North Suburban Counseling

CLIENT INTAKE INFORMATION FORM

Office Use Only

Client #_____
Ins Dx # _____
Therapist _____
CPT_____

Ins copy? ❑Y ❑N
EAP? ❑Y ❑N

Today's Date _____ /_____ /_____

The information requested in this form will be kept confidential
GENERAL INFORMATION - *Please print*

Name: Last_____ First _____ MI _____
Address_____ City_____ State_____ Zip_____
Birth date _____ /_____ /_____ Age_____ ❑Male ❑Female Social Security # _____

Responsible Party (if different than above): Relationship to Client_____
Name: Last_____ First _____ MI _____
Address_____ City_____ State_____ Zip_____
Birth date _____ /_____ /_____ Age_____ ❑Male ❑Female Social Security # _____
Phone (circle preferred number): Home_____Work_____Cell _____
Email address _____

Phone (circle preferred #) May we leave messages?

Home_____ ❑Y ❑N
Work_____ ❑Y ❑N
Cell _____ ❑Y ❑N

Email address
_____

EMERGENCY CONTACT

Name _____
Relationship _____Phone _____
Address_____
City_____State_____
Zip_____

Marital Status: ❑Single ❑Married/Partnered (# years_____)
❑Separated ❑Divorced ❑Widowed
Spouse/Partner's Name_____

How did you hear about us? ❑M.D. ❑Brochure ❑Family/Friend ❑Internet ❑Insurance ❑Therapist
Client referred by: _____

Type of counseling you are seeking: ❑Individual ❑Couples ❑Family

Are you using insurance benefits? ❑Y or ❑N Are you: ❑Primary Policyholder or ❑Dependent

Policyholder's Information: Relationship to Client_____
Name: Last_____ First _____ MI _____
Address_____ City_____ State_____ Zip_____
Birth date _____ /_____ /_____ Age_____ ❑Male ❑Female Social Security # _____
Phone (circle preferred #): Home_____Work_____Cell_____
Policyholder's Employer_____ Insurance Authorize #_____
Insurance Company _____ Insurance Company Phone #_____
Insurance ID #_____ Group #_____ # of Authorized Visits_____

Our Financial Policy

We understand that the cost of counseling can be a major concern of our clients. Our financial policy provides payment policies and options to all of our clientele. Each therapist at North Suburban Counseling has established his or her own fee structure. Please ask about their fees during your first visit.

The person responsible for payment of account is required to sign this form at the bottom, indicating that they have read, understand, and agree with the provisions of this policy.

If you are using your health insurance to pay for a portion of your counseling fees, you need to remember that your insurance policy is a contract between you and your insurance company. Your counselor is NOT part of this contract, unless they have established a separate contract with your insurance company or the company that administers your mental health benefits. In these situations, (usually associated with "managed care") the responsible party is ONLY responsible for a co-pay fee as defined in their insurance plan, and is not responsible in any way for fees that are charged by their counselor to the client's managed care corporation. *Please ask your clinician if they participate in your insurance companies managed care plan.* If your insurance is NOT a managed care plan, or you are using "out of network" benefits and you wish your therapist to bill your insurance company, you will need to discuss the terms of payment and the specifics with your counselor during your initial visit.

Generally speaking, insurance deductibles and co-payments are due at the time of service. The person responsible for payment will be financially responsible for payment of professional fees, and for paying all fees not paid by insurance companies or third-party payers after 60 days, except in cases (as noted above) where your clinician has a contract with a managed care corporation that administers your plan. Any payments owed by the client and not received after 90 days need to be discussed with your counselor. All insurance benefits will be assigned to your therapist unless the person responsible for payment of account pays the entire balance each session.

Payment methods include: Check, Cash, VISA, MASTERCARD, and DISCOVER (NOVUS).

I (we) have read, understand, and agree with the provisions of the Financial Policy.

Signature of Person Responsible for Payment **Date**

Signature of Co-Responsible Party **Date**

Pre-authorization for health care

I authorize my therapist to *keep my signature on file*, and *assign my mental health care insurance benefits* to them for services provided to me or to those whom I am responsible. I understand that my authorization, which is granted here, is valid for all services performed by my therapist, and that this authorization will remain in effect until I cancel the authorization by written notice to my therapist.

_____ _____

Insured Person's Signature **Date**

Release of Information to Insurance Company

I (we) authorize the mental health professional who provides services to us to disclose case records to the third-party payer or insurance company listed on the Client Information form completed on this date, for the purpose of receiving payment reimbursement directly to this clinical provider.

I (we) understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) can revoke this consent at any time by providing written notice, and that after one year this consent expires. I (we) have been informed what information will be given, it's purpose, and who will receive it. I (we) certify that I (we) have read and agree to these conditions and have received a copy of this form.

_____ _____

Signature of Person Responsible for Payment **Date**

_____ _____

Signature of Person Receiving Services **Date**

_____ _____

Signature of Parent or Guardian **Date**

Release of Information to Primary Care Physician

I (we) authorize the mental health professional who provides services to us to disclose case records to the primary care physician listed below, for the purpose of continuity and coordination of care.

I (we) understand that I (we) can revoke this consent at any time by providing written notice, and that after one year this consent expires. I (we) have been informed what information will be given, it's purpose, and who will receive it.

_____ _____

Signature of Person Receiving Services **Date**

_____ _____

Signature of Parent or Guardian **Date**

_____ _____

Witness **Date**

Physician Name _____ Phone_____

City_____ State_____ Zip_____

Medication List

Please advise us of any medications you are currently taking by completing the form below.

Medication	Dose	Frequency	Prescribing Physician

_____ _____

Client Name **Date**