COUNSELING ASSOCIATES of EDMOND

Adult Intake Form

Client's Full Name: _____

Client's Date of Birth: _____

Client's Address: _____

City, State, Zip Code: _____

Can mail be sent? Y N

Client's Phone Number:_____

□ Cell □ Home □ Work Can messages be left? Y N

Alternate Phone Number: _____

□ Cell □ Home □ Work Can messages be left? Y N

Email Address: _____

Can email be sent? Y N

Emergency Contact Name: _____

Emergency Contact Number: _____

Relation to Client: _____

Please take the time to fill out this form in its entirety.
Your answers on the following pages will help me give you the best possible care.

Family Information
Please list everyone living in your home and other significant family members:

Name	Relationship	Age	Health Concerns	Comments

Medical Information
From whom or where do you get your medical care?

Clinic/Doctor's name: _____Phone:_____
Address: _____

Current Mediation

Medication	Strength	Dosage	Length Taken	Side Effects

Significant medical problems and/or diagnoses ☐ Yes ☐ No

If yes, provide the description of problem(s):

_____
_____

Have you ever been hospitalized for a mental illness? ☐ Yes ☐ No

If yes, provide the description of problem(s):

_____
_____

Work History

Occupation: _____

Do you like your job? ☐ Yes ☐ No

If unemployed, describe the situation: _____

_____

Hobbies/Interests: _____

Emotional Status

What are you seeking help for at this time? _____

_____

How much are you troubled by this?

Circle one: constantly often somewhat not very much

Are you struggling with suicidal thoughts? ☐ Yes ☐ No If yes, how often? _____

Circle one: constantly often somewhat not very much

Have you tried to commit suicide in the past? ☐ Yes ☐ No If yes, when? _____

What would you like to accomplish with counseling? _____

_____

What kind of obstacles could get in the way? _____

_____

Have you been in therapy before or received any prior professional assistance for your concerns?

If so, please give dates of treatments and results:

_____

_____

_____

_____

To the best of my knowledge, the information provided is accurate and true.

_____

Signature of Client/Guardian Date

Counseling Informed Consent

CONFIDENTIALITY: Everything you say in these sessions and the written notes I take are confidential and may not be released to anyone without your written permission, except where disclosure is required by law.

_____
initial

EMERGENCY: If there is an emergency during therapy or after therapy, and I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychotherapy, I will do whatever I can within the limits of the law to prevent you from injuring yourself or others and to ensure that you receive the proper treatment. For this purpose, I may also contact the person whose name you have provided on the client information sheet.

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_____
initial

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS: Disclosure of confidential information may be required by your health insurance carrier or other third-party payer in order to process the claims. Only the minimum necessary information will be communicated to the carrier.

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_____
initial

RECORDS AND YOUR RIGHT TO REVIEW THEM: The law requires that I keep treatment records for at least 6 years. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when I feel that releasing such information might be harmful in any way. Upon your request, I will release information to any agency/person you specify unless I feel that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family therapy, I will release records with signed authorizations from all the adults involved in the treatment.

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_____
initial

TELEPHONE & EMERGENCY PROCEDURES: If you need to contact me between sessions, please call Debbie Moore at 405-822-1297. **Communication via text or email is used for scheduling purposes only**. If an emergency situation arises, indicate it clearly in your message and if you need to talk to someone right away call 911 or go to your nearest emergency room.

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_____
initial

THE PROCESS OF THERAPY/EVALUATION AND SCOPE OF PRACTICE: Therapy can affect you in many ways. You may resolve the problem you came in for, but it takes effort on your part. I want you to be open and honest. We may talk about unpleasant events which may cause you discomfort and I may challenge some of your ways of thinking. You must also know that while we expect change, there is no promise that this therapy will yield a positive result. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. I am likely to draw on various psychological approaches. These approaches may include: Behavioral, Cognitive Behavioral, Cognitive Psychodynamic, Existential, System/Family, Developmental, Reality, Gestalt or Psycho-Educational. I do not prescribe drugs.

_____
initial

TREATMENT PLANS: I usually consider our first 1-3 sessions to be an evaluative time where I am working to better understand you and your concerns and you are exploring what it would be like to continue working together. Should we feel that I am a good fit for you, I will typically schedule one session per week at a time we agree on, although we may decide to meet more or less frequently. I will then discuss with you my working understanding of the problem, treatment plan, therapeutic

objectives, and my view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy or about the treatment plan, please ask and I will explain it to you. You also have the right to ask about other treatments for your condition and their risks and benefits. . _____

initial

TERMINATION: After the first meeting, I will assess if I can be of benefit to you. I do not accept clients who, in my opinion, I cannot help. In that case, I will give you a number of referrals you can contact. If at any point during therapy you are non-compliant, I will terminate treatment. In such a case, I will give you a number of referrals that may be of help to you. You have the right to terminate therapy at any time. . _____

initial

DUAL RELATIONSHIPS: Not all dual or multiple relationships are unethical or avoidable. Therapy never involves any dual relationship that impairs the therapist's objectivity, clinical judgment or can be exploitative in nature. It is important to realize that in some areas multiple relationships are unavoidable. I will never publicly acknowledge working with you without written permission. I will not accept you as a client if I feel a significant dual or multiple relationships exists. It is your responsibility to advise me if any dual or multiple relationships becomes uncomfortable for you in any way. I will always listen carefully and respond to your feedback and will discontinue the dual relationship if you find it is or may interfere with the effectiveness of the therapy or your welfare. You may do the same at any time. . _____

initial

COURT TESTIMONY: The goal of psychotherapy is the reduction of stress and interpersonal conflict. **Additionally, by starting treatment, you are agreeing not to involve me in legal proceedings or attempt to obtain treatment records for legal or court proceedings**. In the event that I am required to provide treatment records or testimony in any legal proceeding, you will be charged $250 per hour for any preparation time I or other personnel spend getting ready to appear or turn over documents. You are agreeing to pay $750 per 4-hour block of time that I spend being "on call" to testify, traveling to and from court/deposition, waiting to appear, and/or testifying. The minimum charge will be for 4 hours of time and subsequent time will be billed in 4-hour blocks. The initial $750 is due in full one-week prior to any scheduled court appearance/depositions. . _____

initial

SOCIAL NETWORKING AND INTERNET SEARCHES: At times, I may conduct a web search on my clients before the beginning of therapy or during therapy. If you have concerns or questions regarding this practice, please discuss them with me. I do not accept friend requests from current or former clients on social networking sites, such as Facebook. I believe that adding clients as friends on these sites and/or communicating via such sites is likely to compromise their privacy and confidentiality. For this same reason, I request that clients not communicate with me via any interactive or social networking sites. . _____

initial

I have read the above policies. I understand them and agree to comply with them.

_____ _____

Client's Signature Date

_____ _____

Therapist's Signature Date

Counseling Associates of Edmond

307 E. Danforth Road, Suite 150

Edmond, OK 73034

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices. The notice states how we may use and/or disclose your health information. You can find a copy of the Notice in our office or on our website.

Please sign this form to acknowledge receipt of the Notice.

You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

□ The patient refused to sign.

□ Due to an emergency situation, it was not possible to obtain an acknowledgment.

□ We weren't able to communicate with the patient.

□ Other (please provide specific details) _____

_____

_____ _____

Therapist Signature Date

My valid credit card information is

Credit Card: VISA MASTERCARD DISCOVER (circle one)

Name on Card: _____

Number: _____

CVS: _____

Expiration Date: _____ Billing Zip Code: _____

The following is about who carries the insurance

Subscriber's Full Name: _____

Subscriber's Date of Birth: _____

Subscriber's Address: _____

City, State, Zip Code: _____

Subscriber's Phone Number: _____

Insurance Company: _____

Subscriber ID: _____

Policy Group Number: _____

Client's Relationship to the insured: □ Self □ Spouse □ Child □ Other

I authorize the release of any medical or other information necessary to process this claim. I also request payment of medical benefits to the supplier of services, Counseling Associates of Edmond.

_____

Signature of Client/Guardian Date

Counseling Associates of Edmond

Financial Policy and Missed Appointment Policy

Welcome to Counseling Associates of Edmond. Please read over our Financial and Missed Appointment Policy. If you have questions, feel free to ask the front desk staff.

Financial Policy

Fees: Counseling sessions are 50 minutes long. The fee for a 50-minute session, either face-to-face or by phone, is **$150** for the initial session and $125 for each subsequent session. Payment is collected at the time of the session. We also ask you to place a credit card on file for future billing.
Charges: Occasionally there are extra charges or other altered charges, but in your case the fee for a 50-minute session will be _____.

Insurance Patients: If you have health insurance, Counseling Associates of Edmond will contact your insurance company and verify your insurance benefits. We will file your insurance as a courtesy to you. If your insurance covers a portion of your therapy, we will wait up to 90 days for your insurance to pay their portion. You will, however, be responsible for your deductible and co-pay or co-insurance. That portion of your care will be due at the time of your appointment. Your will be responsible for all charges not covered by your insurance company.

Self-Pay Patients: Patients without insurance, with high deductibles, or who choose not to use their insurance, are responsible for the cost of care. Payment is expected at the time of service.

Methods of Payment: Counseling Associates of Edmond accepts cash, checks, and Visa, MasterCard and Discover.

Payment in Advance: If your therapist suggests more than 10 visits, you may pay for them in advance and receive a discount of 15%. Payment for multiple visits must be made by the third visit.

Missed Appointment Policy

Twenty-four hour notice is required for the cancellation of an appointment. Appointments canceled with less than 24 hour notice, will be charged your full fee. This includes the reimbursable amount paid by the insurance company, not just your co-pay. Appointments missed because of inclement weather will not be charged. The charge will be applied to your credit card on file. Notice of cancellation for a Monday appointment is preferred on Friday but can be given over the weekend.

Signature of
Client/Guardian_____Date_____