Adult Intake Information – Please fill out for CLIENT information

Last Name: _____ First Name: _____ MI: _____

Social Security Number: _____ -_____ - _____ Date of Birth: _____/_____/_____

Gender: ○ Male ○ Female Age: _____ Ethnicity: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Other Phone: _____ May we leave a message? ○ Yes ○ No

Please indicate any calling/contact restrictions: _____

Email Address: _____ Language Spoken: ○ English ○ Spanish ○ Other

Employment:

Employer: _____ Work Phone: _____

How long have you worked here? _____ Start Date: _____

Relationship/Family:

Marital Status: ○ Single ○ Engaged ○ Housemates ○ Married ○ Divorced ○ Widowed

Spouse/Significant Other:

Name: _____ Age: _____ Years/Time Together: _____

Do you have any children? ○ Yes ○ No If yes, please list children and step-children below:

Name:	Gender:	Age:	Name:	Gender:	Age:
_____	M F	_____	_____	M F	_____
_____	M F	_____	_____	M F	_____
_____	M F	_____	_____	M F	_____

Please describe briefly the reason you are seeking counseling at this time:

_____

_____

Name of Counselor _____ Date of Initial Appointment: _____/_____/20_____

Chief Complaints: (Please check all that apply):

__Very Unhappy
__ Impulsive
__Depressed
__Irritable/Angry
__Anxious
__Worried
__Temper Outbursts
__Behavioral Problems
__Lying
__Withdrawn
__Panic attacks
__Excessive Crying
__Short attention span
__Mood Swings
__Addiction
__Self-mutilating
__Intrusive Thoughts
__Alcohol Use
__Drug Use
__Lethargic, No Energy
__Sleeping Problems
__Eating Problems
__Intimacy Issues
__Trust Issues
__Grief
__Fearful
__Spiritual Issues
__Parenting Issues
__Trauma
__Relationship Issues
__Abuse Victim
__Suicidal Thoughts
__Low Self-Esteem
__Divorce
__Hallucinations/Delusion
__Educational Issues

Medical/Mental Health:

Please rate the general condition of your health: ◯ Good ◯ Fair ◯ Poor

Describe any difficulties: _____

Please list any medication that you currently take below or check for ◯ no medications.

1)_____ Dose _____ Freq _____ Purpose _____ Start Date _____

2)_____ Dose _____ Freq _____ Purpose _____ Start Date _____

3)_____ Dose _____ Freq _____ Purpose _____ Start Date _____

4)_____ Dose _____ Freq _____ Purpose _____ Start Date _____

Please name any diagnosis you have been given: (This includes for Medical and Mental Health)

Diagnosis:	Approx. Date:	Physician:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been hospitalized for medical or psychiatric reasons? ◯ Yes ◯ No

Hospital	Month/Year	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Military: Do you or anyone in your family have military experience? ◯ Yes ◯ No

If yes, please explain _____

Legal Matters:

Have you ever been arrested? ◯ Yes ◯ No If yes, how many times? _____

Have you been incarcerated? ◯ Yes ◯ No If yes, how many times? _____

Have you ever been on probation or parole? ◯ Yes ◯ No Currently? ◯ Yes ◯ No

If yes, please explain and name probation/parole officer:

_____

Do you have any criminal charges pending? ◯ Yes ◯ No

If yes, please explain: _____

Do you have current legal (including divorce or custody) matters? ◯ Yes ◯ No

Are you coming to counseling at the request of an attorney or another? ◯ Yes ◯ No

If yes to either of the above, please explain: _____

Emergency Contact: In case of an emergency, who should we contact?

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Healthcare/Payment Resources: Please check the method to pay for counseling

◯ Private Pay ◯ Insurance ◯ Medicaid ◯ Superior ◯ Amerigroup ◯ EAP ◯ Another Source

Insurance Information (Please supply a copy of the insurance card and driver's license):

Primary Insurance: _____ Phone: (_____) _____

Insured's Name: _____ DOB: _____/_____/_____

SS#: _____/_____/_____ Policy ID #: _____

Group #: _____ Relationship to Insured: ◯ Spouse ◯ Daughter/Son ◯ Other

Secondary Insurance: _____ Phone: (_____) _____

Insured's Name: _____ DOB: _____/_____/_____

SS#: _____/_____/_____ Policy ID #: _____

Group #: _____ Relationship to Insured: Spouse Daughter/Son Other

Other: Who is responsible for payment of services (if different from above)?

Full Name: _____ DOB: _____

Address: _____ Relation to Client: _____

City: _____ State: _____ Zip Code: _____

Please note that we accept cash, check, or credit card for private pay or co-pays. Payment is expected at the time of service.

We want to thank you for choosing Crossover Counseling!

I _____ give consent for Crossover Counseling to release diagnostic codes and session dates to my insurance(s) (and person responsible for payment), if needed for billing purposes. This also allows Crossover Counseling to communicate with my Emergency Contact, in case of emergency.

_____ _____

Client's Signature **Date**

We are pleased you have chosen Crossover Counseling. We recognize the boldness required to initiate the counseling process, and we hope and pray this experience will be positive and beneficial for you. This is your informed consent for entering into the therapeutic relationship. It details general counseling information, HIPAA information, our office and confidentiality policies. If you have any questions or concerns, please do not hesitate to speak with one of our office managers or your counselor.
You will be provided with a copy of your signed consent upon request.

General Counseling Information:

Goals of Therapy: Counseling is a process whereby the counselor partners with each client and s/he moves toward healing and resolution of any pertinent matters which are brought to the counseling process. Counseling may be beneficial for most people, but at the same time there are risks. These risks may include the client experiencing intense feelings, such as sadness, anger, fear, guilt or anxiety while issues are being discussed. It is important to remember that these feelings are a natural and normal part of the counseling process. In fact, this indicates progress toward healing. Even though the emotions may be intense at first, with continued progression, these feelings should subside.

Active Client Involvement: Crossover Counseling expects that clients will participate in the development of a service approach that best fits their personal strengths, abilities, needs, and preferences. Together, the client(s) and counselor will assess the issues presented and establish goals for counseling that might best serve the client. Each counselor will not make decisions for the client, but will assess and facilitate achievement of the specified goals. Clients' input and feedback in the process, including indications that treatment is complete, is a vital part of a successful outcome in therapy.

HIPAA: Laws and Regulations: HIPAA is an acronym for the Health Insurance Portability and Accountability Act and is enforced "to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes." Section one of the HIPAA legislation intended to lower the risk of individuals losing their existing health care coverage, limiting the use of pre-existing conditions, and helping those without insurance coverage find it on their own. A full description of the HIPAA rules/regulations forms are available upon request.

Office Policies:

Hours of Operation: Crossover Counseling has regular scheduled office hours Monday-Friday 8:00-5:00. Appointments are scheduled on an individual basis by your counselor. Evening appointments may be available upon request depending on the availability of the counselor.

Messages: Calls are either received by a staff member or recorded by a confidential voice mail system and are returned as soon as possible. To facilitate this, the caller needs to leave a daytime/evening

phone number along with current concerns. *NOTE:* ***We are NOT an emergency crisis facility.*** If you have an emergency, please call 911 or the mental health crisis hotline at 1-**800-392-8343**. If you have a life-threatening emergency, please go to the nearest Emergency Room. In an emergency, please contact an emergency facility or hotline as listed above FIRST. There is also a national suicide prevention hotline **1-800-SUICIDE** that is available 24 hours daily.

Appointments: Counseling services are offered by appointment only. The length of the counseling session is typically a clinical hour (approximately 45-50 minutes). We require a 24-hour cancellation notice if you are unable to make your scheduled appointment. *You are financially responsible for a missed session unless there is an emergency or 24-hour notice is given.*

Grievance Policy: We hope that our clients will find Crossover Counseling to be a safe and pleasant environment. However, in the event that a client may have an issue with one of our staff members, please see that staff member to resolve the issues. If resolution does not occur, please then see Laura Smith, LPC-Supervisor who will work with all parties involved to seek remedy for any problems that have occurred. Also, it is important that each client understand they have the right to change counselors to facilitate the best therapeutic relationship for their own counseling process. Persons filing grievances are free from restraint, coercion, reprisal, or discrimination.

Confidentiality Policies and Limitations:

Confidentiality: In general, the privacy of all communications between a client and a provider is protected by law, and a provider can only release information about therapeutic work to others with a client's written authorization, or if subpoenaed by a judge.

Limitations of Confidentiality: There are certain instances that a counselor is required by law to report. Below are the instances where professional counselors are required to report:

- Reported or suspected physical or sexual abuse (including neglect) of a child, dependent or elderly adult
- If a client is threatening serious bodily harm to another person/s, the provider must notify the police and may have the right to inform the intended victim based on individual clinical opinion.
- This release includes reporting information indicating the intentional spreading of a communicable or venereal disease, which may include, but are not limited to diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as the acquired immune deficiency syndrome (A.I.D.S.)
- If a client intends to harm him/herself, a provider will make every effort to develop a safety plan with the cooperation of the client. If necessary, the counselor is required by law to take further measures with or without the client's permission to ensure the client's safety.
- If a client reports an intended (future) crime or reveals a past crime, the counselor retains the right to report the said crime.

Signature of Client or Parent/Guardian	Printed Name of Client
Printed Name of Signor, if not client	Relationship to Client
Signature of Counselor	Date Signed

Service Fees

Description	Includes	Fee
Individual Counseling	45-55min session with an LPC	$100 a session
Marriage/Family Counseling	45-55min session w/ two or more people with an LPC	$125 a session
Counseling With LPC-Intern	45-55min session with an LPC-Intern	$50 a session
Consult	20-30min with an LPC to discuss counseling options	$50 a consult
Psychological Services	There are various types of assessments and testing available	Please consult with office for the specific testing needed
Supervised Visitation	45-55min of supervised visit of a child and family member by LPC or LPC/Intern	LPC - $50 per session LPC-Intern - $30 per session
Court Retainer Fee	Includes: 1.) Testimony in court 2.) Reading over notes 3.) Calls to reschedule clients 4.) Legal counsel	$500 first 4 hours $100 per additional hour
Initial Subpoena Retainer Fee	Includes: 1.) Testimony for deposition 2.) Copies of records 3.) Legal counsel	$200 first hour $100 per additional hour
School Consult	4-hour consult including observation with client, parents, and school personnel	$500 first 4 hours $100 per additional hour
Copy of Records	Includes copies of counseling notes, pictures, drawings, correspondences through mail or email (Allow two weeks)	$25 min/varies for size Additional fees if subpoenaed
Phone Consult/ Phone Counseling	Any conversation over 10 minutes with an LPC, LPC/Intern	Fee varies depending upon duration. Minimal $25
Missed Session Fee	Fee for a missed session without 24-hour notice (except in emergency)	$50 per missed session

Initials

_____ Note any bill outstanding above $200 will cause a suspension of counseling services. These services may resume after the bill is paid in full or a payment plan is agreed upon with office management.

_____ I understand that I am responsible for payment of all services rendered. I agree to pay for any outstanding balance not covered by insurance.

Client Name: _____ Signature: _____ Date: _____