

*Virginia Kelley ACSW, LCSW*

*4300 N. Miller Rd., #218  
Scottsdale, AZ 85251*

*Tel: 480-429-6390*

**Intake Information**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Employer: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Education: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Name: \_\_\_\_\_

Children (name & age) \_\_\_\_\_

Have you received counseling before? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, name of provider \_\_\_\_\_ Date \_\_\_\_\_

Referral source: \_\_\_\_\_

**Confidentiality:** What is discussed in therapy is strictly confidential until you give consent to its release, with two exceptions: Virginia Kelley LCSW is compelled by law to inform appropriate legal authorities if she believes that a client is in danger of hurting himself/herself or someone else, and/or if there is reasonable suspicion that a child or elder has or is being abused.

**Insurance Authorization & Receipt of Privacy Notice:** I authorize my insurance to make payments directly to Virginia Kelley LCSW/Scottsdale Psychotherapy for services I receive. I understand that I am financially responsible for all charges incurred by me during the course of treatment. I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date