PROFESSIONAL COUNSELING SERVICES

ADULT INTAKE FORM

TODAY'S DATE:_____

PATIENT'S NAME:_____

HOME ADDRESS:_____ CITY _____ STATE _____ ZIP _____

PHONE:_____ MALE: ☐ FEMALE: ☐ MARITAL STATUS _____

DATE OF BIRTH:_____ AGE:_____ SS#_____

NAME OF PHYSICIAN:_____ TELEPHONE #_____

MEDICATION /ALLERGIES:_____

EMPLOYER:_____ PHONE:_____

OCCUPATION:_____

REFERRED BY:_____

SPOUSE INFORMATION

NAME OF SPOUSE:_____ BIRTH DATE:_____

OCCUPATION:_____ SS#_____

CHILDREN:

NAME:_____ AGE:_____ NAME:_____ AGE:_____

NAME:_____ AGE:_____ NAME:_____ AGE:_____

EMERGENCY CONTACT:

NAME:_____ RELATION:_____

PHONE:_____

PRIVACY REQUEST: PLEASE ANSWER YES OR NO

_____ ***YOU MAY CALL ME AT HOME.***

_____ ***YOU MAY CALL ME AT WORK***

TO CONFIRM APPOINTMENTS YOU MAY CALL ME AT HOME _____ ***AT WORK*** _____

YOU MAY LEAVE A MESSAGE AT HOME _____ ***AT WORK*** _____ ***TO CONFIRM APPOINTMENTS***

NUMBERS TO CALL:_____

INSURANCE INFORMATION

PATIENT'S NAME: _____

NAME OF INSURANCE: _____ INSURANCE PHONE # _____

ID# _____ GROUP # _____

INSURED'S NAME: _____ D.O.B. _____

INSURED'S EMPLOYER: _____ SS# _____

HAVE YOU CALLED YOUR NSURANCE TO VERIFY YOUR MENTAL HEALTH BENEFITS? _____

DO YOU NEED AUTHORIZATIONS FOR COUNSELING? _____

AUTHORIZATION # _____ ***NUMBER OF SESSIONS AUTHORIZED*** _____

I understand that if I don't provide insurance information, get required authorizations, or use an "out of network" provider, that I am liable for the charges of all services.

SIGNATURE: _____ DATE: _____

***AUTHORIZATION**: I authorize Professional Counseling Services to release any information obtained during examination or treatment of this patient which is necessary to expedite and support any insurance claims on this account. I understand that I am responsible for all charges, regardless of insurance coverage. I authorize payment of benefits directly to Professional Counseling Services.*

SIGNATURE: _____ DATE: _____

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INSURANCE WAIVER

ONLY SIGN BELOW **IF YOU ARE NOT** USING INSURANCE.

IF YOU WILL NOT BE USING INSURANCE, PLEASE READ AND SIGN THIS PAY FOR SERVICE AGREEMENT.

I, _____, choose not to utilize insurance benefits (if any) at this time. I understand that if I do decide at a future date to file my insurance, that Professional Counseling Services is not bound by any contractual agreement to accept provider discounts for prior dates of service that have been paid for.

I have read and understand the agreement.

_____ _____

Patient/Parent's signature Date signed

CLIENTS'S INFORMED CONSENT

I have chosen to receive psychological services through Professional Counseling Services for myself and/or my child. If consent is for my child, I am the legal custodial parent of that child. My choice has been voluntary and I understand I may terminate therapy and any time.

I understand there is no assurance I will feel better. Therapy is a cooperative effort between myself and my therapist, and I will work with my therapist in a cooperative manner to resolve my difficulties.

I understand during the course of my therapy, material may be discussed which will possibly be upsetting in nature and this may be a component to aid in resolving my problems.

I have read and had explained to me the basic rights of individuals participating in the therapy. These rights consist of:

1. The right to be informed of the various steps and activities involved in receiving services.

2. The right to confidentially under federal and state laws relating to the receipt of services, including the right to confidentially of HIV/AIDS status and testing.

3. The right to humane care and protection from harm, abuse, or neglect in the least intrusive method in the least restrictive environment.

4. The right to make an informed decision whether to accept or refuse treatment, including the right to refuse medications prescribed.

5. The right to file a grievance concerning treatment of procedures. If the grievance is not resolved internally, I have the right to contact my insurance company. If these internal mechanisms do not resolve my concern, I ultimately have the right to contact the Illinois Dept. of Insurance Regulation or, if I am involved in substance abuse treatment, the Illinois Dept. of Alcohol and Substance Abuse.

6. The right to equal access to treatment regardless of my sex, religion, age, ethnicity, and sexual preference or handicapping condition.

I have read and understand the above consent form.

_____ _____

Client/Patient Signature Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Witness' Signature Date

Note: If requested, a copy of this form should be given to the client.

Patient/Provider rights and obligations

Please read carefully and sign where indicated

Professional Counseling Services offers psychological evaluations and treatment. In providing these services Professional Counseling Services exercise their clinical judgment regarding the methods of treatment that will serve the best interest of their patients/clients. In return, Professional Counseling Services expect you to make a good-faith effort to fulfill our treatment recommendations and to make timely payments for our services.

Confidentiality: It is our responsibility to ensure that all progress notes and testing reports/results become part of your chart and to keep all information in your chart confidential. Although our staff will have access to your chart in order to provide you with necessary clinical and clerical services, we will not release the information in your chart to anyone else unless you or your legal guardian have given us written permission to do so, the law requires us to do so (such as incidents of child abuse/neglect), or it is necessary for us to do as a result of a medical emergency (such as imminent threat of harm to self or others).

If we request records or information from you, it is your responsibility or the responsibility of your parent or guardian to obtain that information and provide it to us.

Cancellations and Missed Appointments: We have 24 hour cancellation policy. You must call 24 hours prior to your session if you need to cancel your appointment. Sessions canceled with less than a 24 hour notice will be charged $25.00. Missed appointments, without a phone call made, will be charged $35.00.

Payments: Payment is due at the time services are rendered, unless prior arrangements you have made. Any outstanding bill for services rendered, will be sent to our attorney for collections. You will be held responsible for the unpaid balance, attorney and court fees. Our fee for checks returned is $20.00.

Although we will work with you to obtain payment from your insurance company, you (or your parent or guardian) have the primary duty and obligation to pay for any services you receive from us, regardless of any agreement that you or your parent or guardian may have with another party (for example, and insurance company, employer, union, etc.). Therefore, although we may accept assignment of your insurance benefits, such an assignment will not release you from the responsibility to pay for our services.

_____ _____ _____ _____

Patient/Client Date Parent or Guardian Date

GUARENTEE OF PAYMENT

The undersigned jointly and severally unconditionally guarantee that the prompt payment of all fees and charges for services rendered to the above-mentioned client. In addition, the undersigned agree to pay all costs and expenses incurred in enforcing this guarantee.

_____ _____

Guarantor/Relationship Date

_____ _____

Witness Date