Client Intake Form

Name: _____
(Last) (First)

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Phone: ( ) _____ May we leave a message? □Yes □No
May we text you? □Yes □No

E-mail: _____ May we email you? □Yes □No
*Please be aware that email might not be confidential.

Birth Date: _____ /_____ /_____ ☐ Male ☐ Female ☐ Other ☐ Prefer Not to Say
Month Day Year

Occupation and Employer: _____

Marital Status:
☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

_____ ____ /_____ /____
Partner's Full Name Date of Birth

Emergency Contact
Name: _____ Relationship: _____

Address: _____
(Street and Number)

_____ Phone: _____
(City) (State) (Zip)

Health Insurance Information
Company Name: _____ Subscriber's DOB _____

Policy#: _____ Group #: _____

Deductible Remaining: _____ Co-Payment: _____

Subscriber's address (if different from above): _____

_____

Referred by

How did you hear about us? _____

Mental Health History

Have you had previous psychological counseling? ☐ Yes ☐ No

Have you been given a mental health diagnosis by a healthcare provider? ☐ Yes ☐ No

If yes, what was that diagnosis? _____

_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?

☐ Yes ☐ No

If yes, please list what you are taking:

_____

_____

May I contact your primary care physician regarding collaboration in treatment and treatment goals? ☐ Yes ☐ No Signature: _____

If yes, _____

(Provider's Name)

_____

(Office name and address)

Please describe any injuries or serious physical or mental illness.

_____

_____

_____

Spiritual Information

Do you attend a local place of worship? ☐ Yes ☐ No Name: _____

If yes, how often do you attend? _____

Counseling Expectations

Briefly describe what you hope to accomplish with counseling.

_____

_____

_____

THERAPEUTIC SERVICES CONTRACT

This document contains important information about my professional services and business policies. Please read it carefully. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. It is my aim, to provide psychotherapy that leads to better relationships, solutions to specific problems, and better emotional health.

PROFESSIONAL DISCLOSURE

Please refer to http://www.alliancecounselinggroup.com/our-team/ for a complete listing of my educational background, professional credentials, and scope of practice.

PROFESSIONAL FEES

The hourly fee is $160 for initial diagnostic interview and intake, and $150 per regular therapeutic session. In addition to charging for therapy sessions, I charge the full hourly rate ($150 per hour) for other professional services I provide (including, but not limited to, report writing, phone calls, transportation time, and so forth), whether these services are provided at your request, at the request of your lawyer, or at the request of any other individual who is acting on your behalf. I will prorate the hourly cost if I work for periods of less than one hour.

Our agreed upon session fee is: _____

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

BILLING AND PAYMENTS

You will be expected to pay for each session at the time of service. Cash, checks, and credit card are accepted. Payment methods include check, cash, or the following charge cards: Visa, Mastercard, American Express, and Discover. A 3% convenience fee will be added to all credit and debit card transactions. A receipt is available upon request. Checks can be written to the Burke Group.

INSURANCE
I accept a variety of insurances. I recommend calling your insurance provider before your appointment in order to be aware of your insurance coverage (including your deductible and co pays). I use a third party biller for insurance billing and the claims will be processed through the Burke Group Counseling and Consulting LLC. *Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance company.*

As a service to you, the clinic will bill insurance companies and other third-party payers, but cannot guarantee such benefits or the amounts covered, and is not responsible for the collection of such payments. In some cases, insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases you, the client, are responsible for payment of these services. Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS
We may use or disclose information in your records for treatment, payment, and health care operations purposes with your consent. Personal health information (PHI) refers to information in a client's record that could identify that client. *Use* of this information refers only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you. *Disclosure* of information refers to activities outside of my office such as releasing, transferring, or providing access to information about you to other parties. Throughout this notice, the term "you" may refer to the individual who is the client or the individual's parent, legal guardian or adult who has been legally determined to be responsible for the client.

In providing for your treatment, we may use or disclose information in your record to help you obtain health care services from another provider, or to assist me in providing for your care through consultation with other treatment providers, outside clinical supervisors, and/or supervisors within the Alliance Counseling Group office. For example, we might consult with another health care provider, such as your child's pediatrician or another therapist.

In order to obtain *payment* for services, we may use or disclose information from your record, with your consent. For example, we may submit the appropriate diagnosis to your health insurer to help you obtain reimbursement for your care.

We also may use or disclose information from your record to allow *health care operations* (e.g., quality assessment and improvement activities, business---related matters such as audits and administrative services, and case management and care coordination).

MISSED APPOINTMENTS
Once an appointment hour is scheduled, you will be expected to pay a full session fee unless you provide 24-hour advance notice of cancellation. I cannot offer exceptions to this policy.

CONTACTING ME
I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voicemail that I monitor frequently. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available and alternative numbers to call. If you are unable to reach me and feel that you cannot wait for me to return your call, please contact **911** (24 hours/day) or proceed to the nearest emergency room. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

EMAIL
If agreeing above to being contacted by email, please be aware of the following: 1) The use of email is limited to *setting up* or *canceling appointments*, *for sending appointment reminders,* and for *sharing resources or homework assignments*. 2) Due to security, details of your treatment cannot be discussed via email. 3) Email may also not be used as a means of providing services. 4) You also agree to not use the clinic email address when trying to contact the clinic or your service provider in the event of an emergency, as we cannot guarantee rapid response via email. 5) By consenting to email, you are aware that email is not a guaranteed or secure way of sending and receiving information and that you may not hold Alliance Counseling Group or your therapist responsible for any breach of confidentiality that results from the use of the email address listed above.

MINORS
If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request that your parents agree to waive access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss

CONFIDENTIALITY
In general, the privacy of all communications between a client and a therapist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

- If I believe that a child, psychologically or physically compromised adult, or an elderly person is being abused, I must file a report with the appropriate state agency.
- If a client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection
- If I believe that a client is threatening serious bodily harm to another person, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action. I have read the information in this document and agree to abide by its terms during our professional relationship.

QUESTIONS AND COMPLAINTS

If you have questions about our privacy practices or are concerned your privacy rights have been violated and you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter (all complaints must be in writing) outlining your questions or concerns to:

Dan Zomerlei, PhD, LMFT- Clinical Director
Alliance Counseling Group
PO BOX 283
Grandville, MI 49468

You may also send a written complaint to the Secretary of the U. S. Department of Health and Human Services. I can provide you with the appropriate address upon request. You will not be penalized or otherwise retaliated against for filing a complaint.

Client Name (please print): _____

Client Signature: _____ Date: _____

Parent/Guardian Signature
(if client is under 18 years): _____ Date: _____

Acknowledgment of Review of the HIPAA Notice of Confidentiality

BACKGROUND: The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was enacted by congress to help protect health coverage for workers and their families. It also addresses electronic transaction standards and the need to ensure the security and privacy of health data. I am required by law to maintain the privacy of protected health information, and must inform you of my privacy practices and legal duties. The security and privacy of your protected health information is the subject of this Privacy Notice.

The *HIPAA Notice of Privacy Practices* and the *Patient's Rights and Responsibilities* documents can be printed for you upon your request and is also posted and available for download at www.alliancecounselinggroup.com/resources/

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE HIPAA NOTICE OF CONFIDENTIALITY AGREEMENT AND AGREE TO ITS TERMS, AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE BEEN OFFERED AND DECLINED OR OFFERED AND FURNISHED WITH THE HIPAA NOTICE OF PRIVACY PRACTICES.

Client Name (please print): _____

Client Signature: _____ Date: _____

Parent/Guardian Signature
(if client is under 18 years): _____ Date: _____