fun _____
- Feeling easily hurt _____

- Lacking confidence_____
- Feeling grouchy_____
- Depressed_____
- Feeling lonely_____
- Not enjoying usual activities_____
- Feeling inferior_____
- No one understands me_____
- Worried about health_____
- Can't concentrate_____
- Can't get going_____
- Feeling angry_____
- Don't like being alone_____
- Always worried_____
- Nightmares_____
- Feeling panicky_____
- Can't make decisions_____
- Can't make friends_____
- Unable to relax_____
- Feeling fearful_____
- Overly sensitive_____
- Anxious inside_____
- Panic/Anxiety attacks_____
- Sexual problems_____
- Easily excited_____
- Quick tempered/lose temper_____
- Impatient with people_____
- Very restless_____
- Feel like hurting someone_____
- Feel like smashing things_____
- Shy with people_____
- Feelings of guilt_____
- Unable to pray_____
- Unable to forgive_____
- Unable to feel forgiven_____
- Loss/disappointment_____

Informed Consent

Welcome to New Reflection's Clinical Services. I would like you to have a clear understanding of the services that I provide and my expectations of you, my client. Please read the following information so that you can knowledgeably sign the Informed Consent. If you have any questions or need clarification, please ask for assistance.

Services Offered

New Reflection's Clinical Services provides outpatient counseling. I work with all age groups, providing individual, group, couple, family and interventions. Psychiatrist services can be arranged through a referral. Sessions are 50 minutes in length. Telephone consultations are also available.

I strive to return all messages as quickly as possible Monday through Saturday. Routine messages left on the weekend may be returned on Monday. I do not guarantee 24 hour crisis coverage and if I am not available when you feel you are in crisis, please call the DuPage Crisis line at 630-627-1700, proceed to your local hospital emergency room, or call 911.

Initial Assessment and Counseling Process

Initial assessments take place at the first appointment. These appointments are used to gather data, complete intake information, and to determine the best course of care. If on going counseling is recommended, I will diligently work to provide the best therapeutic methods and tools available. For counseling to be successful, your commitment to the process is absolutely essential. This includes regular attendance and active participation, assignments between sessions to enhance or speed your growth, and completion of the therapeutic process through planned termination of counseling services.

You may begin to find some relief of symptoms initially, and it may be tempting to terminate. However, this initial relief is often temporary if counseling is stopped abruptly. As all therapists want to see clients have the greatest growth possible during the time they are with them, I will work with you to plan a successful wrap-up. This is an important part of the counseling process, and I highly encourage you to honor your own effort by not neglecting this phase.

Fees

Individual, family, couples and interventions are \$100. per session. Group therapy is \$50. per session. Home interventions are \$120. per session. If you are paying out of pocket, there is a 20% discount. I am also able to do a sliding scale, given the situation. Telephone consultation less than 10 minutes is complimentary if not overused. Phone consultation 11-30 minutes is billed at \$25. Insurance companies will not cover these fees.

If a check is returned for insufficient funds, the client is responsible for any bank fees assessed, and an alternate method of payment is required.

Insurance

I will bill most insurance companies' as a courtesy to you. If I am not able to work with your insurance company, I will request payment in full and provide you the necessary information to submit your claim. **The first session must be paid in full until benefits, deductibles, and co-pays are verified by your insurance company.** If benefits have already been verified, you will find this information on the attached **Benefits Inquiry sheet.**

Cancelled or Missed Appointments

Due to the nature of counseling services, I do not overbook my schedule: therefore I request a **24-hour notification of cancellation** so that others may utilize that time. I also realize financial accountability enhances your commitment to your counseling work. As a result, charge your insurance company and a \$60.00 fee for those paying out of pocket, If I do not receive this notice. Insurance companies will not cover missed appointments. Full payment for the missed session is due within one week. Please note that 2 or more instances of missed appointments without notifying me may result in termination of services.

Confidentiality

Legal and ethical standards require me to maintain confidentiality. Information cannot be divulged without your written consent. There are two major exceptions: if you are or become a danger to yourself or others. In addition, I am mandated by the State of Illinois to report any real or alleged abuse to children, elderly, or incapacitated people.

Agreement

I have read and understand the above statement on services, policies, and procedures. My signature below indicates that I give my full consent to receive services at:

New Reflection's Clinical Services
francoise mastroianni ms.,lcpc.,cadc.,ceda.,ccsas.

Client (age 17 and over)_____Date_____

Client (age 12-16)_____Date_____

Client (under age 12)_____Date_____

Client guardian (for minors)_____Date_____