FAMILY CONCERN COUNSELING

NEW CLIENT INTAKE

Office Use Only:
Counselor's Name:_____ ICD-10 Code:_____ Date: _____

Complete and accurate information is required. All information will be kept confidential.

CLIENT INFORMATION

Name—First: _____ M.I. ___ Last: _____

Preferred Name: _____ Date of Birth: _____

Address _____

City: _____ State: _____ Zip: _____

Sex ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Other

Cell Phone: _____ Work Phone: _____

Home Phone: _____ Email Address: _____

Primary Care Physician_____ Phone: _____

Psychiatrist/APRN/NP _____ Phone: _____

APPOINTMENT REMINDERS

Please send appointment reminders via: ☐ Text Message—cell ph# provided ☐ Email—provided
☐ Phone Call—Best number to call_____

☐ *No Reminder is Needed*

EMPLOYMENT/STUDENT STATUS

☐ Employed-FT ☐ Employed-PT ☐ FT Student ☐ PT Student ☐ Other _____

Place of Employment/School: _____ Phone: _____

EMERGENCY CONTACT PERSON

Person to contact in case of an EMERGENCY

Name: _____ Relationship to Client:_____

Cell Phone: _____ Other Phone: _____

CANCELLATION POLICY

If you need to cancel your appointment, we request a 24-hour notice. Appointments that are canceled with less than 24-hour notice will be charged a $50.00 cancellation fee. If you do not show for your appointment you will be charged a $50.00 no show fee. I understand and agree to abide by this policy.

_____ _____

Signature *Date*

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NEW CLIENT INTAKE

RESPONSIBLE PARTY—*Name and address of person responsible for any balance NOT COVERED by insurance:*

☐ Same as Client ☐ Other

Name: _____ Date of Birth: _____

Address: ☐ Same as Client _____ City: _____ State: _ Zip: _____

Cell Phone: _____ Home/Work Phone: _____

INSURANCE—*Include copy of front and back of insurance card:*

PRIMARY INSURANCE

PRIMARY Insurance: _____

Insurance Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Subscriber/ID#: _____ Group#: _____

SUBSCRIBER—CARD HOLDER INFORMATION

☐ Same as Client ☐ Same as Responsible Party ☐ Other

Client Relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other (specify) _____

Subscriber Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

PLACE OF EMPLOYMENT: _____ Phone: _____

SECONDARY INSURANCE

SECONDARY Insurance: _____

Insurance Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Subscriber/ID#: _____ Group#: _____

SUBSCRIBER—CARD HOLDER INFORMATION

☐ Same as Client ☐ Same as Responsible Party ☐ Other

Client Relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other (specify) _____

Subscriber Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

PLACE OF EMPLOYMENT: _____ Phone: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I hereby authorize the Provider of service to furnish information to insurance carriers concerning my condition and treatment. I hereby assign to the provider all payments for medical services rendered to my dependents or myself. **I understand that I am responsible for any amount NOT covered by insurance.**

_____ _____

Signature of Client, Parent, Guardian or Personal Representative *Date*

_____ _____

Please print name of Client, Parent, Guardian or Personal Representative *Relationship to Client*

Please check all that apply.

In the last year, I have experienced concerns about the following checked reason(s) for counseling **at least once**:

REASON(S) I AM COMING TO COUNSELING					
☐ Abandonment	☐ Bulimia	☐ Elder Care	☐ Inactivity	☐ Oppositional	☐ Shame
☐ Abuse	☐ Child Care	☐ Employment	☐ Inattention	☐ Pain	☐ Sibling Conflict
☐ Affair	☐ Codependency	☐ Emptiness	☐ Inhibition	☐ Panic	☐ Social Skills
☐ Alcohol	☐ Compulsions	☐ Enabling	☐ Impulsivity	☐ Rage	☐ Sleep
☐ Alienation	☐ Conduct	☐ Family Conflict	☐ Irritability	☐ Rationalization	☐ Somatization
☐ Anger	☐ Crisis	☐ Fear	☐ Isolation	☐ Rejection	☐ Stress
☐ Anorexia	☐ Delusions	☐ Grades	☐ Jealousy	☐ Relationships	☐ Trauma
☐ Anxiety	☐ Denial	☐ Grandiosity	☐ Legal Problem	☐ Resistance	☐ Trust
☐ Avoidant	☐ Depression	☐ Grief	☐ Marital	☐ Ruminative	☐ Worry
☐ Appetite	☐ Disability	☐ Guilt	☐ Medical	☐ School Problem	☐ Other, please list:
☐ Blended Family	☐ Disorganized	☐ Hallucinations	☐ Memory Loss	☐ Self-Absorption	
☐ Body Image	☐ Distractible	☐ Histrionic	☐ Mood Swings	☐ Self-Esteem	
☐ Bonding	☐ Divorce	☐ Hyperactive	☐ Obesity	☐ Separation Anxiety	
☐ Boundaries	☐ Drugs	☐ Idealization	☐ Obsessions	☐ Sexual Abuse	

The following person(s) will be supporting me through the counseling process:

SUPPORT				
☐ Spouse	☐ Nuclear Family	☐ Extended Family	☐ Close Friend	☐ Other, please list:
☐ Church/Mosque/Temple	☐ 12 step	☐ Service System	☐ Group of Friends	

CONSENT FOR TREATMENT

I, the undersigned, agree, and consent to participate in the mental health services, as defined in Indiana law,

offered by ***(counselor's name)***_____ a

- ☐ Clinical Psychologist
- ☐ Licensed Clinical Social Worker
- ☐ Licensed Mental Health Counselor
- ☐ Licensed Marriage and Family Therapist
- ☐ Master's Level Counselor/Therapist/Social Worker
- ☐ Counseling Intern
- ☐ Practicum Student

I understand that I am consenting and agreeing only to those mental health services that the above-named provider is qualified to provide within: (a) the scope of the provider's license, certification, and training, or (b) the scope of license, certification, and training of those mental health providers directly supervising the services received by me, the client.

☐ As an intern/practicum student, I am under the supervision of a licensed therapist.
If you have any questions about my services, please contact my supervisor:

_____ _____ -or- (219)_____

name of supervisor email phone

Signature for Consent to Treatment

_____ _____

Client Signature *Date*

_____ _____

Guardian Signature *Date*

_____ _____

Provider Signature *Date*

FAMILY CONCERN COUNSELING

2004 Valparaiso Street, Valparaiso, Indiana 46383 | 219.477.5646 | FAX 219.728.4765 | info@familycounsel.org

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature and date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, including teletheraphy, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? ☐YES ☐NO

May we leave a message on your answering machine at home or on your cell phone? ☐YES ☐NO

May we discus your medical condition with any member of your family? ☐YES ☐NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
please print

Signature: _____