



Client Intake Form

Client Information

Full Name: [_____]

Date of Birth: [_____] **Age:** [_____] **SSN:** [_____]

Gender: Male Female Non-binary Prefer not to say

Race/Ethnicity: [_____]

Parent/Legal Guardian (if under 18): [_____]

Address: [_____]

Home Phone: [_____]

Cell/Work Phone: [_____]

Is it okay to leave a voicemail? Yes No

Email Address: [_____]

(Please note: Email correspondence is not considered a confidential medium.)

Insurance Information

1. Primary Insurance Details

Insurance Company Name: [_____]

Policyholder's Name: [_____]

Relationship to Client: Self Spouse Parent Other: [_____]

Policy Number: [_____]

Group Number: [_____]

Insurance Company Phone Number: [_____]

Insurance Company Address: [_____]

Effective Date of Policy: [_____]

2. Secondary Insurance (if applicable)

Insurance Company Name: [_____]

Policyholder's Name: [_____]

Relationship to Client: Self Spouse Parent Other: [_____]

Policy Number: [_____]

Group Number: [_____]

Insurance Company Phone Number: [_____]

Insurance Company Address: [_____]

Effective Date of Policy: [_____]



3. Additional Details

Is prior authorization required for services? Yes No

Authorization Number (if applicable): [_____]

Does the insurance cover mental health services? Yes No Unsure

Copay Amount: [_____]

Deductible (if known): [_____]

4. Other Billing Information

Responsible Party for Payment (if different from client):

Name: [_____]

Address: [_____]

Phone Number: [_____]

Preferred Payment Method: Cash Check Credit Card Other: [_____]

Emergency Contact

Full Name: [_____]

Phone Number: [_____]

Relationship: [_____]

Address: [_____]

Marital Status

Never Married

Domestic Partnership

Married

Separated

Divorced

Widowed

How Long? [_____]

Describe relationship satisfaction: [_____]

Educational Background

High School Some College College Degree Graduate Degree

Major/Area of Study: [_____]

High School Some College College Degree Graduate Degree

Major/Area of Study: [_____]



High School Some College College Degree Graduate Degree

Major/Area of Study: [_____]

Employment

Current Job Title: [_____]

Employer: [_____]

Do you enjoy your work? [_____]

Any stress related to your current job? [_____]

Family Background

Significant adults in your life growing up:

Name	Relationship	Describe in 3-5 words
[_____]	[_____]	[_____]
[_____]	[_____]	[_____]
[_____]	[_____]	[_____]
[_____]	[_____]	[_____]

Siblings and Ages:

Name	Age	Occupation	Describe in 3-5 words
[_____]	[_____]	[_____]	[_____]
[_____]	[_____]	[_____]	[_____]
[_____]	[_____]	[_____]	[_____]
[_____]	[_____]	[_____]	[_____]
[_____]	[_____]	[_____]	[_____]

Parents' relationship during childhood: [_____]

Your relationship with parents during childhood: [_____]

Physical, mental health, or substance use issues in your family? [_____]

Mental Health History

- Reason for seeking counseling: [_____]



- **Current coping strategies:** [_____]
- **What do you hope to achieve in counseling?** [_____]
- **Previous mental health services?** Yes No
If yes, please list services, dates, and diagnoses:
[_____]
- **Trauma history (e.g., abuse, violence, disasters):** Yes No Unsure *If yes, please describe:*
[_____]

Suicidal history:

- **Thoughts of suicide:** Yes No
- **Attempts:** Yes No
Details (when, how many times): [_____]

Current Mental Health Concerns

Check all that apply:

- | | | |
|---|--|--|
| <input type="checkbox"/> Sleeping too much | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Anxiety/worry/panic |
| <input type="checkbox"/> Not sleeping enough | <input type="checkbox"/> Stress | <input type="checkbox"/> Loss of a loved one |
| <input type="checkbox"/> Decreased energy | <input type="checkbox"/> Decreased concentration | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Bad dreams | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Trust issues |
| <input type="checkbox"/> Parenting challenges | <input type="checkbox"/> Job changes | <input type="checkbox"/> Addiction |
| <input type="checkbox"/> Unwanted thoughts | <input type="checkbox"/> Obsessions | <input type="checkbox"/> Relational tension |
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Dissociation | <input type="checkbox"/> Divorce |
| <input type="checkbox"/> Financial concerns | <input type="checkbox"/> Change in residence | <input type="checkbox"/> Perfectionism |



- | | | |
|--|---|--|
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Hearing voices | <input type="checkbox"/> Memory loss |
| <input type="checkbox"/> Shyness | <input type="checkbox"/> Impulsive behavior | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Unwanted memories | <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Legal issues |

Physical Health History

Current health rating: Poor Average Good Excellent

Health concerns or diagnoses: [_____]

Last physical exam date: [_____] **Primary Care Provider:** [_____]

Exercise: Yes No *How often?* [_____]

Substance Use

Substances used (current or past):

Substance	First Use Date	Frequency	Last Use Date
[_____]	[_____]	[_____]	[_____]
[_____]	[_____]	[_____]	[_____]
[_____]	[_____]	[_____]	[_____]
[_____]	[_____]	[_____]	[_____]

Other troubling habits:

Pornography Gambling Overeating Self-harm Other: [_____]

Spiritual Background

Do you consider yourself spiritual? Yes No

Is faith important to you? Yes No

If yes, explain: [_____]

Would you like faith integrated into your sessions? Yes No



Additional Information

Is there anything else you'd like your counselor to know?

[_____]

Signatures

Patient Signature

Date

Resident in Counseling Signature

Date

Supervisor Signature

Date



Consent to Bill Insurance Form

Client Information

Client Name: _____ Date of Birth: _____

Insurance Provider: _____ Policy Number: _____

Group Number (if applicable): _____

Authorization to Bill Insurance

I, _____, authorize Ervin's Village Family Support LLC to bill my insurance provider for covered therapy services. I understand and agree to the following terms:

1. Billing & Coverage

- I authorize Ervin's Village Family Support LLC to release necessary information to my insurance provider to process claims.
- I understand that insurance coverage is not a guarantee of payment and that I am responsible for verifying my benefits
- I acknowledge that some services may not be covered by my insurance and agree to pay for any non-covered services.

2. Co-Payments & Deductibles

- I am responsible for any applicable co-pays, deductibles, or coinsurance as outlined by my insurance plan.
- Co-payments are due at the time of service unless prior arrangements have been made.

3. Client Responsibility for Denied or Unpaid Claims

- If my insurance denies or does not pay a claim, I understand that I will be responsible for the full amount of the session fee.
- I agree to provide updated insurance information if my coverage changes.

4. Right to Revoke Authorization

- I may revoke this authorization in writing at any time, but it will not affect services already provided or claims already submitted.

Client or Guardian Signature: _____ Date: _____

Provider Representative Signature: _____ Date: _____



No Show/Late/Cancellation Policy for Insurance-Pay Clients

At Ervin's Village Family Support LLC, we strive to provide the best care for all clients. To maintain our commitment to accessible and high-quality care, we have established the following No Show, Late Arrival, and Cancellation Policy for clients using insurance coverage for therapy services.

1. No Show Policy

- If a client fails to show up for a scheduled therapy session without prior notice, it will be considered a No Show.
- Insurance does not cover missed appointments, and a \$25 fee will be charged to the client's account.
- Repeated no-shows (3 or more) may result in a review of continued services.

2. Late Arrival Policy

- If a client arrives more than 15 minutes late, the appointment may need to be rescheduled at the provider's discretion.
- If the session must be shortened due to lateness, the full session fee will still be billed to the insurance provider.

3. Cancellation Policy

- Clients must provide at least 24 hours' notice to cancel or reschedule an appointment.
- Late cancellations (less than 24 hours' notice) may result in a \$25 Late Cancellation Fee.

4. Insurance and Client Responsibility

- Insurance does not cover fees for No Shows or Late Cancellations.
- Clients are responsible for these fees and must pay them before scheduling their next appointment.

Client or Guardian Signature: _____ Date: _____

Provider Representative Signature: _____ Date: _____



Client's Rights and Responsibilities

Client Rights

As a client of Ervin's Village Family Support LLC, you have the right to:

1. Be treated with dignity, respect, and compassion at all times.
2. Receive care without discrimination based on race, ethnicity, gender, religion, sexual orientation, or disability.
3. Participate actively in the development and implementation of your treatment plan.
4. Be informed about the qualifications and credentials of your therapist or service provider.
5. Expect confidentiality of your records and sessions, as required by law.
6. Be informed of the risks, benefits, and alternatives to proposed treatments.
7. Ask questions and receive clear explanations regarding your care and fees.
8. Refuse any recommended services or treatment to the extent permitted by law.
9. Provide feedback or file a complaint without fear of retaliation.

Client Responsibilities

As a client of Ervin's Village Family Support LLC, you agree to:

1. Treat staff and other clients with respect and courtesy.
2. Provide accurate and complete information about your health, concerns, and needs.
3. Attend all scheduled appointments or provide at least 24 hours' notice for cancellations.
4. Be on time for appointments and understand that late arrivals may result in shorter sessions or rescheduling.
5. Comply with the agreed-upon treatment plan to the best of your ability.
6. Pay all fees at the time of service or as arranged in advance.
7. Inform your therapist of any changes in your condition or circumstances that may impact your care.
8. Notify the office of any changes to your contact or insurance information.
9. Respect the confidentiality and privacy of others receiving services.

Acknowledgment

By signing below, I confirm that I have read and understood the Client Rights and Responsibilities. I agree to uphold my responsibilities and understand my rights as a client of Ervin's Village Family Support LLC.

Client Signature

Date



Self-Pay Service Fee Table

Self-Pay Service Fees

Service	Description	Fee
Initial Consultation	Comprehensive intake and assessment	\$175.00
Individual Counseling Session	30-60 minute counseling session	\$125.00
Family Counseling Session	60-90 minute family therapy session	\$150.00
Group Counseling Session	Group therapy (per participant)	\$75.00
Telehealth Counseling Session	Remote counseling session via secure platform	\$125.00
No-Show Fee (self-pay)	Fee for missed appointments without notice	\$140.00
No-Show Fee (insurance)	Fee for missed appointments without notice	\$25.00
Late Cancellation Fee (self-pay)	Fee for cancellations made with less than 24 hours' notice	\$100.00
Late Cancellation Fee(insurance)	Fee for cancellations made with less than 24 hours' notice	\$25.00
Returned Check Fee	Fee for Returned Check	\$35.00

Payment Policies

1. All fees are due at the time of service unless prior arrangements have been made.
2. Accepted payment methods include Cash, Check, Credit/Debit Card (processing fee).
3. Fees are subject to change with 30 days' written notice.

Acknowledgment

By signing below, I confirm that I have reviewed and understood the Service Fee Table. I agree to the fees outlined above and accept full financial responsibility for services rendered by Ervin's Village Family Support LLC. Should they not be covered by my Insurance Company.

Client Signature

Date



Consent for Telehealth Agreement

I, _____, acknowledge and agree to the following:

1. I consent to receive services via telehealth from Ervin's Village Family Support LLC.
2. I understand that telehealth involves the use of electronic communications to provide healthcare services remotely.
3. I agree to use a secure, private location for all telehealth sessions and ensure that I have the necessary technology to participate.
4. I acknowledge that telehealth is not suitable for emergency situations and agree to contact emergency services or visit the nearest hospital in such cases.
5. I understand that all telehealth sessions will be conducted through a secure, HIPAA-compliant platform.
6. I acknowledge that no telehealth session will be recorded without my explicit written consent.

Acknowledgment

By signing below, I confirm that I have read and understood this Consent for Telehealth Agreement and agree to its terms.

Client Signature

Date



Your Rights Under the Health Insurance Portability and Accountability Act (HIPAA)

As a client of Ervin's Village Family Support LLC, you have the following rights regarding the privacy and security of your Protected Health Information (PHI):

1. **Right to Access Your Records**

- You have the right to inspect and obtain a copy of your PHI, including medical and billing records. Requests must be made in writing, and reasonable fees may apply.

2. **Right to Request Amendments**

- You have the right to request corrections to your PHI if you believe it is inaccurate or incomplete. Ervin's Village Family Support LLC may deny your request under certain circumstances, but you will be provided with an explanation.

3. **Right to Confidential Communications**

- You have the right to request that we communicate with you in a specific way (e.g., via mail or phone) to protect your privacy.

4. **Right to Request Restrictions**

- You may request restrictions on how your PHI is used or disclosed for treatment, payment, or healthcare operations. While we are not required to agree to all requests, any approved restrictions will be honored.

5. **Right to an Accounting of Disclosures**

- You have the right to request a list of certain disclosures of your PHI made outside of routine treatment, payment, or healthcare operations.

6. **Right to a Paper Copy of This Notice**

- You may request a paper copy of this notice at any time, even if you have agreed to receive it electronically.

7. **Right to File a Complaint**

- If you believe your rights under HIPAA have been violated, you may file a complaint with Ervin's Village Family Support LLC or with the U.S. Department of Health and Human Services (HHS). Filing a complaint will not affect your care or services.

Our Responsibilities To file a complaint with HHS, you can call **1-800-368-1019**.

1. We are required by law to maintain the privacy and security of your PHI.
2. We will notify you promptly if a breach occurs that compromises the privacy or security of your PHI.
3. We must follow the duties and privacy practices described in this notice.
4. We will not use or disclose your PHI for marketing purposes or sell your information without your explicit authorization.

Acknowledgment

By signing below, I confirm that I have received, read, and understood my HIPAA rights as described above.

Client Signature

Date