

CLIENT INTAKE INFORMATION 2/2010
Please PRINT All Information clearly
(For relationship counseling, each party completes their own form)

Appointment Date _____ Therapist you will be seeing: _____

YOUR FULL NAME: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

e-mail address: _____ (Y / N) send newsletter

Date of Birth: ____/____/____ **Age:** ____ **Sex:** (M) ____ (F) ____

Home Phone # (____) _____ **cell or work #** (____) _____ **ext:** _____
Please indicate which number to use for appointment reminders

SS # ____--____--____ **Church Affiliation:** _____

Marital Status : (S)____ (En)____ (M)____ (How long : ____) How many times have you been married? ____.
 How many times has your spouse (or fiancé) been married? ____ (Div)____ (How long: ____)
 (Sep) ____ (How long : ____) (Wid.) ____ (How long : ____)

Family Members: (if married - include spouse)

Name	Age	D.O.B.	Relationship	Living At Home With You (✓)
_____	_____	____/____/____	_____	_____
_____	_____	____/____/____	_____	_____
_____	_____	____/____/____	_____	_____
_____	_____	____/____/____	_____	_____

How were you referred to the Counseling Center? _____

In case of Emergency, the Therapist may contact: _____

Phone #: (____) _____ Relationship to Client: _____

Responsible party for this account / bill: _____
 Relationship to client: Self ___ Spouse ___ Parent ___ Priest EAP service ___

If responsible party is other than client or EAP - please ask for a release of information to sign.

Do you have **health insurance to cover your mental health counseling?** ___ Yes ___ No
 Do you want us to file insurance for you? _____

Insurance Company: _____ Phone # (____) _____

Insured Person _____ Ins. ID#: _____

Employer: _____ Auth. # if required: _____

Job experience / Skills: Current Employer: _____

Occupation: _____ Address: _____

City: _____ State: _____ Zip: _____

Working: ___ Full Time ___ Part Time ___ Student ___ Other _____

Description of the problem(s): The following is a list of areas in which you may be experiencing some difficulty. Please check (✓) any of the symptoms that apply to you or help to describe a problem you are having.

A. PHYSICAL CONCERNS

1. CHANGE IN:

- Sleep
- Appetite
- Physical Energy
- General Health
- Weight
- Interest in Activity

2. INCREASED USE OF:

- Alcohol
- Drugs
- Pain relievers
- Antacids
- Laxatives
- Diet pills
- Sleeping pills
- Other: _____

3. RECENT HISTORY OF:

- Nausea & Vomiting
- Diarrhea
- Fever, Chills, Sweats
- Chest pain
- Shortness of breath
- Palpitations (pounding heart)
- Rapid breathing
- Severe headache
- Head injury
- Loss of consciousness
- Loss of memory
- Change in vision
- Difficulty in speech
- Loss of balance
- Swollen joints

- Skin rash
- Miscarriage
- Abortion
- Seizure (s)
- Numbness
- Paralysis
- Dizziness
- Tingling
- Blackouts
- Delirium Tremors
- Flashbacks
- Illness
- Hospitalization
- Bleeding
- Infection

B: PSYCHOLOGICAL CONCERN

1. THOUGHTS OF:

- Suicide
- Harming self
- Harming others

2. EXPERIENCE OF:

- Vivid dreams or nightmares
- Decreased need for sleep
- Hearing voices
- Seeing visions
- Being out of body
- Thought control
- Racing thoughts

3. FEELINGS OF:

- Anxiety
- Depression
- Dread
- Despair/Hopelessness
- Low self worth
- Jealousy
- Tension
- Rage
- Persecution
- Boredom
- Loneliness
- Guilt
- High Energy

4. FEAR OF:

- Loss of control
- Death
- Being alone
- Objects
- Animals
- Places
- Situations
- Being possessed
- Being insane
- Cancer
- AIDS
- Exposure
- Punishment

C. SOCIAL - OCCUPATIONAL CONCERNS

1. CONFLICT WITH:

- Spouse
- Family member
- Child
- Friend / peer
- Work supervisor

2. PROBLEM WITH:

- Finances
- Legal authorities
- Job
- School

3. VICTIM OF:

- Bad accident
- Rape
- Physical abuse
- Sexual abuse
- Verbal abuse
- Violent crime
- Persecution
- Discrimination
- Disfigurement
- Vandalism

- Emotional abuse
- Spouse or child abuse
- Harassment
- War injury
- Natural disaster
- Witness to violence / death
- Cult group / practice
- Slander
- Malpractice

On the scale below, please estimate the severity of your problems:

Mild Moderate Severe Extreme Incapacitating

In your own words, state the nature of your problem(s)? What has been tried that has helped or tried and made things worse? (Use the back if more space is needed).

Job satisfaction: _____ Very High, _____ High, _____ OK, _____ Low, _____ None, _____ Minus

Job Status: (____) secure, (____) in jeopardy, (____) unemployed, (____) retired, (____) disabled, (____) worker's comp., (____) social security, (____) working more than one job, (____) other: _____

Other kinds of work I am qualified to do: _____

Highest level of completed education: _____ Elementary _____ Junior/Middle School
High School _____ College _____ Graduate School _____ Doctorate _____

Past Psychological Treatment:

Have you ever had previous therapy or been hospitalized for a nervous or mental disorder? Yes No

When? _____ For How Long? _____

Where? _____

Who was your Doctor? _____

Have you ever attempted suicide? No Yes

When? _____ How? _____

General Health: How would you rate your overall health?

Excellent Good Average Poor

Primary Care Physicians Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone # (____) _____ Date of last physical: _____

List ALL Medication being taken at this time: _____

Medical History (List problems, allergies & dates including surgeries): _____

EPISCOPAL COUNSELING CENTER POLICY STATEMENT

I understand that I am consenting to treatment or testing, have read the policy letter, and that my **records** will remain with the Episcopal Counseling Center.

I authorize the Episcopal Counseling Center to **release** any necessary information to expedite insurance claims if they are being filed on my behalf. I understand that it is customary to pay for professional services when they are rendered, that I am responsible for all charges, regardless of insurance coverage, and that my account may be turned over to a collection agency if payment is not made.

I also understand that unless I give a 24 hour notice to cancel an appointment, **I will be financially responsible for a charge of \$50** for a missed appointment (regardless of insurance coverage). There is a voicemail answering service (or machine) available to leave a message if the office is closed, and emergency situations can be discussed with my therapist.

The State of Florida requires that the Episcopal Counseling Center inform you that under the following circumstances, **confidentiality will be breached:**

- 1). When there is cause to suspect a child, adolescent, or elder has been or may be abused.
- 2). When there is reasonable cause to believe that you pose risk of imminent harm to yourself.
- 3). When there is reasonable cause to believe that you pose risk of imminent harm to another individual.
- 4). When there is a valid court order compelling records or witness testimony.

If supervision is required by a student therapist or registered intern therapist, client information will be released only to the supervisor and your therapist will inform you if that is the case.

A have read the HIPAA Notice of Privacy Practices located at www.ecc1021.com or have received a hard copy from the office. (Please ask for a copy, we are happy to give it to you).

I have read and understand all of the above.

(Client signature)

(Spouse or parent signature)
If needed

(Client **PRINTED** name)

(Date)

PLEASE
DO NOT
STAPLE
IN THIS
AREA



CARRIER

HEALTH INSURANCE CLAIM FORM

PICA [] [] PICA [] []

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)</small>		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY STATE		7. INSURED'S ADDRESS (No., Street)	
ZIP CODE TELEPHONE (Include Area Code) ()		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		11. INSURED'S POLICY GROUP OR FECA NUMBER	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
c. EMPLOYER'S NAME OR SCHOOL NAME		b. EMPLOYER'S NAME OR SCHOOL NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. INSURANCE PLAN NAME OR PROGRAM NAME	
		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	
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14. DATE OF CURRENT: MM DD YY		ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE				17a. I.D. NUMBER OF REFERRING PHYSICIAN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. _____	
1. _____ 3. _____						23. PRIOR AUTHORIZATION NUMBER _____	
2. _____ 4. _____							

24. A	DATE(S) OF SERVICE						B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
	From	To	MM	DD	YY	MM										
1																
2																
3																
4																
5																
6																

25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$ _____		29. AMOUNT PAID \$ _____		30. BALANCE DUE \$ _____	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)				33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #			
SIGNED _____ DATE _____				PIN# _____				GRP# _____			

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



AUTHORIZATION TO RELEASE INFORMATION

Release of information will not be honored unless an original signed release with all information completed is submitted.

- * Jerrold F. Beaumont, D.D., Ph.D.
- * Constance L. Cox, M.A.
- * Dale D. Eshleman, M.S.
- * Ruan C. Humphrey, M.A.
- * Sharon F. Jones, Ph.D.
- * Barbara R. Keene, Ph.D.
- * Ginette E. Olsen, Ph.D.
- * Sarah B. Phillips, M.S.
- * Wallace A. Reynolds, Ph.D.
- * Mark S. Sears, M.A.
- * Michael J. Story, M.
- * Deborah Wennerstrom, Psy.D.

I hereby authorize _____ of the Episcopal Counseling Center to (release or obtain) confidential professional information, including personal, psychological, mental health, substance abuse, AIDS-related information, records, and opinions resulting from my contacts with them.

INFORMATION IS TO BE -RELEASED TO/ OBTAINED FROM: (circle one)

Name _____

Address _____

City/ State/ Zip _____

ATTN: _____

Phone # (_____) _____ Fax # (_____) _____

This request specifically includes the following: Psycho Social History Psychological Testing
 Session Summary Progress Notes Billing All records Other _____

Dates to be covered by reports: From: _____ To: _____

I also authorize _____ to communicate with _____ regarding all aspects of my treatment, diagnosis and prognosis.

I understand that I have no obligation to disclose the requested information and that I may revoke this consent at anytime by informing any of the above named individuals. This release of information shall be terminated one year from date of signatures, regardless, and any information released may not be re-disclosed without further authorization by signature. The client has been given the opportunity to discuss the possible benefits and disadvantages of releasing the information and a copy of the HIPPA notice of privacy practices is available if requested.

In consideration of this consent, I hereby release the above parties from any and all liability arising there from.

Client, Parent or Guardian Signature

Date

Client's Printed Name

Date of Birth

Relationship to Client

Signature Witness

Date

Printed Name

Phone #

FINANCIAL DISCLOSURE FORM

The Episcopal Counseling Center is not externally funded to cover the expenses of providing psychological services. Therapists are not salaried but are paid a percentage of their client payments.

As a ministry, we offer an adjustment on the fee for those families and individuals whose GROSS yearly income is less than \$70,000. **This gross amount is based on total household income.**

To become eligible for the fee reduction, we must have a listing of all sources of income and benefits and their yearly amounts. In the event that you determine this information to be too private or personal, the sliding scale will be waived and the full fee of \$125.00 per hour will be charged. If someone other than the client will be paying this bill, please ask for the Financial Agreement form.

If there is a concern about the fee you are being charged, please discuss it with your therapist.

INCOME SOURCES:

	<u>Place of Employment</u>	<u>Gross Yearly Income</u>
Man/ Husband:		\$
Woman/ Wife		\$
Alimony (paid to you)		\$
Child Support (paid to you)		\$
Dividends/ Interest		\$
Government Assistance		\$
Other Sources		\$

I certify by my signature below that this information is an honest and accurate representation of the total sources of income and revenues. I further understand that the Counseling Center pledges not to reveal this information to anyone without my consent.

(CLIENT or guardian signature)

(DATE)

(CLIENT PRINTED NAME)