EMBRACE THE CHANGE COUNSELING ◆ Alba Reynoso, LCSW, ATR-BC ◆ 179 W. Chestnut Hill Rd, Suite 6, Newark, DE 19713
302-358-6237 ◆ Fax: 888-972-7649 ◆ Website: embracethechangecounseling.com ◆ email: alba@embracethechangecounseling.net

CLIENT INFORMATION

DEMOGRAPHICS

First Name	Middle Name	Last Name(s)	Last 4 digits of Social Security #

Date of Birth	Age	Gender Identity	Ethnicity / Race (Optional)	Marital Status
		☐ Male ☐ Female		

Street Address	City	State	Zip Code

Email Address	Cell Phone	Home/Work Phone
	( )	( )

May we leave a voicemail? ☐ Yes ☐ No If No, preferred contact: _____

FOR MINORS (UNDER 18) — COMPLETE IF APPLICABLE

Parent/Guardian #1 Name	Relationship	Cell Phone	Email

Parent/Guardian #2 Name	Relationship	Cell Phone	Email

Parents separated/divorced? ☐ Yes ☐ No Legal custody: _____ Court order visiting arrangements:

Delaware law grants minors age 12+ certain confidentiality rights. The scope of confidentiality with be discussed at the first appointment.

Person helping you complete this form, if any: _____ Relationship to client: _____

EMERGENCY & DESIGNATED CONTACTS

Emergency Contact Name	Relationship	Phone

Designated Contact Name (optional)	Phone	Email

The designated contact may manage appointments and administrative matters but will NOT have access to psychological records without a separate HIPAA authorization.

PRIMARY CARE PHYSICIAN

Physician / Provider Name	Practice Name	Phone

_____ (Initial)	**I authorize my therapist to contact my primary care physician for coordination of care.**
_____ (Initial)	**I do NOT authorize contact with my physician. (Information for records only.)**

PAYMENT & INSURANCE

_____ (Initial)	**I am NOT using insurance.:** *I accept full responsibility for all fees. My PHI will NOT be disclosed to any insurer. If applicable, a superbill will be provided upon request for potential reimbursement through your insurer.*
_____ (Initial)	**I will use health insurance.: If applicable,** *I authorize Embrace the Change Counseling to bill my insurer and release the minimum necessary PHI for billing. Insurance information is needed to provide you with a superbill.*

If using insurance, complete below:

Insurance Company	Insurance ID #	Group #
Cardholder's Full Name	**Cardholder's DOB**	**Relationship to Client**

FINANCIAL AGREEMENT & CONSENT FOR TREATMENT

FEES & FINANCIAL POLICIES

Sessions & Billing: Services not covered by insurance are billed to you directly. Phone calls under 5 minutes are not billed; calls over 5 minutes are billed at $25.00 per 15-minute increment or a session fee if past 30 minutes. Extended correspondence, assessments, and letters to outside professionals are billed at $175.00/hour.

Cancellation & No-Show: 24 hours' notice is required. A $50.00 fee applies to late cancellations or no-shows. Not billable to insurance; must be paid before the next session.

Credit/Debit Card: A 4% processing fee applies. Overpayments will be refunded or credited.

Legal/Court Services: If required to appear in court or provide legal services: $1,750/day or $300/hour, payable in advance. Not covered by insurance.

Insurance: You are responsible for verifying your own benefits, deductibles, and copayments. Account balances must be paid before or at the next session.

Financial Hardship: Please speak with your therapist. A sliding scale may be available on a case-by-case basis.

Legal / Court Involvement: Embrace the Change Counseling does not provide custody or forensic evaluations, including recommendations regarding parental fitness or legal determinations. If required to participate in legal proceedings:

- Applicable fees will apply as outlined in the financial agreement. Confidentiality may be limited.
- Information disclosed may become part of the public record

_____ (Initial)	**I have read and agree to the Fee Agreement and Financial Policies above.**

RESPONSIBLE PARTY (IF SOMEONE OTHER THAN THE CLIENT WILL PAY)

Responsible Party Name	Relationship	Phone	Email

HIPAA — NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received and had the opportunity to read Embrace the Change Counseling's Notice of Privacy Practices (NPP), which explains how my protected health information (PHI) may be used and disclosed. I understand that:

- My PHI may be used for treatment, payment, and healthcare operations without additional authorization.
- I may request an updated NPP at any time. My treatment is not conditioned on signing this acknowledgment.
- I have the right to access, amend, and obtain an accounting of disclosures of my health information.
- I have the right to file a complaint with the Privacy Officer (Alba Reynoso) or the U.S. Secretary of HHS — without fear of retaliation.

• I may revoke any authorization in writing at any time, except where action has already been taken.	
_____ (Initial)	**I have read and understood the above NPP. I acknowledge receipt of the Notice of Privacy Practices.**
☐ Client Refuses to Acknowledge Receipt	**Staff Signature (if refused):**

LIMITS OF CONFIDENTIALITY

Confidentiality is an essential part of the therapeutic relationship. However, there are circumstances in which your therapist is legally or ethically required to disclose information without your consent, including:

- Risk of harm to yourself or others. Suspected abuse or neglect of a child, elder, or dependent adult.
- Court orders or legal proceedings. Compliance with legal, licensing, or regulatory requirements
- Defense against a claim, complaint, or legal proceeding brought by the client or on behalf of the client, disclosing only the minimum necessary information in accordance with applicable law.
- Medical emergencies or coordination of care when necessary. Limited disclosures for billing, payment, or healthcare operations. Reasonable efforts will be made to inform you of such disclosures when appropriate.

_____ (Initial)	**I have read and understood the limits of confidentiality**

BREACH NOTIFICATION AUTHORIZATION

I authorize Embrace the Change Counseling to contact me by telephone or verbally in the event of a breach of protected health information (PHI). Such notification shall be documented. Consistent with the HIPAA Breach Notification Rules, this verbal/telephonic notice is for administrative convenience only and does not waive any rights I have under HIPAA.

_____ (Initial)	**I authorize telephonic/verbal notification in the event of a PHI breach.**

CONSENT FOR TREATMENT & AUTHORIZATIONS

Consent for Treatment: I voluntarily consent to receive psychotherapy, art therapy, and related therapeutic services from Embrace the Change Counseling and Alba Reynoso, LCSW, ATR-BC. The nature, purpose, benefits, and risks have been explained to me.

HIPAA Billing Authorization: I authorize the use and disclosure of my PHI for treatment, payment, and healthcare operations. I assign all applicable mental health benefits directly to my therapist until revoked in writing.

Art Therapy & Artwork: I consent to photographs or videos of my artwork for record-keeping. Artwork not picked up prior to my discharge will be disposed of per applicable law.

Therapeutic Techniques: I understand that some therapeutic techniques may involve therapist's proximity and/or limited, non-invasive touch, such as to the hand, arm, shoulder, or forehead, when clinically appropriate and only with my permission. I understand that touch is optional, may decline or stop at any time, and declining will not affect my care.

Electronic Records: I consent to my records and artwork being photographed, scanned, or stored in HIPAA-compliant systems.
Administrative Discharge / Inactive Client Status: Clients who have not attended a session and have not contacted the practice for 90 consecutive days may be discharged from services. Reasonable efforts will be made to contact the client prior to case closure.

Rights & Revocation: My participation is voluntary. I may revoke this consent in writing at any time. Revocation does not affect prior actions taken in reliance on this consent.

Financial Agreement: I agree to the cancellation policy ($50 fee), all applicable copays, deductibles, and a 4% fee for credit/debit card payments.

CLIENT RIGHTS: As a client, you have the right to: Ask questions about your treatment. Refuse or discontinue services at any time. Request referrals or a second opinion. Access your records in accordance with applicable law. Receive services in a respectful and professional environment.

_____ (Initial)	**I have read, understand, and consent to the treatment terms and authorizations above.**

TELEHEALTH CONSENT — COMPLETE ONLY WHEN APPLICABLE

Telehealth uses electronic communications (video, phone, or secure messaging) to deliver healthcare services remotely. It includes assessment, diagnosis, treatment, and care management.

Benefits: Improved access, continuity of care, reduced travel, flexible scheduling.

Risks: Technology failures may interrupt sessions. Electronic transmission carries some risk of interception. The therapist may determine telehealth is not clinically appropriate and recommend in-person care.

Platform: Sessions use HIPAA-compliant platforms. You are responsible for participating from a private, confidential location using a secure internet connection.

Licensure & Jurisdiction: Services are provided in accordance with Delaware state licensure laws. Telehealth services may only be provided when the client is physically located in a state where the therapist is licensed or otherwise legally authorized to provide services at the time of the session.

Emergency Procedures: If a crisis arises, your therapist will attempt to reach you by phone and/or contact your emergency contact or local emergency services. You are responsible for maintaining current emergency contact information.

Embrace the Change Counseling is not an emergency service. If you are experiencing a crisis, call 911, go to the nearest emergency room, or contact the 988 Suicide & Crisis Lifeline.

Session Location: I understand that I am responsible for informing my therapist of my current physical location at the start of each telehealth session for safety and legal purposes.

Recording Policy: Unauthorized audio, video, or screen recording of telehealth sessions is prohibited without prior written consent.

If Connection Drops: Attempt to reconnect using the same platform. If reconnection is not possible within 10 minutes, the therapist will contact you by phone to continue the session or reschedule if necessary.

Usual telehealth location (for reference only):	
_____ (Initial)	**I have read and understand the above. I consent to receiving services via telehealth. I may withdraw this consent at any time without affecting my right to future care.**

COMMUNICATION POLICY

Communication outside of scheduled sessions (phone, email, or messaging) is intended for administrative purposes only.

- Messages are monitored during business hours
- Responses may take up to 24–48 hours
- Communication should not be used for emergencies or urgent clinical concerns

_____ (Initial)	**I understand and agree with the communication policy.**

PROFESSIONAL BOUNDARIES ADN SOCIAL MEDIA

To protect your privacy and confidentiality:

- You may choose to follow or interact with the therapist and/or practice's public social media accounts; however, this is entirely optional
- The therapist does not provide clinical services, respond to personal concerns, or engage in therapeutic communication through social media
- Any interaction on public platforms will remain general and professional and will not acknowledge your status as a client

_____ (Initial)	**I understand and agree with professional boundaries and social media policy.**

COMPLETE IF APPLICABLE - PERSONAL REPRESENTATIVE / LEGAL AUTHORITY

If signing on behalf of another individual, please indicate your legal authority (e.g., power of attorney, healthcare surrogate, legal guardian). By signing on behalf of another individual, you confirm that you have the legal authority to consent on behalf of the client and will provide supporting documentation upon request. Please provide a copy of the legal document.

Representative's Name	**Relationship**	**Legal Document / Court Order Reference #, if applicable**

By signing below, I confirm that I have read, understood, and agreed to all terms on the sections above.

Client / Guardian Signature	**Print Name**	**Date**

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CLINICAL INTAKE — PRESENTING CONCERNS

All information is confidential and protected under HIPAA.

REASON FOR SEEKING SERVICES

Briefly describe why you are seeking treatment at this time:	
When did you first notice this?	**How often does it occur?**
What have you already tried to address this problem?	
What are your goals for therapy? How would you know the problem is resolved?	
A.	
B.	
C.	

CURRENT SYMPTOMS — CHECK ALL THAT APPLY

☐ Under too much pressure / stressed	☐ Excessive anxiety or worry	☐ Blackouts or memory loss
☐ Feeling lonely	☐ Angry feelings or outbursts	☐ Use of alcohol
☐ Feeling in a constant state of crisis	☐ Feeling numb or cut off from emotions	☐ Nightmares
☐ Excessive fear of places or objects	☐ Difficulty making friends	☐ Concerns about finances
☐ Feeling as if you'd be better off dead	☐ Feeling people are 'out to get you'	☐ Inability to control thoughts
☐ Feeling manipulated or controlled	☐ Difficulty making decisions	☐ Crying spells
☐ Loss of interest in sexual relationship	☐ Concerns about physical health	☐ Digestive issues
☐ Loss of appetite — since when? _____	☐ Increased appetite — since when? _____	
☐ Low self-confidence / self-esteem	☐ Loss of interest in usual activities	☐ Feeling trapped in rooms or buildings
☐ Significant weight **loss** — how much?	☐ Insomnia — bedtime:_____ asleep hrs:___ since:___	☐ Waking at night — how many times? ____
☐ Significant weight **gain** — how much?	☐ Oversleeping — hours/day? _____ since? _____	☐ Use of non-prescription / prescription drugs
☐ Hallucinations (auditory/visual/other)	☐ Feeling distant from God / spirituality	☐ Obsessions or compulsions
☐ Behavioral issues (yelling, hitting, lying)	☐ Inability to concentrate at work/school	**Others:**

BACKGROUND

Physical Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor **Mental Health:** ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Role of spirituality/religion in your life: ☐ A lot ☐ A little ☐ Not significant

Who do you live with?	Employer (if applicable)

PSYCHIATRIC, MEDICAL & SUBSTANCE HISTORY

PSYCHIATRIC HISTORY

Have you received mental health treatment before? ☐ Yes ☐ No

Previous Therapist / Provider	Approximate Dates	Reason for treatment
Psychiatrist Name (if any)	Last seen	Reason for ending

Please list any psychiatric/mental health diagnoses you have received:

Have you ever been hospitalized for psychiatric or substance-related reasons? ☐ Yes ☐ No If yes explain:_____

Have you ever felt suicidal? ☐ Yes ☐ No If yes, when? _____ Explain: _____

Are you currently experiencing suicidal thoughts? ☐ Yes ☐ No If yes, do you have a plan? _____

Do you own a firearm? ☐ Yes ☐ No If yes, describe storage: _____

LEGAL INVOLVEMENT

Have you ever been arrested? ☐ Yes ☐ No Are you currently on probation? ☐ Yes ☐ No

Is counseling mandatory for you? ☐ Yes ☐ No If yes, explain: _____

Are you involved in legal proceedings (family court, immigration, disability, workers' compensation)? ☐ Yes ☐ No

HISTORY OF ABUSE — CHECK ALL THAT APPLY

Type	When did this occur?	Who was the abuser?	Additional info
Physical			
Emotional			
Sexual			

MEDICAL HISTORY

Family Doctor Name	Last Time Seen
Medical/physical conditions you have been diagnosed with:	

Have you had surgery? ☐ Yes ☐ No If yes: _____

Current Medications (OTC or Prescribed)			
Medication	**Dosage**	**Reason**	**Prescribing Physician**

CURRENT OR PAST HABITS

Drugs/ Substance / Habit	Current	Past	How Much	How Often	Last Used	Notes

For alcohol/drug use: note in Notes column if currently sober and for how long.

CERTIFICATION

I certify that all information provided in this intake packet is accurate and complete to the best of my knowledge. I understand that falsification of information may result in termination of services.

Client or Guardian Signature	Print Name	Date

ADDITIONAL AUTHORIZATIONS — MEDIA, MARKETING & COMMUNICATIONS

Client Name	Date of Birth	Date

#	AUTHORIZATION	DESCRIPTION & CONSENT	INITIALS
1	**Audio Recording (AutoNotes AI, Zoom AI & Similar)**	I authorize the use of audio recording technology, including Zoom AI transcriptions, AutoNotes AI, or similar applications, solely for clinical, administrative, and billing documentation. Recordings are deleted after transcription and NOT used for vendor software training. I may withdraw this consent in writing at any time without affecting my treatment.	_____
2	**Unsecure Communication (Email, Messaging, Chats)**	I authorize Embrace the Change Counseling, Inc. to communicate with me via unsecure platforms (Email, WhatsApp, Telegram, SMS), which may not fully protect my information under HIPAA. I have been offered information about more secure options. I may revoke in writing at any time.	_____
3	**Photography for Clinical Record Keeping**	I authorize photography and video during sessions or events exclusively for clinical documentation and record keeping per clinical and legal standards. These images will not be used for marketing without a separate authorization.	_____
4	**Testimonial & Publicity**	I authorize Embrace the Change Counseling, Inc. and Alba Reynoso, LCSW, ATR-BC to use my testimonials, comments, photos, videos, and audio recordings for marketing, advertising, and social media (website, Instagram, Facebook, YouTube). My PHI will be handled per HIPAA. I may revoke this authorization in writing at any time.	_____
5	**Photography, Video & Recording**	I authorize Embrace the Change Counseling, Inc. to photograph and audio/video record me during sessions, workshops, or events for clinical documentation, training, and/or marketing purposes, including social media. Participation is voluntary. I may revoke in writing at any time.	_____
6	**Email Marketing Communications**	I authorize Embrace the Change Counseling, Inc. to send me emails about new services, workshops, events, and marketing materials. Participation is voluntary and not required for treatment. I may opt out or revoke in writing at any time.	_____

By initialing only those authorizations I wish to grant (and leaving blank those I decline), I confirm I have read each item and understand my choices are independent and will not affect the quality of my care.

Client/Guardian Signarure:_____

For office use only: Date received: _____ *Reviewed by: Alba Reynoso*