FCC
Family Concern Counseling

INTAKE

Counselor's Name:______________________________ Date: ________________

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

CLIENT INFORMATION

Name—First: ________________ Nickname: ________ M.I.___ Last:____________________

Address: ____

City: ______________________________ State: ______ Zip: __________

Date of Birth: ____________________ SS#: ____________________

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 cancelled with less than 24-hour notice will be charged a $25.00 cancellation fee. If you do not show for your appointment you will be charged a $25.00 no show fee. I understand and agree to abide by this policy.

____
Printed Name

______________________________ ________________
Signature *Date*

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

☐ Same as Client ☐ Other

Name: ____________________ Date of Birth: ____________SS#: ______________

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: __________SS#: __________

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: __________SS#: __________

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*

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CONSENT FOR TREATMENT

I, the undersigned, agree, and consent to participate in the mental health services offered by ______________________________ a mental health provider, as defined in Indiana law. 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.

______________________________	______________
Signature of Client, Parent, Guardian or Personal Representative	*Date*
______________________________	______________
Please print name of Client, Parent, Guardian or Personal Representative	*Relationship to Client*

NOTICE OF PRIVACY PRACTICES CONSENT FORM

Effective April 14, 2003 a federal regulation, commonly known as the "HIPAA Privacy Rule", requires that we must provide all of our clients with a detailed notice, in writing, of our privacy practices. We have this lengthy "*Notice of Privacy Practices*" available at our office and is also on our web site: www.familycounsel.org. A written copy of this policy is available upon request.

I understand that as a condition to my receiving treatment, Family Concern Counseling (FCC) may use or disclose my personally identified health information for treatment, to obtain payment for the treatment provided, and as necessary for the operations of this office. These uses and disclosures are more fully explained in the Privacy Notice that has been provided to me, and which I have had the opportunity to review.

I understand that the privacy practices described in the "*Notice of Privacy Practices*" may change over time, and that I have a right to obtain any revised Privacy Notices, if requested.

I also understand that I have the right to request FCC to restrict how my health information is used or disclosed. FCC does not have to agree to my request for the restriction, but if FCC does agree, FCC is bound to abide by the restriction as agreed.

Finally, I understand that I have the right to revoke/withdraw this consent in writing, at any time. My revocation/withdrawal will be effective except to the extent that FCC has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if I withdraw my consent.

______________________________	______________
Client Signature	*Date*
______________________________	______________
Guardian Signature	*Date*
______________________________	______________
Provider Signature	*Date*