NEW VISION COUNSELING

# Intake

Referral Date: _____

Name: _____ Current age: _____

Gender: _____

Address: _____

Phone Number _____ Work Phone: _____

County: _____ Email: _____

Birthdate: _____ Social Security Number: _____

Parent or Guardian (if applicable: _____

Spouse (i.a.): _____ Siblings (i.a.): _____

Insurance plan: _____ Insurance ID: _____

Insurance phone: _____ Insured Name: _____

Insurance plan 2: _____ Insurance 2 ID _____

Insurance 2 phone: _____ Insured 2 Name: _____

Other Information: _____

## Consent for Treatment

I hereby consent to take part in the treatment, therapy, and other interventions by the New Vision therapist. I agree to take an active role in the development of the intervention plan and the development and the revision of the goals set forth and to meet at the scheduled times and locations. I understand that the success of these interventions will be determined by the work I do to complete these goals. I understand that no promises have been made to me as to the results of treatment provided by the therapist. I understand that I have the right to ask questions concerning my treatment and progress. I am aware that I may stop treatment with this therapist at any time. I understand that payment for services is my responsibility, although New Vision Counseling will bill my insurance or other payment sources. I agree to give 24 hours notice if I should need to cancel or reschedule and appointment and if I fail to give this notices it is up to the clinician's discretion whether to continue services. I also acknowledge that:

- ☐ I have received a copy of the Notice of Privacy Practices, Grievance Procedure, Non-discrimination Policy and Client Rights.
- ☐ I have been informed of program costs.
- ☐ I have been informed of available crisis resources.

Client (or legal guardian) signature: _____ Date: _____

Name: _____ Birthdate: _____

***Office use only:***

Referral Source: _____

Referral Date: _____

Means of Referral: Call: _____ In Person: _____

Referral Agent:(if other than self) _____

Agent phone: _____ Agent fax: _____

Agent e-mail: _____

Substance Abuse: _____ Drug of Choice: _____

IV Use: _____ Completed SA Programs: _____

Tobacco Use: _____ Pregnant: _____

Presenting situation and symptoms: _____

How immediate are services needed?

Emergency: ☐ Within 24 hours: ☐ Within 48-72 hours: ☐

1 week: ☐ Routine appointment: ☐

Referred to: _____ Appointment: _____

Insurance Verified: _____ Copay: _____ Co-insurance: _____

Deductible: _____

Authorization: _____

Taken by: _____

| **Quarterly Treatment Plan Schedule** | | |
|---|---|---|
| Referral Date | Date Treatment Plan Due | Turned in |
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