Intuitive Trance-Formations®

CLIENT INTAKE FORM SIDE "A" PLEASE PRINT LEGIBLY AND INITIAL

Client's Name:	***Today's date:*** / /
Address:	
City:	*State:* *Zip Code + 4:*
Phone # ☐ *Mobile* ☐ *Work:* ( )	*Age:* *DOB* / /
E Mail:	*Occupation:*

Marital Status: ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widow*	*# of Children*	*Ages:*	*Religion:*
Emergency Contact Name and Phone #:			***Relationship:***
Referred By:			*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 #:			
Have You Been Hypnotized Before? ☐ *Yes* ☐ *No Results?*			
What Do You Expect from Therapy?			

THERAPEUTIC PROCESS:

Initials: ☐

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.
MEDICAL HYPNOSIS*: Hypnosis is effective in relieving some medical conditions (i.e. pain management, migraines, IBS, etc.) a signed release from my doctor or appropriate health care professional is required prior to initiating any such sessions.*

Initials: ☐

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.*

Initials: ☐

I 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 the therapist cannot tell me exactly how many sessions will be required for my successful recovery and that in order for the process to be successful I must commit to my continued, uninterrupted attendance. It is my responsibility to follow suggestions and instructions to the best of my abilities in order to obtain the desired outcome. Furthermore, I agree to always show up on time, and attend all the sessions required for the successful completion of the proposed program.*
It is my responsibility to make a confirmation call 24 hours in advance for ALL my scheduled appointments. My time slot will not be kept unless I make this confirmation of attendance.

Initials: ☐

CANCELLED/MISSED APPOINTMENTS: *A scheduled appointment means that the therapist's time is reserved ONLY for ME. There will be NO refund on deposits for cancellations or for any no shows for any reason. A 15-minute grace period will be allowed for tardiness. Sessions are 60 minutes and start running from the time the session was scheduled.* ***If I must reschedule due to an emergency, I am responsible to ensure that my therapist gets notified as soon as possible.***

Initials: ☐

EMERGENCY PROCEDURES:
I should always contact 911 emergency assistance or the nearest hospital, my physician or other health care provider depending on the severity of my needs. Emergency or urgent assistance from this or other associate therapist(s) may be provided to me only under approval from my physician.

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CLIENT INTAKE FORM SIDE "B" PLEASE PRINT LEGIBLY AND INITIAL

Initials: ☐ ***FINANCIAL TERMS/INSURANCE COVERAGE:***

Cash, Money Orders, and Cashier Checks are acceptable form of payment. ***On-line payment and Credit cards are accepted when processed via PayPal. Insurance is NOT accepted as a form of payment.*** *Sessions are scheduled in advance and by pre-payment of a deposit. You are responsible for full cash payment of my 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.*

Initials: ☐ ***All prepaid sessions are non-transferrable and will expire after 6 months. Cancelled packages will be refunded on a pro-rated manner.***

Medical Hypnotherapy and any other long term therapies (multiple session packages) must be paid in full prior to the initial session. All appointment policies apply to this. It is your responsibility to obtain information about your insurance coverage and to provide your physician with insurance forms and prior approval for your Medical Hypnotherapy sessions before your therapist can accept any third party payments.

Initials: ☐ ***RELEASE OF INFORMATION:***

By my signature below:

☐ ***I Authorize*** ☐ ***I decline*** *the release of information regarding my care to my primary care physician as indicated by my initials here to inform my 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 Authorize*** ☐ ***I decline*** *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.*

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.*

I understand that confidentially regarding my sessions will be honored between the therapist and me. This same confidentially is applied when working with minors under the age of eighteen.

Initials: ☐ ***CLIENT CONSENT:***

I AM AWARE *and understand that in some cases it may be necessary for the practitioner to respectfully place their hand on my shoulder(s), hand, arm, wrist or forehead as part of an induction or anchoring technique. I give the practitioner permission and consent to do so in order to help me establish a beneficial state of hypnosis.*

Initials: ☐ ***I UNDERSTAND*** *that the success of hypnosis/NLP/EFT sessions depends greatly on my own ability and desire to affect change in myself. I understand that because the results of my sessions depend greatly upon my own serious participation that my therapist cannot offer any guarantee of the success of my treatment. Therefore, no refunds for services are given.*

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 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.*

Initials: ☐ ***I AM AWARE*** *and understand my responsibility about my therapeutic process, therefore, I hereby release Leticia Montiel and Intuitive Trance-Formations from any liability.*

Initials: ☐ ***I AGREE TO*** *present honest and truthful information to assist in the best outcome for my program to the best of my abilities.*

My signature below states that all information provided is true to the best of my knowledge. I have received, read and I understand what I have read, and I take responsibility for any event that arises from not complying with the therapist's suggestions or recommendations.

Date: / /	***Signature:***

For minors only: *I, the parent/guardian of the mentioned minor give my permission for the child to attend and receive the prescribed assistance through the aforementioned therapeutic processes. My signature below states that pertinent both parental and/or medical approval has been given for this child to attend these sessions and that such approval is available.*	***Date:*** / /
Print Minor's Name:	***Age:***
Print parent's Name:	***Signature:***
Therapist Name:	*Office use: Notes/Code:*