

Tim Dallacqua, MSW, LCSW — Client Forms

FORM 1: NEW CLIENT INTAKE FORM

Tim Dallacqua, MSW, LCSW Licensed Clinical Social Worker | Teletherapy Services
Phone: (406) 564-1848 | Fax: (406) 564-1844 Email: TimDallacqua.LCSW@gmail.com

Date: _____

Personal Information

Full Name: _____

Preferred Name / Nickname: _____

Pronouns: _____

Date of Birth: _____ Age: _____

Gender Identity: _____

Sexual Orientation (optional): _____

Race / Ethnicity (optional): _____

Primary Language: _____

Contact Information

Home Phone: _____

Cell Phone: _____

Email Address: _____

Preferred Contact Method: Phone Text Email Video

Best Time to Contact: _____

State of Residence: _____

Emergency Contact

Name: _____

Relationship: _____

Phone: _____

May I contact this person in a mental health emergency? Yes No

Referral / How Did You Hear About Me?

Insurance Information

Do you have health insurance? Yes No Self-Pay

If yes: Insurance Company: _____

Member ID: _____ Group Number: _____

_____ Primary Insured Name: _____

_____ Primary Insured Date of _____

Birth: _____

Current Concerns

What brings you to therapy at this time? (Please describe in your own words)

How long have you been experiencing these concerns?

Have you been in therapy before? Yes No

If yes, when and with whom? _____

What was helpful or not helpful about previous therapy?

Mental Health History

Have you ever been diagnosed with a mental health condition? Yes No

If yes, please list: _____

Are you currently taking any psychiatric medications? Yes No

If yes, please list (medication, dose, prescribing provider):

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

If yes, please describe: _____

Safety

Are you currently having thoughts of harming yourself? Yes No

Are you currently having thoughts of harming others? Yes No

Have you ever attempted suicide? Yes No

Medical History

Do you have any significant medical conditions? Yes No

If yes, please list: _____

Primary Care Provider (if any):

Phone: _____

Substance Use

Do you currently use alcohol? Yes No Occasionally

Do you currently use recreational drugs or cannabis? Yes No

Do you currently use tobacco or nicotine? Yes No

Goals for Therapy

What would you like to accomplish in therapy? What would success look like for you?

Client Signature: _____ Date: _____

FORM 2: INFORMED CONSENT FOR THERAPY SERVICES

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Phone: (406) 564-1848 | Fax: (406) 564-1844 Email: TimDallacqua.LCSW@gmail.com

Please read this document carefully. It describes the nature of therapy services, your rights as a client, and the policies of this practice. Please ask any questions before signing.

About My Practice

I am Tim Dallacqua, a Licensed Clinical Social Worker (LCSW) with a Master of Social Work (MSW) degree and over 50 years of experience in mental health. My practice provides individual teletherapy services to adults via secure video platform. I hold licensure in the State of Montana and provide services only to clients residing in states where I am licensed to practice.

My areas of specialization include:

- LGBTQ+ affirming therapy
- Transgender identity and transition support
- Hard-to-treat and complex presentations
- Grief, loss, and end-of-life concerns
- Trauma and trauma-informed care
- Individuals involved in the legal/criminal justice system
- Eating disorders
- General mental health and life transitions

Nature of Therapy

Therapy is a collaborative process. Sessions are typically 50 minutes in length and are conducted via secure video platform. The frequency of sessions will be determined together based on your needs and goals. With teletherapy, sessions may occur every few weeks or monthly depending on your treatment plan — the goal is always what is in your best clinical interest.

Therapy involves discussing personal and sometimes difficult topics. While therapy can be highly beneficial, it is not without risk. Some clients temporarily experience increased distress as they work through difficult material. I will work with you to manage this process safely.

Confidentiality

Everything you share in therapy is confidential. I will not disclose your information without your written consent, with the following legally required exceptions:

1. **Imminent danger:** If you present a serious and imminent threat of harm to yourself or others, I am required to take protective action, which may include contacting emergency services or a third party.
2. **Child or elder abuse:** If I have reasonable cause to suspect abuse or neglect of a child, elder, or dependent adult, I am required by law to report this to the appropriate authorities.
3. **Court order:** If a court of law orders the release of records, I am required to comply.
4. **Supervision and consultation:** I may consult with other licensed professionals for clinical guidance. In these cases, your identity is protected to the extent possible.

Teletherapy

Teletherapy services are provided via a HIPAA-compliant video platform. You are responsible for ensuring a private, secure location for your sessions. You must be physically located in a state where I am licensed to practice at the time of each session. Teletherapy carries some unique risks including potential technology failures, reduced ability to observe non-verbal cues, and the possibility that sessions could be interrupted. If a technology failure occurs, I will contact you by phone to continue or reschedule the session.

Fees and Payment

My fee for a 50-minute individual therapy session is: \$_____

Payment is due at the time of service. I accept: Credit/Debit Card Check Other:

Insurance: Please contact me to discuss insurance coverage and billing. You are responsible for any co-pays, deductibles, or amounts not covered by your insurance.

Self-Pay: If you are paying out of pocket, you are entitled to a Good Faith Estimate of expected costs (see Form 7).

Cancellation Policy

I require 24 hours' notice to cancel or reschedule an appointment. Late cancellations or no-shows may be charged the full session fee. Exceptions may be made for genuine emergencies.

Your Rights as a Client

- You have the right to ask questions about my qualifications, training, and therapeutic approach at any time.
- You have the right to refuse or discontinue treatment at any time without penalty.
- You have the right to request a referral to another provider.
- You have the right to access your records (with reasonable advance notice).
- You have the right to file a complaint with the Montana Board of Social Work Examiners if you believe your rights have been violated.

Contact and After-Hours

My office phone is (406) 564-1848. I check messages regularly and will return calls within one business day. I am not available for crisis intervention after hours. If you are in crisis, please call 988 (Suicide and Crisis Lifeline), call 911, or go to your nearest emergency room.

By signing below, I acknowledge that I have read, understood, and agree to the terms described in this Informed Consent for Therapy Services.

Client Name (Print): _____

Client Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

FORM 3: NOTICE OF PRIVACY PRACTICES (HIPAA)

Tim Dallacqua, MSW, LCSW Licensed Clinical Social Worker | Teletherapy Services
Phone: (406) 564-1848 | Fax: (406) 564-1844 Email: TimDallacqua.LCSW@gmail.com

Effective Date: January 1, 2025

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

How I Use and Disclose Your Health Information

For Treatment: I may use your health information to provide you with mental health treatment and services, and to coordinate your care with other providers (with your written consent).

For Payment: I may use your health information to submit claims to your insurance company or to collect payment for services rendered.

For Healthcare Operations: I may use your health information for quality improvement, training, and administrative purposes.

As Required by Law: I may disclose your health information when required to do so by federal, state, or local law, including mandatory reporting of child abuse, elder abuse, or imminent danger to self or others.

Your Rights Regarding Your Health Information

- **Right to Access:** You have the right to inspect and receive a copy of your health records. Requests should be made in writing.

- **Right to Amend:** You have the right to request that I correct information you believe is inaccurate.
- **Right to an Accounting:** You have the right to request a list of disclosures I have made of your health information.
- **Right to Restrict:** You have the right to request restrictions on how I use or disclose your information. I will consider your request but am not required to agree to all restrictions.
- **Right to Confidential Communications:** You have the right to request that I communicate with you in a specific way (e.g., only by email, only at a certain phone number).
- **Right to a Paper Copy:** You have the right to receive a paper copy of this notice upon request.

My Duties

I am required by law to maintain the privacy of your health information, to provide you with this notice, and to follow the terms of this notice currently in effect.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with me directly or with the U.S. Department of Health and Human Services, Office for Civil Rights. I will not retaliate against you for filing a complaint.

To file a complaint with HHS: www.hhs.gov/ocr/privacy/hipaa/complaints

FORM 4: HIPAA ACKNOWLEDGEMENT OF RECEIPT

Tim Dallacqua, MSW, LCSW Licensed Clinical Social Worker | Teletherapy Services

I acknowledge that I have received a copy of the Notice of Privacy Practices for Tim Dallacqua, MSW, LCSW, and that I have had the opportunity to review it and ask questions.

Client Name (Print): _____

Client Signature: _____ **Date:** _____

If you were unable to sign this acknowledgement, please explain:

Therapist note:

FORM 5: ELECTRONIC COMMUNICATION CONSENT

Tim Dallacqua, MSW, LCSW Licensed Clinical Social Worker | Teletherapy Services
Phone: (406) 564-1848 | Fax: (406) 564-1844 Email: TimDallacqua.LCSW@gmail.com

Purpose of This Form

This form explains the risks and limitations of communicating electronically (by text message, email, or video) and asks for your informed consent before we use these methods.

Important Notice: Standard Electronic Communication Is Not HIPAA-Secure

Standard text messages (SMS) and standard email are **not encrypted** and are **not HIPAA-compliant**. This means that messages sent through these channels could potentially be intercepted or accessed by a third party. Despite these risks, many

clients prefer the convenience of text and email for routine, non-clinical communication.

What I Will and Will Not Communicate Electronically

Acceptable for text or email (with your consent):

- Appointment reminders and scheduling
- Requests to call or contact the office
- Brief administrative questions (e.g., “Did you receive my form?”)
- Links to secure documents or forms

NOT appropriate for text or email:

- Clinical information, symptoms, or treatment details
- Crisis situations (please call 988 or 911)
- Sensitive personal health information
- Anything you would not want a third party to see

Video Therapy Platform

All therapy sessions are conducted via a HIPAA-compliant, encrypted video platform. Session links will be sent to you in advance. Do not use standard video calls (FaceTime, Zoom personal, etc.) for therapy sessions.

Your Consent Options

Please initial next to each method you consent to:

_____ **Text Message (SMS):** I understand that standard text messages are not encrypted and not HIPAA-secure. I consent to receive appointment reminders and brief administrative messages by text to my mobile number on file. I understand I can opt out at any time by replying STOP.

_____ **Email:** I understand that standard email is not fully encrypted and carries privacy risks. I consent to receive appointment-related communications by email to the address on file. I understand I can opt out at any time.

_____ **Encrypted Email (ProtonMail):** For more sensitive communications, I may use TimDallacqua,LCSW@protonmail.com, which provides end-to-end encryption. I understand that full encryption only applies when both parties are using ProtonMail.

_____ **I do NOT consent** to any electronic communication. Please contact me by phone only.

Acknowledgement

I have read and understand this form. I understand the risks associated with electronic communication and I am choosing to communicate in the ways I have initialed above. I understand that my consent is voluntary and that I may withdraw it at any time by notifying Tim Dallacqua in writing.

Client Name (Print): _____

Mobile Number for Texts: _____

Email Address: _____

Client Signature: _____ **Date:** _____

FORM 6: CANCELLATION AND ATTENDANCE POLICY

Tim Dallacqua, MSW, LCSW Licensed Clinical Social Worker | Teletherapy Services
Phone: (406) 564-1848 | Fax: (406) 564-1844

Appointment Scheduling

Appointments are scheduled by phone or by mutual agreement. You will receive a confirmation with the secure video link prior to each session.

Cancellation Policy

I require **24 hours' advance notice** to cancel or reschedule an appointment. This allows me to offer the time to another client.

Late Cancellations and No-Shows: Appointments cancelled with less than 24 hours' notice, or missed without notice, may be charged the full session fee. This fee is your responsibility and is generally not covered by insurance.

Exceptions: I understand that genuine emergencies occur. Please contact me as soon as possible if an emergency prevents you from attending your appointment.

Tardiness

If you are more than 15 minutes late to a session, we may need to shorten or reschedule the appointment. The full session fee may still apply.

Technology Issues (Teletherapy)

If you experience a technology failure at the start of a session, please call me at (406) 564-1848. We will attempt to reconnect or switch to a phone session. Technology failures on your end that prevent the session from occurring may be treated as a late cancellation at my discretion.

Repeated Cancellations

Consistent attendance is important for therapeutic progress. If you miss three or more consecutive sessions without contact, I may need to close your case. You are always welcome to return when you are ready.

By signing below, I acknowledge that I have read and agree to this Cancellation and Attendance Policy.

Client Name (Print): _____

Client Signature: _____ Date: _____

FORM 7: GOOD FAITH ESTIMATE

Tim Dallacqua, MSW, LCSW Licensed Clinical Social Worker | Teletherapy Services
Phone: (406) 564-1848 | Fax: (406) 564-1844

Notice to Uninsured and Self-Pay Clients

Under the **No Surprises Act** (effective January 1, 2022), you have the right to receive a Good Faith Estimate of expected charges for healthcare services, including mental health services. This estimate is provided to self-pay clients and those who choose not to use their insurance.

About This Estimate

This Good Faith Estimate shows the costs of services that are reasonably expected based on your needs. It does not include costs for services that cannot be anticipated at this time.

| Service | Billing Code | Estimated Cost Per Session |
|--|--------------|----------------------------|
| Individual Psychotherapy, 45–53 min | 90834 | \$_____ |
| Individual Psychotherapy, 53+ min | 90837 | \$_____ |
| Psychotherapy with E&M, 30 min | 90833 | \$_____ |
| Telehealth modifier (applied to above) | 95 | Included |

Estimated frequency of sessions: _____ sessions per month

Estimated cost for 12 months: \$ _____

Important Notes

- This estimate is not a contract and does not require you to obtain services from this provider.
- Actual charges may differ from this estimate.
- You may request an updated Good Faith Estimate at any time.
- If you are billed more than \$400 above this estimate, you have the right to dispute the bill.
- For questions or to dispute a bill, contact me at (406) 564-1848 or TimDallacqua.LCSW@gmail.com.

For more information about your rights under the No Surprises Act, visit: www.cms.gov/nosurprises

Client Name (Print): _____

Client Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

Good Faith Estimate prepared on: _____
