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5051 Castello Drive Suite 204 Naples, Florida 34103

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Heidi A. Wilson, LCSW\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Client Demographic Intake Form**

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| --- |
| First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI:\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex:\_\_\_\_\_\_\_\_ Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I leave voice/text messages on your phone? Yes\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for your Appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |

 **Insurance Information**

|  |
| --- |
| Policy Holder Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Heidi Wilson, LCSW accepts Medicare, and is an out-of-network insurance provider with all other plans. Heidi Wilson does not accept Medicare replacement plans. If you have insurance other that Medicare, you are expected to pay out of pocket and Heidi Wilson will provide you with a detailed receipt to submit to your insurance provider for reimbursement. Medicare patients- payment of deductible or co-pay, if applicable, is expected at time of service.** |

 **Over**



**Fee Agreement**

 - Except for clients with Medicare (excluding Medicare Replacement Plans), payment is expected at time of service. For those with insurance, I am happy to provide you with a detailed receipt you may submit to your insurance carrier for possible reimbursement or application towards deductible. You are responsible to submit given receipt to your insurance carrier for your reimbursement.

 -Your appointment time is reserved for you; I do not double book appointments. **Therefore, I will charge you a missed fee of $60 if you fail to show up for an appointment or if you cancel less than 24 hours before your appointment**. This charge will be billed to you via credit/debit card. Please complete following credit/debit card information:

**Card Number: #**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Expiration date** (MM/YY):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name on Card**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **3 or 4 Digit CVV Security Code**:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Zip Code Associated with Card**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 -All sessions are $175 and can be paid via cash, check or credit card. I do not charge extra for couple’s therapy.

**I have read the above information. I understand and agree that I am responsible for the balance of my account for any professional services rendered**.

**Client Signature**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Informed Consent For Counseling**

**Please read the following and then sign to indicate agreement:**

 In effort to promote a trusted and productive counseling relationship, the following is provided for your understanding and signed consent.

 **Counseling:** The goal of counseling is positive change. Many people come to counseling because they are ready to make significant changes in their lives. Counseling can be seen as a process or a vehicle to assist in making changes more thoughtfully and/or rapidly.

 There are no guarantees that counseling is going to 'fix' the problem. Counseling is most effective when it is a collaboration between you and your therapist. I will provide you with the absolute highest level of professional care and respect. I may suggest outside reading or activities and may provide 'homework' assignments. If necessary, I may recommend that you consult with a physician to receive medication therapy or other medical treatment. I will make a referral to another therapist if you require services outside of my scope of practice.

 While in counseling, you are responsible for being as honest and open as possible. Change usually involves letting go of things or ideas that are familiar in order that new possibilities can emerge. Effort and risk will be required. You may experience emotional pain, embarrassment, anxiety, frustration, or fear. On the other side of these uncomfortable emotions is healing and growth. Thank you for placing your trust in me.

**Initial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Over**

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**Confidentiality**

Information disclosed by you during therapy will be kept strictly confidential and will not be revealed anyone outside of my office without your written permission. It is important for you to know that there are some exceptions to confidentiality based on Florida law. If an exception should arise, I will make every effort to inform you. For details, please read and keep attached 'Notice of Privacy Practices'. By signing below, you acknowledge you received attached ‘Notice of Privacy Practices’.

**Record Keeping**

I am required by Florida State Law to maintain and keep a full record of services for seven years after the last date of contact.

**Liability**

 You have the right to terminate counseling services with Heidi Wilson, LCSW at any time. If you terminate counseling services before it is agreed upon via a treatment plan, or no show for your appointment, Heidi Wilson, LCSW will not be held liable for any future psychological or medical issues.

**Emergencies or Crisis**

I check my email and voicemail regularly, including weekends and holidays. I will return your call at my earliest opportunity. If you are unable to reach me, or you have a life-threatening emergency, immediately call 911, or go to the hospital emergency room. Your safety and well-being are my primary concern.

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**Consent For Counseling:** I have read and understand the information contained on this form and voluntarily agree to participate in counseling with Heidi Wilson, LCSW. I have received a copy of ‘Notice of Privacy Practices’.

**Printed Name** (first and last)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_