McGILL Counseling

Client Intake Form

Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information.

Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Contact details

		May we leave a message	
Home phone:	_____	Yes ☐	No ☐
Cell phone:	_____	Yes ☐	No ☐
Work phone:	_____	Yes ☐	No ☐
Email:	_____	Yes ☐	No ☐

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Birth Date: _____ Age: _____

Name of parent/guardian (if under 18 years): _____

Marital Status

Never Married ☐	Domestic Partnership ☐	Married ☐
Separated ☐	Divorced ☐	Widowed ☐

Please list any children and their ages

Name	Age

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General Health and Mental Health Information

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

No ☐ Yes ☐ If yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?

No ☐ Yes ☐ If yes, please list: _____

Have you ever been prescribed psychiatric medication?

No ☐ Yes ☐ If yes, please list with dates: _____

How would you rate your current physical health?

☐ Poor ☐ Unsatifactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific health problems you are currently experiencing:

_____

How would you rate your current sleeping habits?

☐ Poor ☐ Unsatifactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific sleep problems you are currently experiencing:

_____

How many times per week do you generally exercise? _____

What types of exercise to you participate in:

_____

Please list any difficulties you experience with your appetite or eating patterns.

_____

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Are you currently experiencing overwhelming sadness, grief or depression?

☐ No ☐ Yes If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or have any phobias?

☐ No ☐ Yes If yes, when did you begin experiencing this? _____

Are you currently experiencing any chronic pain?

☐ No ☐ Yes If yes, please describe: _____

Do you drink alcohol more than once a week?

☐ No ☐ Yes If yes, please describe: _____

How often do you engage recreational drug use?

☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

Are you currently in a romantic relationship?

☐ No ☐ Yes If yes, for how long? _____

On a scale of 1 -10 how would you rate your relationship? _____

What significant life changes or stressful events have you experienced recently?

_____

_____

_____

_____

_____

_____

_____

_____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Alcohol/Substance Abuse

☐ No ☐ Yes If yes, family member: _____

Anxiety

☐ No ☐ Yes If yes, family member: _____

Depression

☐ No ☐ Yes If yes, family member: _____

Domestic Violence

☐ No ☐ Yes If yes, family member: _____

Eating Disorders

☐ No ☐ Yes If yes, family member: _____

Obesity

☐ No ☐ Yes If yes, family member: _____

Obsessive Compulsive Disorder

☐ No ☐ Yes If yes, family member: _____

Schizophrenia

☐ No ☐ Yes If yes, family member: _____

Suicide Attempts

☐ No ☐ Yes If yes, family member: _____

Additional Information

Are you currently employed?

☐ No ☐ Yes If yes, name and address of your employer:

Do you enjoy your work?

☐ No ☐ Yes Is there anything stressful about your current work?

Do you consider yourself to be spiritual or religious?

☐ No ☐ Yes If yes, describe your faith or belief:

What do you consider to be some of your strengths?

What do you consider to be some of your weaknesses?

What would you like to accomplish out of your time in therapy?

Physician Notice and Release of Information

Most insurance plans request that the therapist notify the physician that their patient is being seen in counseling. Please complete and sign. If you do not wish for your physician to have this notice in your medical files, please indicate below.

Name of MD			
Address of MD			
Street		City	
State		Zip	

The client named below is receiving psychotherapy at this office. The client has indicated that you are the primary physician or psychiatrist

If you wish to contact me, please call (217) 531-2736.

Thank you.

McGill Counseling Clinician signature

< Your name below >

I _____ Authorize Do not authorize that this notice be sent to the above named doctor and further authorize consultations between the patient's doctor and therapist relative to my medical and psychological care.

Signature of patient or guardian of minor

Date

Insurance Information

Primary Insurance Subscriber	
Relationship to Client	
Primary Subscriber Date of Birth	
Primary Subscriber Address	
Primary Subscriber Email	
Primary Subscriber Phone	
Insurance ID Number	
Group Number	
Insured Place of Employment	
Name of Insurance Provider	
Insurance Provider Phone Number	
Insurance Provider Address	
ICD 10 Code	
Diagnosis	
Copayment	
Deductible	

HIPPA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective date: March 1, 2014
McGill Counseling is committed to maintaining client confidentiality. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

This notice describes the policies related to the use and disclosure of your healthcare information.

Uses and disclosures of your health information for the purposes of providing services.
Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allows us to use and disclose your health information for these purposes.

Treatment
We may need to use or disclose health information about you to provide, manage or coordinate your care or related services, which could include consultants and potential referral sources.

Payment
Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

Healthcare Operations
We may need to use information about you to review our treatment procedures and business activity. Information maybe used for certification, compliance and licensing activities.

Other uses or disclosures of your information which does not require your consent.
There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse: then by Illinois State Law, we are obligated to report this to the Department of Children and Family Services. If you provide information that informs us that you are in danger of harming yourself or others. Information to remind you of /or to reschedule appointments or treatment alternatives. Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order. I am required by law to report that you own a firearm if you disclose you are in possession of firearms and have been admitted to a psychiatric hospital within the past year or have a mental illness.

Client's signature	Date

Informed Consent

This document is intended to inform you of policies, State and Federal Laws, and your rights. If you have other questions or concerns, please feel free to ask at any time.

McGill Counseling serves children, adolescents, adults, and families using individual, family, and couples therapy. Our therapists practice standard cognitive and dialectical behavior therapy and are solution focused and person centered. Other approaches are available as well and may be utilized during your treatment. Treatment practices, philosophy, and plan limitations and risks will be discussed with you today.

Confidentiality and Emergency Situations:

Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims, b) information you and/or you child or children report about physical or sexual abuse; then, by Illinois State Law, I am obligated to report this to the Department of Children and Family Services, c) where you sign a release of information to have specific information shared and d) if you provide information that informs me that you are in danger of harming yourself or others e) information necessary for case supervision or consultation and f) or when required by law.

If an emergency situation for which the client or their guardian feels immediate attention is necessary, and a call is not returned within 15 minutes, the client or guardian understands that they are to contact the emergency services at the Mental Health Clinic 24 hour crisis line at **(217) 359-4141** in Champaign county, **(217) 442-3200 in Vermilion County,** or (**911**) for those services. Your therapist will follow those emergency services with standard counseling and support to the client or the client's family.

Signature(s)	Date

Financial/Insurance Issues:

As a courtesy, we will bill your insurance company, HMO, responsible party or third party payer at your request. We ask that at each session you pay your co-pay or 100 % of the fee if you do not have insurance. The cost per session is $200 for individual and couple sessions. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time.

For therapy services, a sliding scale fee based on income is available to you if you do not have insurance. If an account is overdue and turned over to a collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. Please authorize payment of medical benefits directly to McGill Counseling.

We do request a copy of your Heath Savings Card, Debit Card, or Credit Card to keep on file. We can automatically run this card for co-pays, self-pay fees, or statement balances for ease of payment. You will receive a receipt via email when your card is charged.

Lastly, if you need to cancel or reschedule an appointment, please call to do so 24 hours prior to your scheduled appointment. **If your appointment is not cancelled prior to 24 hours you will be billed a fee of $75**. We understand that emergencies arise so each client is granted a one-time exception for not canceling prior to 24 hours. Any client arriving later than 15 minutes past their scheduled appointment time will be asked to reschedule. Any client who no calls, no shows more than 2 appointments will be referred out to another agency. We value your time, our time, and the time of our other clients. We hope that you understand the importance of our cancelation policy.

We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances, or payments please feel free to ask. **You may have a copy of this form if requested.**

Signature(s)	Date

Social Media

We cannot accept friend requests on Social Media, but would love for you to find our business page on Facebook for the latest information regarding our company, emotional health tips, therapist's blogs, and therapeutic encouragement.

Notice of Privacy Practices and Client Rights:

I have read and received a copy of the Notice of Privacy Practices and Client Rights document.

Signature(s)	Date

Client Responsibilities

You are responsible for coming to session on time and at the time we have scheduled. Sessions last 45-60 minutes, unless otherwise determined by both of us in advance. If you are late, we will end on time and will not run over into the next person's session.
You are responsible for paying for your session at the time of service unless we have made other arrangements in advance. If we decide to meet for a longer session, we will bill you prorated on the session fee.

Generally, clients may not run a bill. However, under special circumstances, which should be discussed in advance, we may permit you to run a balance of up to two sessions. We do not accept barter of any type in exchange for therapy. If you have ongoing financial problems that make it impossible for you to continue therapy, we will provide a referral to a state, city, or county run mental health service.
Please participate actively in the therapeutic process by (1) collaboratively working on realistic and concrete goals, (2) working on your issues between sessions, and (3) being honest with your therapist. Remember, your therapy is only as good as the effort you put in to it.

Consent For Treatment of Children or Adolescents:

I/We consent _____ may be treated as a client by McGill counseling

_____ _____

Signature Date

_____ _____

Signature Date

Litigation Agreement

The purpose of this contract is to obtain written agreement that no therapist at McGill Counseling will be requested or required for any reason to participate in litigation. The therapist's role could be compromised and any progress made in therapy could be jeopardized if the therapist were to be involved in such litigation. To prevent deterioration of any therapy, it is crucial that we have every reassurance that there will be absolutely no involvement on the part of any therapist at McGill Counseling in current or future litigation.

I wish to enlist the services of McGill Counseling in the treatment of myself and/or my minor child. I understand that such treatment will be compromised if information revealed therein is brought to the attention of the court. I agree that I will not request or require any therapist at McGill Counseling provide testimony in court. If the services of a mental health professional are desired for court purposes, the services of a person outside of McGill Counseling must be secured.

I have read the above and agree to proceed with therapy based on the above stipulations.

Signature	Date
Witness Signature	Date

Symptoms Check List:

Please check any symptoms that you have experienced in the last month.

- ☐ Depression: Feeling Hopeless, Worthless
- ☐ Anxiety: Specific, Social, General
- ☐ Tics: twitching eyes, muscles, etc.
- ☐ Panic/Phobia/Fears
- ☐ Bingeing/Not Eating
- ☐ Purging
- ☐ Worry
- ☐ Sleeping too much/ or too little
- ☐ Mania/Excessive energy: being able to go on little or no sleep.
- ☐ Hallucinations: Audio, Visual, seeing or hearing things that may not be there.
- ☐ Suicidal Ideation: thoughts of dying or killing yourself.
- ☐ Homicidal thoughts/urges: feelings or thoughts of wanting to hurt/kill someone else
- ☐ Difficulty going in public places or leaving your house.
- ☐ Increase or decrease in sexual desire/pleasure
- ☐ Feeling superior to other people.
- ☐ Difficulty concentrating on tasks or following directions.
- ☐ Anger, explosive behavior such as yelling, throwing things, hitting, kicking, etc.
- ☐ Sensitivity to sound, touch, texture, smells or other sensory sensitivity.
- ☐ Difficulty with change in routine
- ☐ Hyperactivity
- ☐ Isolating: wanting to be alone
- ☐ Obsessive thoughts
- ☐ Compulsive behaviors: (doing the same thing over and over again).
- ☐ Memory/Cognitive: Difficulty remembering names, dates, events.
- ☐ Dissociations/Depersonalization: feeling like you are numb or not a real person.
- ☐ Suicidal Urges: Feeling like you want to or will kill yourself. Plan/No plan (please circle one).
- ☐ Paranoid thoughts: feelings or thoughts that people are “out to get me”, after me, following me.
- ☐ Nightmares, bad dreams, night terrors, or flashbacks (memories from the past that pop in your mind).
- ☐ Difficulty being alone: always needing to be with someone else.
- ☐ Feeling inferior to other people.

CLIENT RIGHTS

Right to request how we contact you.
It is our normal practice to communicate with you at the home address and daytime phone number you provided when you scheduled your appointment about health matters, such as appointment reminders. We may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way.

Right to release your medical records.
You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that I acted in reliance on such authorization.

Right to inspect and copy your medical and billing records.
You have the right to inspect and obtain a copy of your information contained in our medical records. Under limited circumstance we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing, and supplies.

Right to add information or amend your medical records.
If you feel that information contained in your medical record is incorrect or incomplete, you may ask to add information to amend the record. We will make a decision on your request with 60 days. Under certain circumstances, we may deny your request to add or amend information. If your request is denied, you have a right to file a statement that you disagree. Your statement and my response will be added to your record. Please submit your request in writing and provide an explanation concerning the reason for your request.

Right to an accounting of disclosures.
You may request an account of disclosures, if any, made related to your medical information, except for information used for treatment, payment, or health care operational purposes or that was shared with you or your family, or information that you gave specific consent to release. It also excludes information we are required to release. To receive information regarding disclosure made for a specific period of time, no longer than six years and after April 14, 2003, please submit your request in writing.

Right to request restrictions on uses and disclosures of your health information.
You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing. However, we are not required to agree to such a request.

Right to file a complaint.
If you believe your rights to privacy have been violated, please contact your therapist and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. There will not be any retaliation for filing such a complaint.

Right to receive changes in policy.
You have the right to receive any future policy changes secondary to changes in state and federal laws.

Credit Card on File or Prepayment on Account

We require a valid debit/credit card number on file to allow a more efficient check in/check out process. We also automatically process missed appointments without canceling at $75 per session using the credit card information you provide.

You may keep a prepayment of $75 on your account instead of a debit/credit card. This payment will be applied to your account if needed for a missed appointment or a balance. You may be asked to replenish this amount when your account reaches a zero balance.

Upon completing treatment, you will be refunded any positive balance on your account. Please choose one of the following options:

Credit or Debit Information:

Name on card _____

Card number _____

Expiration Date _____ 3 or 4 digit security code _____ Zip code _____

_____ _____

Signature of Card Holder Email Address

I would like to add a prepayment of $75 to my account using:

Credit Card

Debit Card

Cash

Check Check Number _____

I consent to the above terms and conditions and give McGill Counseling consent to charge the credit/debit card listed on file for all appointment co-pays, co-insurances, deductibles, and missed appointments without cancelling. I will receive an email when my debit or credit card is charged showing the agreed upon amount.

_____ _____ _____

Printed Name of Responsible Party Signature Date

_____

Client's Name if Minor