FAMILY THERAPY INSTITUTE
MIDWEST

Empowering change through collaboration, education, and connection

Adult Information Form

Client Name ____________ ____ ____________
First Middle Last

Address ____________

City ____________ **State** ______ **Zip** ______

Home ☎ ______ **Office ☎** ______ **Mobile ☎** ______

Email ____________

[Please DO NOT include phone numbers or email addresses at which you do not want to be reached under any circumstances.]

DOB ______ **AGE** ______ **SSN#** ______

SEX ○ Male ○ Female

Marital Status ______ **Income** ______ **Years of Education** ______

Employer or School ______ **Work/ School Status** ______

Referred By ______ **Emergency Contact* [Name & #]** ______

*Please provide a name and phone number for someone who could be contacted in case of a serious health emergency. By providing this number you are authorizing FTI Midwest to contact this person under these unusual circumstances.

Insurance Information

Client's, who qualify by diagnosis, and wish to do so, may choose to have their treatment reimbursed by a medical insurance carrier. You may do this by receiving a bill and forwarding it to your insurance company, or by having us bill the company directly. In either case it is likely to be necessary for us to have some contact with the company to provide information necessary for billing. By signing this form you are agreeing to allow us to provide whatever information is legally allowed to assure reimbursement for services we may render. Typically, this will include diagnosis, but sometimes insurance companies ask for treatment plans, and goals and objectives. Insurance companies are bound by Federal laws guiding confidentiality, but FTI Midwest cannot be responsible for any records once they are released to your company. To learn more about your insurance company's policies on these matters, please contact them directly. PLEASE NOTE: While we do take Medicaid [HW21], WE DO NOT ACCEPT MEDICARE AS PRIMARY OR SECONDARY INSURANCE. EVEN IF A CLIENT HAS ANOTHER INSURANCE POLICY OR MEDICAID, IF THEY ALSO HAVE MEDICARE WE CANNOT SEE THEM because we will not be reimbursed and the client cannot pay us directly.

Relationship of client to policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Does more than one insurance company cover this client? ☐ Yes* ☐ No

*If "yes" you must complete a second form with insurance information. Please ask the receptionist for this form.

If you are the insurance policy holder, you may put "same" in any box that you have already filled out above. If you are not the policyholder you must complete all of the following information for us to bill the insurance company service to the above client.

Policy Holder ______ ______ ______
First Middle Last

Address ______

City ______ **State** ______ **Zip** ______

Home ☎ ______ **Office ☎** ______ **Cell ☎** ______

[Please do not include phone numbers at which you do not want to be reached under any circumstances.]

DOB ______ **Age** ______ **SSN#** ______

Marital Status ______ **Sex** ○ Male ○ Female

Employer or School ______ **Work/ School Status** ______

Insurance Co Name ______ **Ins ID Number** ______ **Group Number** ______

Insurance Co Address ______ **Insurance Co Phone ☎** ______

I have read the above statement or had it explained to me and my questions have been answered. I agree to release FTI Midwest to provide all information necessary to my insurance carrier in order to process my claim and, if FTI-Midwest is billing my company directly, have all benefits assigned to FTI-Midwest.

______________________________ ______________
Client Date

Clinical Information

For us to give the best service possible, we must have the following information. Please answer all of the questions below.

1. Have there been divorces, separations, deaths, or serious illness in your family recently? No ☐ Yes ☐

2. **Academic Information**

Last school attended: ______________________________

Year of last attendance: ____________ Highest grade: ____________

4. **Medical Information**

Your doctor Name & Location: ______________________________

Date of last physical exam or treatment: ______________________________

Are you being treated for any medical or surgical conditions? No ☐ Yes ☐

Have you ever had an injury to the head requiring medical treatment? No ☐ Yes ☐

Do you have allergies, or bad reactions to medications or other substances?
No ☐ Yes ☐ (List:) ______________________________

Current Medications

Name	Indication	Dose/Frequency	Start Date	Prescriber

5. **Counseling and Psychiatric Information**

Treatment Dates	Diagnosis	Inpatient	Outpa-tient	Medications	Clinician/Facility

Have you ever thought of hurting yourself? .... No ☐ Yes ☐
Have you ever attempted suicide? .... No ☐ Yes ☐
Have you ever thought of hurting someone else? .... No ☐ Yes ☐
Have you ever harmed or attempted to harm someone else? .... No ☐ Yes ☐

6. **Substance Use/Abuse History**

Substance Used	Age @ Onset	Current Use Pattern (Frequency/Amount)	Method	Last Used (Time/Amount)

7. **Your Family (the family you raised)**

Children's Name(s)	DOB/Age	Living with (Other than parent)	Medical Problems	Mental Health/ Substance Abuse Tx.

8. **Your Family of Origin (the family that raised you)**

Name	Age	Current Location	Health Status	Mental Health/SA Hx.
Mother				
Father				

Checklist of Concerns

___Abuse-physical, sexual, emotional
___Aggression, violence
___Anger, hostility, arguing, irritability
___Anxiety, nervousness
___Attention, concentration, distractibility
___Childhood issues (your own childhood)
___Children, child management, child care, parenting
___Confusion
___Custody of children
___Decision making, indecision, mixed feelings
___Delusions (false ideas)
___Dependence
___Depression, low mood, sadness, crying
___Divorce, separation
___Drug use-prescription medications, over-the-counter medications, street drugs
___Eating problems, under-eating, appetite, vomiting
___Emptiness
___Failure
___Fatigue, tiredness, low energy
___Fears, phobias
___Financial or money troubles, debt, impulsive spending,
___Friendships
___Gambling
___Grieving, mourning, deaths, losses, divorce
___Guilt
___Headaches, other kinds of pains
___Health, illness, medical concerns, physical problems
___Inferiority feelings
___Interpersonal conflicts
___Impulsiveness, loss of control, outbursts
___Work problems, employment,
___Irresponsibility
___Judgment problems, risk taking
___Legal matters, charges, suits
___Loneliness
___Marital conflict, infidelity/affairs, remarriage
___Memory problems
___Menstrual problems, PMS, menopause
___Mood swings
___Motivation, laziness
___Nervousness, tension
___Obsessions, compulsions
___Oversensitivity to rejection
___Panic or anxiety attacks
___Perfectionism
___Pessimism
___Procrastination, work inhibitions, laziness
___Relationship problems
___School/Career Concerns
___Self-centeredness
___Self-esteem
___Self-neglect, poor self-care
___Sexual issues
___Shyness, oversensitivity to criticism
___Sleep problems-too much, too little, nightmares
___Smoking and tobacco use
___Stress, relaxation, stress management,, tension
___Suspiciousness
___Suicidal thoughts
___Temper problems, low frustration tolerance
___Thought disorganization and confusion
___Weight and diet issues
___Withdrawal, isolating

Payment Agreement

Obligation. By signing this document, you are agreeing to pay for the services you receive at FTI Midwest. We pride ourselves on making our services affordable for families and we will work closely with you to keep your account current. However, we also retain a bill collection agency for outstanding accounts that become delinquent. By signing this document you are releasing us to refer your account to collections in the event that you do not make timely payment. Please read each of the follow paragraphs to assure your understanding of our billing procedure and ask your intake therapist if you have any questions about these procedures.
Insurance: If you have insurance, we will submit claims on your behalf if you authorize us to do so on the insurance form (page 2). However, you must pay all costs insurance does not cover including copayments, coinsurance, deductible and no-show fees (see below). You are responsible for verifying your coverage by calling the number on your insurance card. Some companies REQUIRE YOU TO CALL to get an authorization number before your first session. If you do not make this call, you may end up with a bill that your insurance company will not reimburse. For some diagnoses, some insurance companies require you to pay into your healthcare deductible.

EVERYONE MUST READ AND CHECK ONE OF THE FOLLOWING BILLING OPTIONS:

☐ **Self-Pay**: I do not have or do not wish to use my insurance. I am paying all fees in full by cash, check or credit card at time of service.

☐ **Health Insurance**: I have active health insurance, have contacted my insurance company for authorization (if necessary) and believe they will pay for these services. I agree to pay all costs not covered by insurance including refused claims, deductible, co-pay, no-show fees, or coinsurance.

EVERYONE MUST CHECK AND AGREE TO ALL OF THE FOLLOWING:

☐ I understand that all missed appointments and late cancellations incur a charge of $50. A missed appointment is any appointment not cancelled. A late cancel is any appointment not cancelled with 24 hours notice. Fees for missed or late-cancelled appointments due to legitimate emergencies may be waived.

☐ I understand that if I do not have my payment at the time of service, my appointment will be cancelled.

☐ I understand that I must pay all costs not paid by my insurance carrier. If I am over the age of 18, and have a parent or other party (guarantor) paying my bill, I understand that I remain *primarily responsible*. This means that if that person does not pay outstanding charges, I remain liable for them. I also understand that I am subject to collection action if my account becomes past due. By signing this document, I am releasing FTI Midwest to provide necessary information to its designated collection agency. I also understand that if I move or relocate without making arrangements with FTI for future billing, I am subject to immediate collection action. I also understand that if my check is returned, a $30 fee will be added to my account.

I have read, understood, and agree to the terms regarding consent to treatment and payment for services. I have also reviewed and understand the FTI Midwest's Privacy Policy.

______________________________ ______________
Client Signature Date

______________________________ ______________
FTI Witness Date