centerpoint counseling

**Client Intake Form p. 1**

| **CLIENT INFORMATION** | | | |
|---|---|---|---|
| Client's Full Name: | | | |
| Social Security #: | | How did you hear about us? | |
| Gender: ☐ Female ☐ Male | Marital status ☐ Single ☐ Married | Date of Birth: | Current date & time: |
| Residential Address: | | City: | State & Zip: |
| Permanent or mailing address (if different): | | City: | State & Zip: |
| Primary Phone #: ( home / cell ) | Secondary Phone #: ( home / cell ) | Work Ph #: | |
| Email: | | ☐ Employed ☐ Unemployed ☐ Self Employed ☐ Student | |
| Employer Name, City, and State: | | Employer Ph #: | |
| **DISCLAIMER:** The following information is used solely to track information mandated by federal and state programs. This information is not shared with any other source and is in no way a condition of services. Centerpoint Counseling does not, and shall not, discriminate based on race, color, religion (creed); gender, gender expression, age, national origin (ancestry), disability, marital status, sexual orientation, or military status. | | | |
| Race/Ethnicity: | | Income: ◯ 0 - $12,000 ◯ $13,000 - $24,000 ◯ $25,000 - $48,000 ◯ $49,000 – 86,000 ◯ $87,000 or higher | |
| Preferred Language: | Number of people living in your home: | | |
| **PARENT OR LEGAL GUARDIAN IF CLIENT IS UNDER THE AGE OF 18** | | | |
| Full Name: | | Relationship to client: | |
| Social Security #: | | Date of Birth: | |
| Residential Address: | | City: | State & Zip: |
| Permanent or mailing address (if different): | | City: | State & Zip: |
| Primary Phone #: ( home / cell ) | | Secondary Phone #: ( home / cell ) | |
| Employer Name | | Employer City and State | Employer Ph #: |
| **EMEREGENCY CONTACT INFORMATION:** | | | |
| Full Name: | | Relationship to client: | |
| Residential Address: | | City: | State & Zip: |
| Home Ph #: | | Cell #: | |
| **I AUTHORIZE THE FOLLOWING PEOPLE TO HAVE ACCESS TO MY (OR MY CHILD'S) APPOINTMENT TIMES AND BILLING INFO:** | | | |
| Name: | | Relationship: | Exclusions: |
| Name: | | Relationship: | Exclusions: |
| **INSURANCE INFORMATION. PLEASE PROVIDE YOUR INSURANCE CARD** | | | |
| Primary Insurance Company Name: | | Subscriber or Individual ID #: | Insurance Company Ph: # |
| Primary Insured's Full Name: | | DOB: | Relationship to Client: |

**Client signature**:_____ **Date**:_____

*(Signature of Parent or Legal Guardian if the client is under age 18.)*

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**Client Intake Form p. 2**

| Secondary Insurance Company Name: | Subscriber or Individual ID #: | Insurance Company Ph: # |
|---|---|---|
| Secondary Insured's Full Name: | DOB: | Relationship to Client: |

## BEHAVIORAL HEALTH HISTORY

Please describe the situation/problem(s) which have led you to seek treatment today:

Please describe any recent stressful life events:

Have you **ever** seen any other mental health provider? Yes ☐ No ☐

_____

Have you seen any other psychotherapist or mental health provider in the past year? Yes ☐ No ☐

If yes please list names and dates: _____

Have you experienced past or present thoughts of suicide or homicide? Yes ☐ No ☐

If yes, date of most recent experience: _____

Have you had any psychiatric hospitalizations? Yes ☐ No ☐

If yes, dates and names of facilities _____

**Family Behavioral Health History**

Please identify any psychiatric problems in your biological relatives (i.e. depression, bi-polar (manic depression), panic, anxiety, PTSD, schizophrenia, ADD/ADHD, alcohol or substance abuse, anger, suicide)

| **Relative** | **Yes** | **No** | **Uncertain** | **Type of Problem:** |
|---|---|---|---|---|
| Mother | ☐ | ☐ | ☐ | |
| Mother's Parents | ☐ | ☐ | ☐ | |
| Father | ☐ | ☐ | ☐ | |
| Father's Parents | ☐ | ☐ | ☐ | |
| Your siblings | ☐ | ☐ | ☐ | |

## MEDICAL HISTORY

| | | |
|---|---|---|
| **Past/Present Allergies (food or drug):** | | **Present Status of Allergies:** |
| **Primary Care Physician:** | **City/State:** | **Tel #:** |
| **Psychiatrist:** | **City/State:** | **Tel #:** |
| **Other Physician:** | **City/State:** | **Tel #:** |
| **Please describe your current medical condition:** | | **Date of Last Physical:** |

**Please list any prescription and non-prescription medications you are taking:**

| Medication: | Dose: | Time Taken: | What condition is this for? | Prescriber: |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

What has been your response to these medications in the past?

**Client signature**: _____ **Date**: _____

*(Signature of Parent or Legal Guardian if the client is under age 18.)*

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## Client Intake Form p. 3

**Please describe any past or present issues with the following:**

Dizziness/Balance_____
Headache_____
Ear/Nose/Throat_____
Heart_____
Respiratory_____
Gastrointestinal_____
Urinary _____

Neurological_____
Reproductive_____
Muscle/Bone/Joint_____
Skin_____
Blood/Immune System _____
Pain_____
Other _____

**Have you experienced any of the following?**

☐ Seizures ☐ Head Trauma
☐ Amnesia ☐ Loss of Consciousness
☐ Other Pertinent Issue:_____

**Family Medical History**
**Do you have an immediate relative with:**

☐ High Blood Pressure ☐ High Cholesterol
☐ Stroke ☐ Heart Attack
☐ Diabetes ☐ Thyroid Problems
☐ Cancer ☐ Neurological Disorders

**Have you been disabled or hospitalized during the last year?** (describe)

**Have you had or been advised to have a surgical operation within the last five years?** (describe)

**Have you been diagnosed with any communicable diseases or conditions in the last 14 days?** Yes ☐ No ☐
If so, please list:_____
*If unsure, please ask receptionist for a list of applicable diseases/conditions.*

## PERSONAL PSYCHOSOCIAL HISTORY

Describe your **family relationships while growing up** (too strict, harsh, difficult, affectionate, close, too loose, etc.).

How many siblings do you have? Where do you fit in (order)? Did you get along with them?

Describe your **father's or step-father's personality** and your **relationship** to him.

Describe your **mother's or step-mother's personality** and your **relationship** to her.

Did you experience any **traumatic events or abuse** (sexual, physical, verbal, emotional, neglect) at any time in your life?

Please describe any past or present use of **substances** including alcohol, illicit drugs, prescription/over-the-counter medications, or nicotine:

Did you graduate high School?
Yes ☐
No ☐

Did you attend college? Yes ☐
No ☐
What is your highest degree of education?

Describe your **work experience** (past and present).

How did you do academically, socially, and behaviorally during **grade school years**?

How did you do academically, socially, and behaviorally during **teenage years**?

What are your **strengths/limitations**?

What is your **religious or spiritual affiliation**?

Have you had any legal problems (past or present)?
No ☐ Yes ☐ If yes, please describe:

Have you ever been in jail or prison?
No ☐ Yes ☐ If yes, please describe:

Describe your romantic relationships.
Married ☐ Single ☐ Divorced ☐ Widowed ☐
Married how many times? _____

Describe any past or present problems with your sexual life (low libido, promiscuity, difficulty achieving orgasm or erection, fear, etc.).

Describe your **current social relationships** (shy, outgoing, able to maintain friends, strong support, few friends, etc.)

What are your **hobbies and interests**? Are you participating in them much lately?

What do you hope to accomplish in treatment?

**Client signature**:_____ **Date**:_____
*(Signature of Parent or Legal Guardian if the client is under age 18.)*

**PAYMENT POLICY**

Payments are due at the time of service. CCS accepts cash, personal checks, travelers and cashier's checks, flexible spending account cards, health savings account cards, and major credit cards. If insured, copayments, and amounts applied to deductibles are due at the time of service. Regardless of insurance coverage, all psychological testing is paid for in full prior to testing.

Late fees are assessed each month for nonpayment on past due accounts. Returned check fees are charged if checks are returned from banking institutions. Accounts 90 days past due are assessed an administrative fee and sent to Bonneville Collections, 431 River Pkwy., Idaho Falls, ID 83402. Once accounts are sent to collections, the client must coordinate all repayment efforts with the collections agency, as their account no longer resides with Centerpoint Counseling Services.

**INSURANCE POLICY**

As a courtesy, Centerpoint Counseling Services submits insurance claims for the client when the client provides a copy of their insurance card prior to services. The client agrees to notify CCS of changes to their insurance immediately and will be held responsible for denied claims due to outdated insurance information.

Some of CCS's providers are licensed and are in-network with insurance companies and some are not. Services rendered by non-licensed or out-of-network providers are generally not covered by insurance. It is the responsibility of the client to choose their CCS provider with their insurance coverage and limitations in mind.

CCS encourages the client to understand their insurance coverage and policy deductibles, service exclusions, and limitations. **Obtaining prior-authorizations and in/out-of-network provider affiliation information is the responsibility of the client**. Eligibility, benefits, and policy coverage information obtained from insurance by the client or CCS, verbal or written, is not a guarantee of payment. The services the client receives from CCS may or may not be covered by their insurance, regardless of information obtained at any time prior to or during treatment. If the client's insurance does not pay due to lack of pre-authorization, the client is responsible for the full amount due.

Balances not paid by insurance within 30 days from the date of claims filing, for any reason, become the responsibility of the client. _____

**Client Initials**

(Parent/Legal Guardian if the client is under age 18)

**Employee Assistance Plans (EAPs):**

Centerpoint Counseling Services accepts many Employee Assistance Program (EAP) benefits. With these programs, employers pay the cost of services. Requesting EAP services is kept confidential and is coordinated through the employer's human resources departments. Clients should check with their employers to see if they have these types of benefits.

**AFFORDABILTY POLICY**

CCS attempts to make counseling available to every person, regardless of their ability to pay. Services may be paid partially or wholly through insurance, Medicaid, Employee Assistance Programs, or private 3rd-party individuals or organizations (family, friends, or ecclesiastical endorsements). In addition, CCS provides a 3-Month Payment Plan (pay ½ of services at the time of service and the remaining balance paid in 3 monthly installments and not to exceed $255).

**LATE-CANCELLATION & MISSED APPOINTMENT POLICY**

If the client is unable to keep a scheduled appointment, he must give 24 hours advanced notice to ensure that he will not be charged for the appointment. If less than 24 hours' notice is given and CCS in unable to fill the time slot, the canceling client will be expected to pay a fee. Centerpoint Counseling will try to provide courtesy reminder calls, but it is not guaranteed. Clients may not dispute a late-cancellation or missed appointment fee based upon not receiving a reminder call.

MEDICAID CLIENTS: Please be informed that state law prohibits clinics from charging cancellation fees to Medicaid participants. A pattern of not showing up for appointments could result in a referral to another clinic and discontinuation of services.

**MEDICAID CLIENTS**

The client understands that only one agency may be authorized to provide a specific therapeutic service to me at a time. The client further understands that their choice is voluntary and that the authorization for services may be transferred to another agency at the client's request. There are several agencies offering psychotherapeutic services in the SE Idaho upper valley region, including Child and Family Resource, Ostermiller Counseling, and Upper Valley Resources. The client has acknowledged the various agencies listed and has chosen Centerpoint Counseling Services, LLC as their provider of psychotherapeutic services.

**HIPPA PRIVACY POLICY**

Due to HIPPA, Privacy & Security Law, each client's medical information is kept confidential unless the client designates otherwise. A client may designate another entity access to his medical information on a separate Release of Information Form made available upon request. CCS's HIPPA Privacy Practices are available for review at any time; clients may also request a personal copy of the CCS Privacy Practices.

**OFFICE HOURS AND AFTER-HOURS COMMUNICATION**

Office Hours: 9:00am – 5:00pm* Monday - Friday (Closed Saturday and Sunday)

*Appointment schedules may vary outside of regular business hours depending on provider.

After-Hour Communication: **CCS's after-hours line is for non-crisis issues only**; clients may leave a recorded message, which will be responded to promptly the following business day. **For crisis or emergency issues**, clients are encouraged to call 911 or go to the nearest emergency room.

**CONSENT TO TREATMENT AND POLICIES**

The client or responsible party, has been given the opportunity to discuss any questions regarding CenterPoint Counseling Services' clinical treatment and consents to treatment. The client has received, read, understands, and agrees to their following policies:

The information the client has provided on this form is complete and accurate. The client understands that Centerpoint Counseling offers only outpatient psychotherapeutic services and psychological testing services. The client also understands that they have the right to refuse services at any time.

It is the policy of Centerpoint Counseling Services to respond to all complaints in a systematic and uniform way. Participants who would like to file a complaint may do so in writing. Any complaint may be filed with our practice or directly with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, please write to: Manager of Centerpoint Counseling Services, LLC., 393 E. 2nd N., Rexburg, Idaho 83440. All complaints must be submitted in writing. Participants will not be penalized for filing a complaint.

Client Signature (*required age 14+)*_____ *Date:*_____

Guardian Signature (*all patients under 18*)_____ Date:_____