INNER RESILIENCE
COUNSELING & CONSULTING

Intake Forms

PLEASE PRINT CLEARLY Today's Date _____

PERSONAL INFORMATION

PATIENT (S) _____ **RESPONSIBLE PARTY** _____

Date of Birth _____ Gender _____ Responsible Party's SSN _____

Address _____ Address (if different) _____

_____ _____

City, State _____ Zip _____ City, State _____ Zip _____

Home Phone _____ Home Phone (if different) _____

Work Phone _____ Work Phone (if different) _____

Cell Phone _____ Cell Phone (if different) _____

Please indicate with an * which phone numbers we may NOT leave a message.

Patients' relationship to Responsible Party (check one): Self_____ Spouse_____ Child_____ Other _____

Relative or friend in case of emergency _____
Name Phone# Relationship

How did you hear about Inner Resilience Counseling? _____

FINANCIAL

I understand that Inner Resilience Counseling and Consulting, PLLC does not accept insurance. I will be given a receipt that I may submit to my insurance for possible reimbursement. As well, I understand that if I cancel within 24 hours or do not show up for an appointment I will be billed the entire amount of the session. I have been given the opportunity to ask questions regarding this statement.

_____ _____ _____

Signature of Responsible Party Printed Name Date

Therapist Use Only
Therapist Name _____
Dx _____
Special Instructions _____
_____

Location
☐ Phoenix

Billing
☐ Client Self Pay

INNER RESILIENCE
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FAMILY INFORMATION

NAME	Gender	AGE	DATE OF BIRTH	RELATIONSHIP TO PATIENT &/or MARITAL STATUS	EDUCATION	OCCUPATION
Patient (s)						
1.						
2.						
Parent (s)						
1.						
2.						
Children/Step Children/Siblings						
1.						
2.						
3.						
4.						
5.						
Others Living in Household						
1.						
2.						
3.						
4.						
5.						

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MEDICAL INFORMATION

1. **Patient Name** _____

Have you ever been treated for emotional difficulties before (When and Where?) _____

_____

Physician: Name/Practice _____ Address_____ Phone _____

Date of last physical exam _____ Height _____ Weight _____

How is your general health now? _____ Medications? _____

Are you presently being treated by a physician for any physical condition? _____

Have you had any serious illness? (List) _____

Have you ever had any surgery? (List) _____

2. **Patient Name** _____

Have you ever been treated for emotional difficulties before (When and Where?) _____

_____

Physician: Name/Practice _____ Address_____ Phone _____

Date of last physical exam _____ Height _____ Weight _____

How is your general health now? _____ Medications? _____

Are you presently being treated by a physician for any physical condition? _____

Have you had any serious illness? (List) _____

Have you ever had any surgery? (List) _____

***If more than two patients, please indicate above medical information on separate sheet for other patients.**

PLEASE MARK ALL THAT APPLY: (If more than one patient, please separately initial)

___Anger	___Grief	___Paranoia
___Anxiety	___Guilt	___Physical Aggression
___Behavior Problems	___Hallucinations	___School/Work Problems
___Changes in Appetite/Eating Habits	___Hopelessness	___Self Abusive Behavior
___Criminal Activity	___Hyperactivity	___Sleep Disturbance
___Decreased Energy	___Impulsiveness	___Somatic Complaints
___Delusions	___Interpersonal Conflicts	___Suicidal Thoughts/Attempt
___Depressed Mood	___Irritability	___Weight Gain
___Disruption of Thought Process/Content	___Manic	___Weight Loss
___Emotional/Physical/Sexual Trauma	___Mood Swings	___Worthlessness
___Excessive Crying	___Oppositional	___Other (Specify)
___Family Conflicts	___Panic Attacks	

INNER RESILIENCE
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Privacy Practices Form

You, or a member of your family, are about to become involved in counseling or psychotherapy with a trained and licensed/certified therapist. We wish to take this opportunity to welcome you and also to state some basic principles we believe essential in establishing a good counseling relationship between us. Please read through this information, asking questions as needed.

1. INITIAL INTERVIEW: Your first visit is considered a diagnostic or evaluation interview. At the time of this appointment, the following decisions will be made with you:
   a) Type of therapy needed (individual, group, etc.)
   b) Frequency of therapy sessions (weekly, biweekly, etc.)
   c) Goals of therapy (what you hope to gain from this process.)

2. APPOINTMENTS: Each appointment is approximately 50 minutes. At the end of each appointment you can discuss future appointments with your therapist.

3. CANCELLATIONS: If you find that you need to cancel an appointment, please give as much notice as possible so that we can schedule people that are on our waiting list. You will be personally charged for your appointment if not canceled at least 24 hours in advance other than for emergency reasons.

4. PAYMENTS: We would greatly appreciate payment in full for each office visit when you come for your appointment. If you do not pay in full at the time of service. These fees will be negotiated individually with your therapist. We accept cash, credit/ debit card and check. Please make checks out to "Inner Resilience Counseling and Consulting, PLLC".

5. INSURANCE: Insurance is an agreement between you and your insurance company as to how counseling will be paid for. We will assist you in any way possible by providing receipts and documentation. We currently do not directly participate with insurance plans. However, we will assist you in contacting your insurance, giving you receipts to submit, and follow up contacts. Many insurance companies will pay for a portion of outpatient mental health services. You should check with your insurance company representative to find out specific requirements and limitations of this coverage. We will be happy to assist you in the preparation of insurance forms if you feel there is a chance your insurance company will pay for these services. The hourly rate will apply. Payments for services received through Inner Resilience Counseling and Consulting, PLLC are ultimately your responsibility.

6. CONFIDENTIALITY: All information regarding the specific nature of your counseling or psychotherapy is maintained at Inner Resilience Counseling and Consulting is considered confidential within the office unless specified by you in writing. However, each therapist at this office reserves the right to use specialty consultation with other therapists at the office as deemed necessary. We follow HIPAA and maintain confidentiality. We are bound to report suspected child abuse/neglect, harm to self/others, or follow a court-issued subpoena.

If more than one adult patient, each person should check and initial boxes.

☐ Yes	☐ No	I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions.
☐ Yes	☐ No	I have received a copy of the Privacy Practices Form.
☐ Yes	☐ No	I consent to the exchange of treatment information between IRCC and my primary care physician.

Patient(s):
Physician's Name/Office and Phone Number _____

Signed: _____ Date: _____

Signed: _____ Date: _____

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5. INSURANCE: Insurance is an agreement between you and your insurance company as to how counseling will be paid for. We will assist you in any way possible by providing receipts and documentation. We currently do not directly participate with insurance plans. However, we will assist you in contacting your insurance, giving you receipts to submit, and follow up contacts. Many insurance companies will pay for a portion of outpatient mental health services. You should check with your insurance company representative to find out specific requirements and limitations of this coverage. We will be happy to assist you in the preparation of insurance forms if you feel there is a chance your insurance company will pay for these services. The hourly rate will apply. Payments for services received through Inner Resilience Counseling and Consulting, PLLC are ultimately your responsibility.

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Physician's Name/Office and Phone Number _____

CLIENT COPY – KEEP THIS FORM FOR YOUR RECORDS