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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Client Name (Please Print) | | SSN | | | | | Relationship Status  S M D W | | | Gender | DOB | | | Age |
| Phone Number | | Email Address | | | | | | Sexual Orientation/ Identity (Heterosexual, Transgender, Homosexual, Pansexual, other) | | | | | | |
| Street Address | | | | City, State | | | | | | | | Zip Code | | |
| Client Employer or School Name (if minor) | | | Occupation or Student | | | | | | How long employed? | | | | Work # | |
| Spouse or Parent's Name (if minor) | | | Occupation | | | | | | How long employed? | | | | Work # | |
| Person Responsible for Payment | | | Phone Number | | | | | | DOB | | | | SSN | |
| Street Address | | | City | | | | | | State | | | | Zip Code | |
| Emergency Contact Person | | | | | | Phone Number | | | | | | | | |
| Primary Care Physician | Phone Number | | | | Street Address (City, State, & Zip Code) | | | | | | | | | |

**Initial Patient Paperwork**

|  |  |  |  |
| --- | --- | --- | --- |
| Referred By | Street Address (City, State, & Zip Code) | | |
| Phone Number | | May we thank them? | Comments |

Please sign and date below confirming all the information provided is accurate to your best knowledge.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/ Representative Signature Date

**CONFIDENTIAL INTAKE FORM**

**(To be completed by the patient and/or guardian)**

Client name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate client’s reasons for seeking counseling: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long has the client been experiencing these issues? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the client previously received counseling? ( ) Yes ( ) No

If yes, please indicate reasons for previous treatment, approximate dates of treatment, outcomes, and diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate symptoms currently/ recently experienced by client:

|  |  |  |  |
| --- | --- | --- | --- |
| * Changes in appetite | * Changes in sleep patterns | * Memory issues | * Substance abuse |
| * Depression/ Extreme sadness | * Anxiety/ Excessive worry | * Relationship Issues | * Obsessive behaviors |
| * Paranoia | * Hallucinations | * Unstable mood | * Sexual issues |
| * Difficulty concentrating | * Impulsivity | * Aggressive behaviors | * Domestic violence/ Physical abuse |
| * Panic | * Trauma-related issues | * Thoughts of harming self or others | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Is the client currently being treated for any mental health issues? ( ) Yes( ) No

If yes, please indicate prescribing provider (e.g., psychiatrist), diagnosis, and all medications the client is currently prescribed, and whether or not they are helpful: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL AGREEMENT**

*Please initial next to each item indicating your understanding and acceptance.*

\_\_\_\_\_I understand that unless other arrangements have been made, payment is due at the time of service.

\_\_\_\_\_ I understand that if my insurance requires authorization, I am giving Breakthroughs permission to release my healthcare information to the insurance company for authorization purposes only. I also understand that if I do not accept this condition, and my insurance requires authorization for services then I will be required to pay out of pocket for any and all visits. Please initial here if you do not wish to have your information released \_\_\_\_\_\_.

\_\_\_\_\_ I understand that I am fully responsible for any charges not covered by my insurance provider. This may include but is not limited to denial of claims, copay, unmet deductible, etc.

\_\_\_\_\_ The insurance information I have provided represents a full disclosure of the insurance/ third party benefits to which I am entitled. I understand that failure to disclose pre-certification/ second opinion requirements for any and all plans to which I subscribe, may incur full liability for professional charges as a result of non-payment by any carrier.

\_\_\_\_\_ I understand that I will be charged a forty-five-dollar ($45) fee for missed appointments or appointments that are rescheduled or cancelled within 24 hours of scheduled appointment time.

\_\_\_\_\_ Unpaid balances for a period greater than one hundred twenty (120) days will be turned over to a collection agency.

\_\_\_\_\_ In the event of a returned check, I will be assessed a thirty-five-dollar ($35) processing fee.

\_\_\_\_\_ If I am requesting substance abuse-related services (e.g., court-ordered substance abuse evaluation) I may be required to submit to a urine screen. The cost for a urine screening is forty-five dollars ($45) and may not be included in the cost of my services received.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/ Representative Signature Date