Untangled Counseling

PATIENT INFORMATION FORM

Date: _______________

Patient 1 Name: ____
(First) (Middle) (Last)

Address: ____
(Number) (Street)

____
(City) (State) (Zip)

Home Phone: (_____) ____________________ Social Security #: ____________________

Cell Phone: (_____) ____________________ Date of Birth: ____________________

Work Phone: (_____) ____________________ Age: ____________________

Email: ____________________ Gender: ____________________

Marital Status: ____________________

Employed by: ____
(Company Name) (Company Address) (Company Phone)

Patient 2 Name: ____
(First) (Middle) (Last)

Home Phone: (_____) ____________________ Social Security #: ____________________

Cell Phone: (_____) ____________________ Date of Birth: ____________________

Work Phone: (_____) ____________________ Age: ____________________

Email: ____________________ Gender: ____________________

Marital Status: ____________________

Employed by: ____
(Company Name) (Company Address) (Company Phone) Children

Name/s & Age/s: ____

Referred By: ____

Medication(s): ____

Physician(s): ____

Address: ____

Phone: (_____) ____________________ Last Visit: ____________________

Previous Counselor: ____

Address: ____

Phone: (_____) ____________________ Last Visit: ____________________

____
Signature

____
Client Name (Printed)

____
Date

Untangled Counseling

New Client Pre-Screening Questions

Have you received the notice of our HIPPA policies and procedures?	YES	NO
Have you read and signed the Patient Services Agreement (PSA)?	YES	NO
Do you understand that, under particular circumstances, we may be required to release information about you without your permission?	YES	NO
Have you ever had a psychiatric hospitalization?	NO	YES
If so, on what dates? ______________________________		
Have you ever attempted to commit suicide?	NO	YES
Do you ever think about committing suicide or talk about wanting to die?	NO	YES
Do you ever intentionally harm or injure yourself?	NO	YES
Do you ever think about harming or killing someone else?	NO	YES
Have you ever had unusual perceptions or bodily sensations?	NO	YES
Are you currently under the care of another mental health provider?	NO	YES
If so, who? ______________________________		
Have you ever exercised for longer than an hour at a time, used laxatives, or induced vomiting in order to control your weight?	NO	YES
Are you excessively concerned about weight?	NO	YES
Are you now, or have you ever been, a victim of violence or abuse?	NO	YES
If yes, by whom? ______________________________		
Have you ever been violent or abusive toward someone else?	NO	YES
Has anyone in the family ever been violent or abusive?	NO	YES
If yes, who?____and to whom? ______________________________		
Have you ever had, or been told you have, a problem with alcohol or drugs?	NO	YES
Have you ever been arrested or incarcerated?	NO	YES

____
Signature

____
Client Name (Printed)

____
Date

Patient Services Agreement & HIPAA Disclosure

OFFICE FILE COPY

Your signature below indicates that you have read the patient services agreement and that you agree to its terms. It also serves as an acknowledgement that you have received the HIPAA notice.

____
Signature

____
Client Name (Printed)

____
Date

Insurance and Financial Summary

Please Initial

________ INSURANCE COVERAGE

I understand that counselors at Untangled Counseling may participate with ASR, BCBS, Priority Health, and Tri-Care. I understand that I am responsible for my portion of the fee based on the agreement with the insurance company. I understand that I am responsible for contacting my plan administrator with any questions I may have regarding coverage for services prior to my first visit. **IF YOU ARE USING INSURANCE PLEASE INDICATE THE INSURANCE COMPANY YOU WILL BE USING: ______________________________**

________ FEE SCHEDULE

The fee for services at Untangled Counseling is $125 per clinical hour.

BILLING AND PAYMENTS

________ I understand that payment is to be made at the time of service and that I am responsible for services rendered.

________ I understand that credit card information is required prior to the first session. I understand that if credit card information is not provided, then a deposit of $100 will be required.

________ I understand that my credit card will be used to collect outstanding balances unless other arrangements are made.

________ I understand that there will be a $30.00 additional charge for returned checks.

UNPAID BALANCE

________ I understand that excessive outstanding balances or longstanding owed payments may be collected through a collection agency or through other legal means.

MISSED APPOINTMENTS AND LATE ARRIVALS

________ I understand that, because the therapist sets aside time exclusively for my appointment, at least 24-hour cancellation notice is required. I will be charged the full session fee for any late arrival or missed appointment with less than 24-hour notice. Insurance and Flex funds will not pay for less than 24-hour cancelled appointments.

______________________________ ______________________________
Signature (Client) Witness (Counselor)

______________________________ ______________________________
Client Name (Printed) Witness Name (Printed)

______________________________ ______________________________
Date Date

Untangled Counseling

Handling of Confidential Health Information

Home Telephone			**Cell Telephone**			**Work Telephone**		
May we call you at home?	YES	NO	May we call you on your cell?	YES	NO	May we call you at work?	YES	NO
May we leave messages at home?	YES	NO	May we leave messages on your cell?	YES	NO	May we leave messages at work?	YES	NO

Written Communication

May we send mail to your home address: YES NO*

*If no, please provide an alternate address for mailing:

Address: ____

(Number) (Street)

____

(City) (State) (Zip)

Electronic Communication

Untangled Counseling cannot guarantee confidentiality with electronic communications. It is important that you understand that the nature of the Internet is that any e-mails you send or receive may also be intercepted by other people. Therefore, if you send your therapist an email or if you ask your therapist to respond to you about something via an e-mail, you must understand that it is not entirely confidential and may be intercepted by others.

May we communicate with you via e-mail? YES* NO

*If yes, please provide an email address: ____

Are there any restrictions for e-mail? YES* NO

*If yes, describe: ____

____

Other Requests

All reasonable requests to receive communication of your health information by alternative means will be granted. Please describe any additional means of communication by which you prefer to receive your health information.

____

____

____

Signature

____

Client Name (Printed)

____

Date

Untangled Counseling

CREDIT CARD AUTHORIZATION FORM

Because there are times that our clients may not pay at the time of sessions (e.g. forgotten checkbooks, minors coming to therapy without parents, etc.), we ask that you provide us with a credit card number to keep on file, to which any unpaid balance may be charged on a monthly basis. If credit card information is not provided, then a deposit equivalent to the charge for a 45-50 minute session will be required prior to the first appointment.

I, ____, authorize Untangled Counseling, and my respective counselor, to keep my signature on file and to charge my credit card as outlined above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the health care provider.

Patient Name: ____
(First) (Middle) (Last)

Cardholder Name:____
(First) (Middle) (Last)

Billing Address: ____
(Number) (Street)

____
(City) (State) (Zip)

Credit Card Type: (Circle One) Mastercard Visa Discover

Credit Card Number: ____

Expiration Date:_______________________________ V CODE: ___________________________

Card Holder Signature: ____

Today's Date: _________________________________