CLIENT INTAKE FORM

The Independent Practitioners
at the Barn on Sycamore

For office use only:
CL: 01 02 03 04 05 06
DX: _____
MCP:_____

(Please Print)

CLIENT INFORMATION:

Name _____
(Last) (First) (Middle) (Preferred Name/Nickname)

Address _____
(Street) (City) (State) (Zip Code)

Email Address_____ Home Phone (_____)_____

Work Phone (_____)_____ Mobile Phone (_____)_____

Emergency Contact: Name & Phone Number_____ Relationship _____

SS#_____ Date of Birth _____/_____/_____ Age _____ Gender: ☐ Male ☐ Female

Civil Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Race: ☐Asian ☐Black ☐Caucasian ☐Hispanic ☐Native American ☐Other

SPOUSE/PARENT (If the client is a minor):

Name: _____Custody held by: _____

Address (if different from your child): _____

GUARANTOR INFORMATION: Please provide information regarding person(s) responsible for payment of amounts not covered by insurance. Be prepared to supply your insurance card(s) at time of first visit so that a photocopy can be taken. Thank you.

Bill to Parent(s)/Guardian(s) (*if client is a minor*): _____

Address (if different from client): _____
(Street) *(City)* *(State)* *(Zip Code)*

Name of Insurance Policy Holder: _____ Relationship to client: ☐ Self ☐ Spouse
(as it appears on insurance card) ☐ Parent/Guardian

Policy Holder's Employer: _____ DOB: _____ SS# _____

PRIMARY INSURANCE:

Insurance Carrier: _____ ID# _____ Group # _____

Is pre-authorization required? ☐ Yes ☐ No ☐ Not sure What is your deductible? _____

Do you have a co-pay? ☐ Yes ☐ No ☐ Not sure If yes, what is the amount? _____

Annual/lifetime limit: _____ Does it cover mental health services? ☐ Yes ☐ No ☐ Not sure

SECONDARY INSURANCE:

Insurance Carrier: _____ ID# _____ Group # _____

Is pre-authorization required? ☐ Yes ☐ No ☐Not sure What is your deductible? _____

Do you have a co-pay? ☐ Yes ☐No ☐ Not sure If yes, what is the amount? _____

Annual/lifetime limit: _____ Does it cover mental health services? ☐ Yes ☐ No ☐ Not sure

NAME & RELATIONSHIP OF FAMILY MEMBERS:

_____

_____

_____

EDUCATIONAL HISTORY OF CLIENT:

School Attended/Attending _____Graduation Date_____

University/Tech School _____Graduation Date_____

HEALTH INFORMATION:

Have you had any previous mental health treatment elsewhere? □Yes □ No

If yes, where and with whom? _____

List any significant health concerns: _____

_____

_____

Do you smoke? □ Yes □ No Packs per day? _____ For how long? _____

Do you use alcoholic beverages? □ Yes - If yes, how often? _____ □ No

Do you use illegal drugs or substances? □ Yes - If yes, how often? _____ □ No

Are you currently under the care of a physician? □ Yes □ No

Physician: _____ Phone: _____

Please list medications you are currently taking:

Drug _____ Dosage _____ Schedule _____

Drug _____ Dosage _____ Schedule _____

Drug _____ Dosage _____ Schedule _____

Drug _____ Dosage _____ Schedule _____

Were you referred to this office for services? If so, by whom: _____

INSURANCE AUTHORIZATION

I hereby authorize my therapist to release necessary information to insurance carriers concerning my diagnosis and treatment in order to process claims on my behalf. In addition, I hereby authorize direct payment of medical insurance benefits to my therapist for services rendered.

Signed: _____Date _____

(Client – Parent – Guardian)

CONSENT TO TREATMENT

The Independent Practitioners
at the Barn on Sycamore

I, _____ (hereinafter referred to as CLIENT), request the professional counseling

services of _____ (hereinafter referred to as THERAPIST).

In requesting these services, CLIENT understands:

- THERAPIST operates his/her practice individually, separate and apart from other mental health professionals sharing office space with him/her
- other mental health professionals have no responsibility or liability for CLIENT'S treatment unless CLIENT requests their services and signs a treatment agreement with them.
- Psychotherapy has both benefits and risks.
- CLIENT may get worse before getting better, however the profit can outweigh the costs.
- Psychotherapy has been proven to have significant benefits both physically and mentally.
- CLIENT is encouraged to ask questions and offer ideas throughout their treatment.

Communication – initial here to acknowledge acceptance of these terms: ☐

- THERAPIST'S preferred method of scheduling will be through an encrypted client portal. Instructions for registering for the portal will be provided to the CLIENT by request.
- Scheduling will occasionally be accommodated by phone. If THERAPIST is not available to receive a call, phone messages will be returned within 12 hours (with the exception of weekends and holidays.)
- Should THERAPIST choose to offer scheduling via text messages or email, messages will be responded to as thus: text messages within 24 hours, and emails within 48 hours. Information shared via text or email should pertain to scheduling only.
- Contact via social media applications is NOT an appropriate means for CLIENT to communicate with THERAPIST, therefore, THERAPIST will NOT respond to any messages, requests or communications initiated in this manner.

Recordings

- Audio and/or video recordings of sessions is strictly prohibited without the advance, written consent of ALL session participants, including the THERAPIST(S) and CLIENT(S).

Emergencies

- THERAPIST listed above is available by appointment only and will make every effort to return CLIENT's call as soon as possible (with the exception of weekends and holidays.)
- If CLIENT is receiving care when THERAPIST is out of town, THERAPIST may, if needed, provide CLEINT the name of a colleague to contact.
- In the case of an emergency and/or when THERAPIST is not available, CLIENT is urged to call 911, contact Avera Behavioral or visit an emergency room at either Avera McKennan or Sanford Hospital.

Confidentiality

In general, the law protects the confidentiality between CLIENT and THERAPIST. However, the following exceptions may occur:

- *CLIENT authorizes the release of information with a signature.*
- *THERAPIST is ordered by the court to release information.*
- *CLIENT presents a physical danger to self or others or has intent to commit a crime.*
- *There is evidence or reasonable suspicion of child/elder abuse and/or neglect.*

Financial Agreement

- Payment is due at the time of service. This may include CLIENT's full fee (if cash payment option has been chosen) or a co-pay associated with CLIENT's insurance company.
- This office will provide necessary information to your insurance company and attempt to collect payment. CLIENT is ultimately responsible for payment of CLIENT's account. Amounts due and billable may include differences between copay paid by CLIENT and what is actually owed according to CLIENT'S insurer, charges incurred and applied toward CLIENT's deductible and coinsurance.
- Copays, deductibles and/or coinsurance are determined by your insurer, not by your THERAPIST. As a network provider with your insurance company, your THERAPIST is contractually bound to collect the amounts due as defined by your carrier.

If you are unsure of you insurance coverage, you can learn more by referring to your policy booklet or by calling the toll-free number listed on your insurance card.

HIPAA Notice of Privacy Practices

This office is required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. **Please initial here to acknowledge receipt of this Notice.** _____

In regards to CLIENT's rights, CLIENT as the consumer has the right to fair and professional treatment; all HIPAA regulations apply to this office which CLIENT may request at any time.

CLIENT has been given the opportunity to ask questions which have been answered to their satisfaction. CLIENT has read the above and has had the opportunity to discuss this information and any questions with THERAPIST. CLIENT also confirms that the information they have provided THERAPIST for their treatment is current and accurate.

CLIENT completely understands his/her rights, his/her consent to treatment, and accepts his/her responsibilities as stated above.

CLIENT Signature Date

Completed and Witnessed by Date

Parent/Legal Guardian (if CLIENT is a minor) Date