

SRG.

Strength. Resilience. Growth.

New Client Intake Packet

Telehealth Psychotherapy Practice · Bedford, Massachusetts

WHAT'S INCLUDED

1. Client Intake Form · Demographics, health & mental health history, goals
2. Telehealth Informed Consent · Technology, emergency protocol, licensure
3. Limits of Confidentiality · Legal exceptions to confidentiality
4. Financial & Cancellation Policy · Fees, insurance, cancellation terms

Please complete this packet and return it before your first session. All information is confidential and protected under HIPAA and Massachusetts law.

Phone	(781) 352-2647	Platform	Psychology Today
Email	jennifer@srgtherapygroup.com	Location	Bedford, Massachusetts
Clinical Director	Jennifer N. Cohen, LICSW, CMHIMP	Telehealth	HIPAA-compliant video

Please complete all fields as thoroughly as you are comfortable. Fields marked * are required.

IMPORTANT: If you are in crisis or experiencing a mental health emergency, please call or text 988 (Suicide & Crisis Lifeline), call 911, or go to your nearest emergency room. This form is not monitored in real time.

PERSONAL INFORMATION

Last Name *	First Name *	Middle Initial
Date of Birth *	Age	Gender Identity
Pronouns	Marital / Relationship Status	
Marital / Relationship Status		
<input type="checkbox"/> Single	<input type="checkbox"/> Partnered / Domestic Partnership	<input type="checkbox"/> Married
<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
Children / Dependents (names and ages, optional)		
Parent / Guardian Name (if under 18)	Relationship	

CONTACT INFORMATION

Street Address		
City	State	ZIP Code
Cell Phone *	Home / Other Phone	
Email Address *		

Note: Email is not a confidential medium. Please share only non-sensitive information via email.

Emergency Contact Name	Relationship	Phone
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HOW DID YOU HEAR ABOUT US?

- Psychology Today
 Physician / Provider Referral
 Friend or Family
- Insurance Directory
 Other:
- If other, please specify

PHYSICAL HEALTH

Overall physical health: Poor 1 2 3 4 5 Excellent

Current health conditions, diagnoses, or concerns

Current medications (name, dose, prescribing provider)

Have you ever been prescribed psychiatric medication?

No

Yes — please describe below

If yes — medication name, dates, prescribing provider

SLEEP, LIFESTYLE & SUBSTANCE USE

Overall sleep quality: Poor 1 2 3 4 5 Excellent

Describe any sleep difficulties

Exercise frequency (days/week)

Types of exercise

Any difficulties with appetite or eating patterns?

Alcohol use:

Never

Rarely

Socially (1-2x/month)

Weekly

Several times/week

Daily

Recreational substance use:

Never

Infrequently

Monthly

Weekly

Daily

If applicable — substance type, frequency, any concerns

MENTAL HEALTH HISTORY

Have you previously received mental health treatment?

No

Yes — please describe below

If yes — type, dates, provider, what was most/least helpful

Are you currently experiencing any of the following? (check all that apply)

Depression / sadness

Anxiety / worry

Panic attacks

Trauma symptoms

Grief / loss

Anger / irritability

Relationship difficulties

Low self-esteem

Focus / attention difficulties

Chronic pain

Major life transition

Other:

Have you ever had thoughts of suicide or self-harm?

No

In the past, not currently

Currently experiencing

Please describe if applicable

What significant life changes or stressors are you currently experiencing?

FAMILY MENTAL HEALTH HISTORY

Please indicate if any of the following apply to biological family members.

Condition	Yes / No	Family Member(s)
Alcohol / Substance Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Domestic Violence	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Eating Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No	
OCD / Obsessive-Compulsive Behavior	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Schizophrenia / Psychosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Suicide Attempts	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bipolar Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
PTSD / Trauma	<input type="checkbox"/> Yes <input type="checkbox"/> No	

RELATIONSHIPS

Are you currently in a romantic relationship?

No

Yes

Length of relationship
(if yes)

Relationship
satisfaction (1–10)

Current stressors or concerns in your relationship
(if applicable)

WORK & PURPOSE

Current employment status:

Employed full-time

Employed part-time

Self-employed

Student

Retired

Not currently employed

Describe your work or school situation and any
current stressors

ABOUT YOU

What are some of your strengths?

What are some areas you'd like to grow in?

Do you consider yourself spiritual or religious?

Not particularly

Spiritual, not religious

Religious

Both

Feel free to describe your belief or practice

What would you most like to accomplish through therapy?

What does “getting better” look like to you?

Is there anything else you would like me to know before our first session?

Because our sessions take place via secure video, there are specific considerations unique to telehealth that you should understand before we begin. Please read each section carefully before signing.

TELEHEALTH

What is Telehealth?

Telehealth involves the delivery of mental health services using video conferencing technology. Sessions are conducted through a HIPAA-compliant platform. Telehealth is not appropriate for all clinical situations, and I reserve the right to recommend in-person care if clinically indicated.

TELEHEALTH

Technology Requirements & Responsibilities

You are responsible for ensuring access to a private, stable internet connection and a device with video and audio capability. If we are disconnected, I will attempt to reach you by phone. If we cannot reconnect within 10 minutes, the session will be rescheduled at no charge. You agree to participate from a private location where you cannot be overheard.

TELEHEALTH · LICENSURE

Geographic Limitations & Licensure

I am licensed to provide telehealth services in Massachusetts. You must be physically located in Massachusetts at the time of each session. If you travel and wish to continue from another state, please notify me in advance — licensure requirements vary by state.

TELEHEALTH · SAFETY

Emergency Protocol for Telehealth

Please identify a local emergency contact (someone who can physically reach you) and know your local emergency resources: National Crisis Line — call or text 988 | Emergency Services — 911 | Nearest Emergency Room. If I become concerned about your immediate safety, I may contact emergency services at your location.

TELEHEALTH

Recording Prohibition

Sessions may not be recorded by either party without explicit written consent. Unauthorized recording is a violation of this agreement and may result in termination of services.

Physical location state
at time of sessions *

Local emergency
contact name &
relationship

Phone

By signing below, I confirm that I have read, understood, and agree to the Telehealth Informed Consent above.

Signature

Date

Printed Name

Everything shared in therapy is confidential. The following are legally required exceptions under Massachusetts law.

LEGAL REQUIREMENT**Duty to Warn & Protect**

If you disclose a credible intention or plan to harm an identifiable other person, I am required by Massachusetts law to warn the intended victim and notify law enforcement. This obligation may override confidentiality.

LEGAL REQUIREMENT**Risk of Suicide or Self-Harm**

If you disclose or imply a plan for suicide or serious self-harm, I am required to take reasonable steps to ensure your safety. This may include contacting emergency services or family members, even without your consent, if I believe your life is at risk.

MANDATED REPORTING**Abuse of Children & Vulnerable Adults**

I am a mandated reporter under Massachusetts law. If I have reasonable cause to believe a child or vulnerable adult is being abused, neglected, or at risk, I am required to report this to the Massachusetts Department of Children and Families (DCF) or appropriate authorities.

LEGAL REQUIREMENT**Prenatal Exposure to Controlled Substances**

I am required to report admitted prenatal exposure to controlled substances that may be harmful to a developing fetus.

LEGAL**Minors & Guardianship**

Parents or legal guardians of non-emancipated minors (under age 18) have the right to access their child's treatment records, unless a court order or specific clinical or safety considerations apply.

INSURANCE**Insurance & Third-Party Payers**

If you use insurance, your insurer may request clinical information as a condition of reimbursement. Information that may be shared includes: dates and type of service, diagnosis, treatment plan, and clinical progress notes. By using your insurance benefits, you authorize me to share this information with your insurer.

TELEHEALTH**Electronic Communications & Records**

Session notes, records, and billing information may be stored electronically in a HIPAA-compliant system. Email communication between sessions is not confidential — please do not include sensitive clinical information in emails.

LEGAL**Court Orders & Legal Proceedings**

In the event of a court order or subpoena, I may be required to release records or provide testimony. I will notify you promptly if this occurs and will seek to protect your confidentiality to the extent permitted by law.

By signing below, I confirm that I have read and understood the limits of confidentiality described above, and I consent to treatment under these terms.

Signature

Date

Printed Name

Please review the following policies carefully. Your signature below indicates that you have read, understand, and agree to these terms.

FEES**Session Fees**

Individual & Couples Sessions: \$225 per 50-minute session. A limited number of sliding scale spots may be available — please inquire during your consultation if financial hardship is a concern. Accepted payment methods: HSA/FSA · Visa · Mastercard · Venmo · Zelle · PayPal · Check · Cash. Payment is due at the time of service.

INSURANCE**Insurance & Superbills**

SRG Therapy Group is in-network with: Aetna · BlueCross BlueShield · Cigna/Evernorth · Meritain Health · Optum · Tufts · UnitedHealthcare/UBH. If you have out-of-network benefits, we can provide a superbill for reimbursement. Please verify your telehealth mental health benefits — including deductible, copay/coinsurance, and session limits — prior to your first appointment.

CANCELLATION**Cancellation & No-Show Policy**

24-hour notice is required to cancel or reschedule without charge. Cancellations with less than 24 hours' notice, or no-shows, will be charged the full session fee. Exceptions are made for sudden illness, verified emergencies, or technology failures (provided you notify us promptly). Repeated late cancellations or no-shows may result in discharge from the practice.

BILLING**Credit Card on File**

A valid credit or debit card is required to be kept on file. This card will be charged only for unpaid balances, including cancellation fees, after advance notice to you. Your card information is stored securely and is never shared.

BETWEEN SESSIONS**Between-Session Communication**

Jennifer is not available for crisis support between sessions. For non-urgent questions, you may email or leave a voicemail — responses within 2 business days. For urgent or crisis situations, please contact the 988 Lifeline, call 911, or go to your nearest emergency room.

INSURANCE INFORMATION (if using insurance benefits)

Insurance
Provider

Member ID

Group Number

Primary Insured Name
(if different from client)

Primary Insured Date of
Birth

By signing below, I confirm that I have read and agree to the financial and cancellation policy above. I authorize a credit or debit card to be kept on file for any unpaid balances, with advance notice.

Signature

Date

Printed Name