

Toni M Maita, MS MFT
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Client Intake Form

Client Information

Name:		Home Phone:	
Cellular:		Email:	
Address:			
City, State, Zip:			
Date of Birth:		Sex: M or F	Marital Status: S D M W

Insurance Information

Insurance Company		Insurance Company Phone:	
Name of Insured		Group No.	Authorization No.
Date of Birth of Insured		SSN/ID Number of Insured	
Employee Assistance Program Reference No.			
Total Sessions Pre-authorized		Co-payment	

Employment

Employer:		Job Title:	
Years with this employer?			

Persons Living in Household

Name	Sex	Birth Date	Relationship

Emergency Contact		Phone	
Relationship		Address	

Drug & Alcohol Use	Frequency/Amount	Last Date Used

Mental Health History

Therapy Dates	Any psychiatric hospitalizations? Y/N
Therapist(s) or Agency seen	
Describe reason for psychiatric hospitalization:	

Medical History

Any medical hospitalization? Yes/No	
Describe reason for hospitalization:	
Currently being treated for a medical condition? Yes/No	
Briefly describe condition	
Primary Care Physician:	Phone number:

Current Medications

Medication	Dosage/Frequency	Prescribed by:

Describe the reason for your visit today:

Toni M. Maita, MS MFT

RELEASE OF INFORMATION

I _____, give permission to Toni M. Maita, MFT, to discuss the following information:

with _____

This release may be revoked by client at any time, but will automatically expire in 1 year.

Client Date

Parent or Legal Guardian Dare

Witness Date

CLIENT CONFIDENTIALITY

The information discussed in therapy is confidential and cannot be disclosed to anyone. The exceptions are:

1. If there is a suspicion or evidence of child or elder or dependent adult abuse.
2. If the therapist learns that a serious threat exists to the life of the client or the life of another.
3. If client signs a release of information form or you are referred by an EAP or managed care health insurance company that requests information.
4. If client signs a release of information for the therapist to share information with those specified by client.
5. If there is a court order for the therapist to appear or to produce records.
6. I may determine it clinically necessary to discuss some aspects of your psychotherapy with another qualified professional in order to further your treatment goals. If I seek such consultation, neither your name nor any identifying information will be communicated.
7. I may release your name for collections processing. However, not treatment related information will accompany the disclosure

CANCELLATION POLICY

For therapy to be effective, it is important to attend your appointments as scheduled. If you are unable to keep an appointment, please notify me within 48 hours of your scheduled appointment, otherwise there will be a charge of \$120.00. I will attempt to reschedule your appointment to another day and time within the same week of your scheduled appointment, if an appointment time is available.

FEES

The therapy hour is 50 minutes, and the fee is \$120.00. Payment or insurance co-pay is due at time of service.

Client

Date

Therapist

Date