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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 ❑ $49,000 – 86,000 ❑ $13,000 - $24,000 ❑ $87,000 or higher ❑ $25,000 - $48,000	
Preferred Language:	Household Size:		
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 PROVIDER 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 suicidal or homicidal ideation? 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_____	Neurological_____
Headache_____	Reproductive_____
Ear/Nose/Throat_____	Muscle/Bone/Joint_____
Heart_____	Skin_____
Respiratory_____	Blood/Immune System _____
Gastrointestinal_____	Pain_____
Urinary _____	Other _____

Have you experienced any of the following? ___ Seizures ___ Head Trauma ___ Loss of Consciousness ___ Amnesia ___ Other Pertinent Issue: _____	**Family Medical History** **Do you have 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? (please circle) Yes No
f 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

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 cancelling client will be expected to pay a fee: $14 for intern therapists, $40 for licensed therapists, and $50 for PhD-level clinicians.
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.

FEE SCHEDULE

Initial Psychotherapy Appointment: The regular and customary fees for first-time, initial sessions with a non-state licensed Masters level therapist is $75, a state-licensed Masters level therapist is $127, and a state-licensed PhD level clinician is $187. Sessions lasting beyond one hour or less than one hour will be charged at a rate proportional to the hourly rate. Master's Level Psychotherapy Interns, if available, offer initial appointments at a discounted rate of $30 per session, not billable to insurance.

Successive Psychotherapy Appointments: The regular and customary fees for standard sessions with a non-state licensed Masters level therapist is $50, a state-licensed Masters level therapist is $85, and a state-licensed PhD level clinician is $125. Each standard appointment is scheduled for an hour and consists of 50 minutes of face-to-face consultation and 10 minutes of provider documentation. Sessions lasting beyond one hour or less than one hour will be charged at a rate proportional to the hourly rate. Master's Level Psychotherapy Interns, if available, offer successive appointments at a discounted rate of $30 per session, not billable to insurance.

Family Practice Mental Health Appointments (Medication Management): The regular and customer fees for initial sessions with an MD Family Practitioner or PhD-level psychiatrist, lasting 30-45 minutes in length, is $155. Each standard appointment thereafter, lasting 15-20 minutes in length, is $105.

Psychological Testing Appointments: Testing consists of the following steps 1) Administration of the tests,
2) Scoring, analysis and interpretation, documentation (without client present), and 3) Discussion of test results with the client. Time requirements vary by type of test and are charged the regular and customary fee for a state-licensed PhD level psychologist: $187 for the first hour and $125 for every hour after.

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:

☑ Affordability ☑ Fee Schedule ☑ Payment and Insurance ☑ Late Cancellation ☑ HIPPA Privacy Practices

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: _____

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize Centerpoint Counseling Services to use and disclose the protected health information described below to:

_____

☐ ***Primary Care Doctor (Office name, Physician name, Phone & Address)*** ☐ ***Other (Individual's name, Relationship, Contact number)***

I authorize the release of my complete health records including records relating to:

☐ *assessments, evaluations, treatment planning*
☐ *verbal communication*
☐ *billing information*
☐ *progress notes*
☐ *communicable diseases*
☐ *HIV or AIDS*
☐ *treatment of alcohol or drug abuse*
☐ *other:* _____
describe

This medical information may be used by the person/facility I authorize to receive this information for medical treatment or consultation, coordination of care, billing or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization or any specific details pertaining to the authorization, ***in writing***, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

This authorization for release of information expires one year from the date of the signature below.

_____ _____
Printed name of patient ***Date of Birth***

_____ _____
Signature of patient or legal guardian ***Date***

If opting NOT to sign release to Primary Care Physician, please list reason below **and sign**:

☐ ***I do not have a Primary Care Physician***

☐ ***Other:*** _____

_____ _____
Signature of patient or legal guardian ***Date***

I understand that refusing to release medical information to my PCP may affect my insurance coverage for services or my provider's ability to coordinate care.

393 East 2nd North Rexburg, ID 83440 Phone: (208)359-4840 Fax: (208)359-9010 mail@centerpointcounseling.com