Welcome to Blazak Counseling. We thank you for choosing our services, and hope to provide you with the best possible experience. We acknowledge that coming for counseling takes courage, and we hope to support you through your growing process, and provide you with the coping skills to help you lead a more fulfilling life.

We ask for your cooperation in filling out the following forms. All information provided on these documents is confidential, and will help your counselor assess your needs so he/she can provide you with services tailored to you.

You will be asked to read, understand, and fill out the following documents:

- Notice of Privacy Practices (HIPAA)
- Billing and Disclosure Agreement
- New Client Intake Information

These forms can be found on our website:
www.blazakcounseling.com under the "Forms" tab.

If you have any questions concerning these documents, please contact us by calling (585) 750-4772, or emailing prblazak@gmail.com.

Thank you,
Paige Blazak

BILLING AND DISCLOSURE AGREEMENT

It is understood that deductibles and copayments are due when services are rendered unless other arrangements are made. It is understood that you, as the client, are responsible to make sure that your insurance will cover treatment, and you will be responsible for any costs not covered by your insurance. You also agree to have Blazak Counseling submit a claim to your insurance company on your behalf and notify your Primary Care Physician if needed.

24-Hour notice is required for appointment cancellations or changes. If you fail to provide 24-hour notice, you will be billed for your missed, canceled, or changed session. Appropriate fees will be determined by your practitioner. You are responsible for paying fees for missed appointments or late cancellations. These charges cannot be billed to your insurance company. After 45 days, we reserve the right to refer your account to a collection agency for recovery. In such event, you will be fully responsible for all collection and attorney fees.

Please feel free to review the Notice of Privacy Practices (HIPAA), which is posted under the "Forms" page on our website: www.blazakcounseling.com..

Signing below indicates that you have read, understand and agree to the above billing and disclosure policies, and have been provided with an opportunity to read the Notice of Privacy Practices.
Your signature also indicates that in case of emergency, we may communicate limited information that is necessary for your care to your emergency contact person listed on the Intake Information Packet, as indicated by the Notice of Privacy Practices.

If you have questions regarding your personal information or billing procedures, please contact us at prblazak@gmail.com or by calling 585.750.4772

Signature: _____ Date: _____

Relationship to Client: _____
(If other than client, or minor)

CONFIDENTIAL

PERSONAL INFORMATION Date: _____

Name: _____Date of Birth: _____

Social Security: _____--_____--_____

Parent's Names (if a minor): _____

Address: _____

Phone: Home: _____Cell: _____

Email Address: _____

Employer/School: _____

Address: _____

Marital Status: □ Single □ Married ☐ Separated ☐ Divorced ☐ Widowed

MEDICAL INFORMATION

Name of Primary Care Doctor: _____Phone: _____

Address: _____

List ANY Medications you are currently taking: _____

PAYMENT INFORMATION

How will you be paying for your sessions? □ Self-Pay □ Insurance ☐ EAP

Insurance/EAP Provider: _____

Policy Holder: _____

Policy Holder's SS#: _____DOB: _____

Policy Number: _____

COUNSELING INFORMATION

Who referred you to Canandaigua Lake Counseling? _____

List Reasons for Seeking Counseling: _____

PREVIOUS TREATMENT

Have you ever been to counseling before? □ Yes □ No

If yes, who did you see? _____

Address: _____

Reason(s): _____

Have you ever been hospitalized for mental health reasons? □ Yes □ No

If yes, where? _____

Reason(s): _____

Have you ever been on medication(s) for mental health reasons? □ Yes □ No

If yes, what medications? _____

Reason(s)? _____

LEGAL HISTORY

Are you required by a court of law to receive counseling as part of a legal proceeding?

□ Yes □ No If yes, please describe: _____

Have you ever been arrested? □ Yes □ No If yes, when? _____

Where? _____

Reason(s): _____

FAMILY HISTORY

Have any close relatives ever been hospitalized for mental health reasons? □ Yes □ No

Does anyone in your family have a mental health illness? □ Yes □ No

Has anyone in your family ever struggled with substance abuse? □ Yes □ No

Has anyone in your family ever attempted or completed suicide? □ Yes □ No

EMERGENCY CONTACT

Name: _____ Phone: _____

Relation to Client: _____

CONFIDENTIAL

Child's Name: Date: _____

_____ Child's Date of Birth: _____

Your Name: Relation to Child: _____

_____

Inventory of Common Problems

Child Form – Please complete about your child if he/she is under 16 years of age.

The following is a set of common problems children and adolescents face. Please rate how much each of these problems has affected your child over the past two weeks. Please complete a separate inventory for each child that you would like to receive counseling.

Not at all	***A little bit***	***Moderately***	***Very Much***
0	1	2	3

To what degree is your child?

1. Defiant or oppositional	0	1	2	3
2. Throwing tantrums	0	1	2	3
3. Not following directions	0	1	2	3
4. Impulsive	0	1	2	3
5. Sad, depressed, blue	0	1	2	3
6. Anxious or worried	0	1	2	3
7. Having panic attacks	0	1	2	3
8. Refusing to go to school	0	1	2	3
9. Experiencing headaches	0	1	2	3
10. Experiencing stomach aches or nausea	0	1	2	3
11. Having difficulty concentrating	0	1	2	3
12. Easily distracted	0	1	2	3
13. Frequently constipated	0	1	2	3
14. Soiling him/herself	0	1	2	3
15. Wetting the bed	0	1	2	3
16. Having seizures	0	1	2	3
17. Experiencing dizziness	0	1	2	3
18. Having Tics	0	1	2	3
19. Seeing things that aren't there	0	1	2	3

20. Hearing things that aren't there	0	1	2	3
21. Having difficulty separating from their caregivers	0	1	2	3
22. Not making eye contact	0	1	2	3
23. Unaware of other people	0	1	2	3
24. Agitated or grouchy	0	1	2	3
25. Having difficulty calming him/herself	0	1	2	3
26. Experiencing hearing problems	0	1	2	3
27. Experiencing vision problem	0	1	2	3
28. Irritated by certain types of fabrics or labels on clothes	0	1	2	3
29. Having difficulty getting along with their siblings	0	1	2	3
30. Having difficulty getting along with adults	0	1	2	3
31. Stealing	0	1	2	3
32. Lying	0	1	2	3
33. Wanting or trying to hurt him/herself	0	1	2	3
34. Wanting or trying to hurt others	0	1	2	3
35. Making him/herself vomit	0	1	2	3

Please review your above answers and determine which items you marked as moderately or very much a problem for your child (2s and 3s). For each of these numbered items, please list below the approximate date the problem began, and provide a short description.

#_____. Date: _____ Describe: _____

_____

#_____. Date: _____ Describe: _____

_____

#_____. Date: _____ Describe: _____

_____

#_____. Date: _____ Describe: _____

_____

#_____. Date: _____ Describe: _____

_____

#_____. Date: _____ Describe: _____

_____

#_____. Date: _____ Describe: _____

_____

#_____. Date: _____ Describe: _____

_____