Intuitive Trance-Formations®

PATIENT INTAKE FORM *SIDE "A" PLEASE PRINT LEGIBLY.*

Name:				*Today's date:* / /
Address:				
City:			*State:*	*Zip Code + 4:*
Phone # Mobile: ( )		*Age:*	*DOB* / /	
E Mail:			*Occupation:*	
Marital Status: S M D W	*Religion:*	*Emergency Contact Name:*	*Phone #* ( )	*Relationship*
# of Children?	*Ages:*	*Referred By: Name:*	*Ph. # ( )*	
Are You Under Medical Or Psychological Care? ☐*No* ☐*Yes, Describe:*			*Are You Taking Medication?* ☐*No* ☐*Yes, Describe:*	
Do you suffer from any phobias or medical condition?	☐*No* ☐*Diabetes* ☐*Epilepsy* ☐*Asthma* ☐*H B Pressure* ☐*Other: Describe:*			
Primary care Physician's name & phone #: *Ph. # ( )*				
Have You Been Hypnotized Before? ☐*Yes* ☐*No Results?*				
What Do You Expect Out Of The Therapy?				

CANCELLED/MISSED APPOINTMENTS: *A scheduled appointment means that the therapist's time is reserved ONLY for YOU. You will be billed for that time. There will be* ***NO*** *refund on deposits for cancellations or for any no shows. A 15-minute grace period will be allowed for tardiness. Sessions are 60 minutes and start running from the time the session was scheduled.* ***Initial:*** _____

I am willing to be assisted in reaching my goals through coaching, hypnosis, guided imagery, NLP, visualization, kinesiology, and other healing techniques.

I understand that the assistance I will be getting is ***NOT*** *a substitute for medical or psychiatric care. I understand that although this work may be therapeutic, it is not psychotherapy. The facilitator, Leticia Montiel, is not a psychotherapist and serves only as a practitioner. I am encouraged to discuss these sessions with the physician who attends to me now or in the future. I herein state that I am not currently involved in psychotherapy. I have no recent been hospitalized for mental illness I am advised to continue any medication or treatment I am currently on, and to discuss any changes and improvements with my attending physician.* ***Initial:*** _____ *** (See side "B") I am to understand that my participation, commitment and dedication are a must in order to accomplish my goals and for successful and productive sessions. I understand that confidentially regarding my sessions will be honored between the therapist and me. This same confidentially is respected when working with minors under the age of eighteen. *** (See side "B").* ***Initial****:* _____

All information provided is true to the best of my knowledge.

Print Name:	*Signed:*

For minors only:
I, parent/guardian of the mentioned minor give my permission for the child to attend and receive the prescribed assistance through the aforementioned therapeutic processes. I attest that pertinent approval has been given for this child to attend these sessions and that such approval is available.

Minor:

Signed By:

Please turn over and fill out side B

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PATIENT INTAKE FORM **SIDE B** **PLEASE READ AND INITIAL EVERY LINE.**

THERAPEUTIC PROCESS:

You (the client) understand that the therapist cannot tell you exactly how many sessions will be required for your successful recovery and that in order for the process to be successful you must commit to your continued, uninterrupted attendance. It is your responsibility to follow suggestions and instructions to the best of your abilities in order to obtain the desired outcome. Furthermore, you agree to always show up on time, and attend all the sessions required for the successful completion of the program prescribed.* ***It is your responsibility to make a confirmation call 24 hours in advance for ALL your scheduled appointments. Your time slot will not be kept unless you make this confirmation of attendance.
Initials: _____

FINANCIAL TERMS/INSURANCE COVERAGE:

Cash, Money Orders, and on-line transactions are the only acceptable form of payment. ***NO credit cards are accepted, (except by prior agreement).*** *Sessions are scheduled in advance and by pre-payment of a deposit. You are responsible for full cash payment of your sessions at the time services are rendered. It is your responsibility to come prepared to make appropriate payments and the subsequent deposit for your required following session(s) in order for the therapist to be able to book it in a timely manner. Addictions Recovery and any other long term therapies (multiple session programs) must be paid in full prior to the initial session. All appointment policies apply to this. I****nsurance is NOT accepted as a form of payment****. It is your responsibility to obtain information about your insurance coverage and to provide your physician with insurance forms and prior approval for your sessions before we can accept any third party payments.* ***Initials***: _____

CONFIDENTIALITY:

****All information between therapist and patient is held strictly confidential unless:*

1. *- The patient authorizes release of information with her/his signature.*
2. *- The patient presents a physical danger to self.*
3. *- A judge summons is presented.*
4. *- Child/elder abuse/neglect are suspected.**
5. *- The patient presents a danger to others.**

** In the latter two cases it is a legal requirement to inform potential victims and legal authorities in order that protective measurements can be taken.*
Initials: _____

RELEASE OF INFORMATION:

By my signature below I authorize the release of information regarding my care to my primary care physician as indicated by my initials here:
( ) ***I Authorize*** *( )* ***I decline*** *general consent to inform physician(s) that I am receiving these therapeutic services, if declined, authorization may still be provided on an as necessary basis only at a later date. I do authorize release of information on an as necessary basis only as requested by my physician, Health Plane, or legal authorities, and only after my notified consent.* ***Signed:*** _____

EMERGENCY PROCEDURES:

You should always contact 911 emergency assistance or the nearest hospital, your physician or other health care provider depending on the severity of your need. Emergency or urgent assistance from me or other associate therapist(s) may be provided to you only under approval from your physician.

CONSENT FOR TREATMENT AND NOTIFICATION AGREEMENT:

Initials:	*My therapist promise is to respect me and to safeguard my integrity. To devote 100% of the expertise and abilities to assist me. I agree to put my best and most honest effort to accomplish my desired outcome and to commit to my wholeness.*
Initials:	*I agree to present honest and truthful information to assist in the best outcome for my program to the best of my abilities.*
Initials:	*I understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable, and that I may be assigned tasks to complete before my subsequent session. I agree and commit to follow through such tasks in a timely manner.*
Initials:	*I agree to notify my therapist of any and all contact information changes in a timely manner, i.e. address changes, telephone and emergency contact changes as well as health related changes or any other critical information.*

Signed: _____ Date: _____

5/24/2018