



Client Intake

Demographics & Other Information

(Last Name, First.) _____

Mailing Address: _____

Phones: Home _____ Work _____ Cell _____

Email Address: _____ Is it ok for us to email you (esp. for billing purposes)? Y N

DOB: _____ **Age:** _____ **Gender:** Male Female

Marital Status: NEVER MARRIED MARRIED SEPARATED DIVORCED WIDOWED

Spouse's Name: _____ If divorced/separated/widowed, when? _____

Emergency contact name, phone #, and relationship: _____

If Under 18 School attending: _____ Grade: _____

Name of person filling out intake: _____ Relationship to child _____

Biological father's name: _____ **DOB:** _____ **Legal custody:** YES NO

Address: _____ **Phone number:** _____

Still married to biological mother? YES NO If divorced, when? _____

In case of divorce, has father remarried? YES NO If yes, name of step-mother: _____

Biological mother's name: _____ **DOB:** _____ **Legal custody:** YES NO

Address: _____ **Phone number:** _____

Still married to biological father? YES NO If divorced, when? _____

In case of divorce, has mother remarried? YES NO If yes, name of step-father: _____

Standard charge per session, for counseling: \$180(intake), \$120(ind.), \$140(couple/family). From what we know from your insurance company, we expect your portion to be: Co-pay: \$____ or ____% If you have a deductible, you are responsible for knowing the amount and meeting the deductible before the co-pay &/or co-insurance applies. **There are separate charges for non-counseling work.** See below. Please read and **initial:**

_____ I understand the listed charges and accept responsibility for payment of scheduled sessions unless I give twenty-four (24) hours notice of cancellation. **I am responsible** for the standard charge if I fail to provide all information and documentation needed to collect insurance payments, if I have not met my deductible, if I am not covered by the insurance company, or if the insurance company otherwise fails to make payment. I understand that my insurance may not cover me for more than one behavioral/mental health service per day or more than one diagnostic service per 6 month service.

_____ I agree to pay the **full fee** (or allowed/contracted rate if I have valid insurance) for "late cancellations" or "no-shows" (I fail to attend a scheduled session and I also fail to provide cancellation at least 24 hours in advance.) **However, this charge is \$10 if I make the payment within 30 days of the missed session, with no more than 3/calendar year.**

_____ I authorize SEB Health to provide therapy, counseling, and other treatment as deemed necessary for me.

_____ I have received notice of HIPAA and my patient rights and responsibilities.

_____ I agree to pay \$25 for "bounced" check charges.

_____ I understand that I will be responsible for cost of collections if I fail to pay as agreed and that my personal information will be provided to the collection agency chosen by SEB Health. Currently 30% is added to the bill for cost of collections, for which I am responsible if I fail to pay my bill in a timely fashion.

_____ I understand that an interest charge of 7%/annual plus \$10 late fee will be added each month that my bill is over 60 days late, where the date of services (therapy) or the date services requested (all other services) is the date due.

_____ I understand that services I (or someone on my behalf such as my attorney) request that are NOT therapy or routine therapy-related services (e.g., a brief contact with my MD is a routine service) are considered a request for her expertise, and different per-hour rates may apply. Services considered additional or not therapy include but are not limited to: witness in court, disability reports, assessments, letters, summaries, and affidavits.

_____ I understand that **all services from SEB Health must be paid in advance.**

_____ If a spouse or other family members is/are present, I understand that ALL persons present must sign request for any release of records before that record will be released.

_____ I understand that SEB will make every effort to obtain correct information from my insurance company and provide that information to me. However, it is **MY** responsibility to know the limits of my policy, my clinician's participating status and to make the payments required by my insurance. Also, it is **MY** responsibility to file complaints with my insurance and to file and collect from secondary or tertiary sources.

_____ I understand that therapists' work may be supervised by another therapist without additional consent on my part and agree that this is not a breach of confidentiality.

_____ I understand that my therapist and her supervisor (if any) are required by law to try to prevent me from harming myself or another and that if they feel there is such a risk they may have to break confidentiality.

_____ I understand that my therapist and her supervisor (if any) are required by law to report suspicions of child abuse.

Signature

Date

Social Security Number

Briefly describe why you are seeking counseling: _____

What, if anything, led to your contacting me at this time (e.g., a recent incident, court, etc.): _____

Insurance Information of Insured Party

Name of Behavioral Health Carrier: _____ HMO PPO POS
Plan Name: _____ OTHER mental/behavioral health coverage? YES NO
Name of Ins'd Party: Self or: _____ & Relationship to client: SPOUSE PARENT
Insured's DOB: _____ & Address: Same or : _____
Insured's Phone: Same or: _____ & Employer: _____
How long employed here? _____ If EAP, who is your immediate supervisor? _____
Member #: _____ Group #: _____ Effec. Date: _____

Client Background Information

Previous mental/behavioral health providers:

Approximate dates of previous treatment & # of sessions:

Your response to previous treatment:

Prenatal and developmental history (for children and adolescents):

Allergies and medical issues:

Other issues counselor should know about?

Assignment of Medical Benefits

I hereby assign medical benefits to which I am entitled to SEB Health, Inc. A photocopy of this assignment is to be considered as valid as an original. I further authorize said assignee to release the information necessary to secure medical payments for services rendered.

Signature

Date

How did you learn about SEB Health? (Check all that apply.)

- Insurance or EAP provider
- Relative: _____
- Friend: _____
- Other counselor: _____
- Other Agency: _____ Hospital DFACS CAC
- Attorney: _____
- Doctor: _____
- Other: _____

What do consider your religious orientation? Please check all that apply:

- Jewish
- Catholic:
- Protestant:
 - Southern Baptist Other Bap.
 - Methodist
 - Presbyterian
 - Pentecostal/Church of God
 - Church of Christ
 - Other Protestant: _____
- Atheist (don't believe there is a God)
- Agnostic (not sure if there is or is not a God)
- Other: _____
- Prefer not to say

Practicing Not Practicing

If practicing, select most accurate responses, **all that apply:**

- Attend services a few times/year
- Usually attend one service/week
- Usually attend 2 or more services/week
- Read the Bible daily, most days
- Read devotional material most days
- Read Sunday School material most weeks
- Read religious and/or inspirational material weekly or more often

Coordination of Care

Who is your primary care physician? _____ Phone: _____

Mailing address: _____ FAX: _____

Other clinician or psychiatrist: _____ Phone: _____

Mailing address: _____ FAX: _____

I give my permission for SEB Health to contact my PCP and other medical provider listed above after my initial evaluation and at other significant points in treatment, sharing information deemed necessary for coordinated care. This release is valid for the duration of my care up to 3 months after my last session. I understand that I have the right to revoke this release at any time and agree that neither SEB Health nor my therapist at SEB Health are responsible for the actions of the receiving party regarding that information.

Signature

Date

For Office Use ONLY

ROI signed for PCP? ___ Yes ___ No If no, reason: _____

ROI signed for other clinician? ___ Yes ___ No If no, reason: _____

Communication Dates and Comments

Include any problems with the communication below:

Dates & Communication with PCP

Dates & Communication with Other Provider

Diagnosis: _____ Client reports meds: _____

First session here: _____ Sessions are once twice 3x weekly monthly as needed Other: _____

Summary of assessment and treatment plan recommendations:

Please be so kind as to provide me with all relevant clinical information you have that may pertain to this client's mental health or substance abuse issues. Thank you.