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| **New Client Registration** |

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| **Name:** |  | | | | **Date of Birth:** |  | | **Age:** | |  | **Gender:** |  |
| **Address:** | |  | | | | | | | | | | |
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| **May we *discretely* contact you at this mailing address?** | | | | | | |  | | Yes | |  | No |
| **Cell Phone Number:** | | |  | | | | | | | | | |
| **May we *discretely* contact you on your cell phone?** | | | | | | |  | | Yes | |  | No |
| **Home Phone Number:** | | |  | | | | | | | | | |
| **May we *discretely* contact you on your home phone?** | | | | | | |  | | Yes | |  | No |
| **Email Address:** | | |  | | | | | | | | | |
| **May we *discretely* contact you at this email address?** | | | | | | |  | | Yes | |  | No |
| **Marital/relationship status:** | | | |  | | | | | | | | |
| **Ethnic/Cultural Background:** | | | |  | | | | | | | | |
| **Education:** | | | |  | | | | | | | | |
| **Occupation:** | | | |  | | | | | | | | |
| **Employer:** | | | |  | | | | | | | | |

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| **Referal Information** | | | | | | | | |
| **How did you hear about Artisan Counseling?** |  | | | | Google/Internet Search | | | |
|  | | | | *Psychologytoday.com* | | | |
|  | | | | *Goodtherapy.org* | | | |
|  | | | | My Insurance Listing | | | |
| Other (Please Provide Details): | | | | | |  | |
| **Were you referred by a specific person? If so, who referred you to Artisan Counseling?** |  | Yes |  | No | | Referred By: | |  |

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| **eMERGENCY CONTACT** | | | | | |
| **Name:** |  | **Phone Number:** |  | **Relationship:** |  |

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| **INSURANCE INFORMATION** |
| Please be prepared to upload (client portal) or provide your counseling with your insurance card and photo ID so that we may make a copy for your file. |

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| **Primary Insurance Information** | | | | | | |
| **Name of Insurance Company:** |  | | **Policy Owner’s Name:** | |  | |
| **Policy Owners Date of Birth:** |  | | **Policy Owner’s SS#:** | |  | |
| **Insurance ID#:** |  | | **Policy Owner’s Address:** | |  | |
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| **Do you have secondary insurance?** |  | Yes | |  | | No |

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| **Secondary Insurance Information** (if applicable) | | | | | | |
| **Name of Insurance Company:** |  | | **Policy Owner’s Name:** | |  | |
| **Policy Owners Date of Birth:** |  | | **Policy Owner’s SS#:** | |  | |
| **Insurance ID#:** |  | | **Policy Owner’s Address:** | |  | |
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| **Do you have secondary insurance?** |  | Yes | |  | | No |

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| **WHAT BRINGS YOU TO COUNSELING?** |
| *Please provide a brief summary regarding the areas of importance that contribute to seeking counseling services.* |
| **Current Concerns:** |

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| **In what areas do your current concerns impact your life?** | | | | | | | | | | | |
|  | Activities |  | Relationships |  | Sleeping |  | Lifestyle |  | Eating |  | Mood |

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| **Have you ever attempted suicide?** | | | | | | | | |
|  | Yes |  | No | **If yes, when?** | | | | |
| **Are you currently been thinking about suicide?** | | | | |  | Yes |  | No |

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| **Have you ever thought about harming or killing someone else?** | | | | | | | | |
|  | Yes |  | No | **If yes, when?** | | | | |
| **Have you currently been thinking about harming or killing some else?** | | | | |  | Yes |  | No |

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| **Do you use alcohol or drugs?** | | | | | | | | |
|  | Yes |  | No | **If yes, what type and how often?** | | | | |
| **Have you ever received treatment for substance abuse?** | | | | |  | Yes |  | No |
| **If yes, please provide details about substance abuse treatment services received:** | | | | | | | | |
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| **Treatment History** | | | | | |
| **Are you currently being treated by a mental health professional or physician for the problems noted above?** | |  | Yes |  | No |
| **If yes, please provide additional information:** | Name of Provider: |  | | | |
| Agency Name: |  | | | |
| Contact Information: |  | | | |
| Type of Services: |  | | | |

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| **Current Medications** (type, dosage, time of day) |
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| **Previous Mental Health Treatment** (dATES, NAME OF PROFESSIONAL, TYPE, WHY DISCONTINUED) | | | | |
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| **Have you ever been hospitalized for mental health treatment?** |  | Yes |  | No |
| **If yes, please provide the name of the hospital or facility and reason for hospitalization:** | | | | |
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| **Health Information** (Who is your current Primary Care physician?) | | |
| **Name of PCP:** |  | |
| **Practice Name:** |  | |
| **Contact Information:** |  | |
| **When were you last seen by your PCP?** | |  |
| **Current Health Concerns:** | |  |

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| **Email and Texting Policy** | | | | | |
| While we make every effort to protect text and email, we can provide no assurance confidentiality or security. The standard email you use at home or work is most likely not HIPAA secure and could be vulnerable to unauthorized access. Electronic communications are not appropriate if you are experiencing a crisis. We may not check email every day. With your consent, we may send automated email or text appointment reminders. Each client must weigh the benefits against the potential risk and determine the communication types they are comfortable using. | | | | | |
| **Initial Below** |  | **Indicate by placing an X** | | | |
|  | Please sign below that you understand and agree with the above policy. I consent to using email communication: |  | Yes |  | No |
|  | I consent to using text message communication: |  | Yes |  | No |

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| **initial** | **Please carefully read the statement below and** |
|  | I have received and/or reviewed the general practice information which is available on the website and printed within the office. |
|  | I consent for myself (or my child) to receive behavioral health services **at Artisan Counseling.** |
|  | I have read, understand, and agree to comply with the fee policy and the **Missed Appointment Policy.** |
|  | **I have reviewed the Notice of Privacy Practices (HIPAA)** which is available both on the website and within the office. |
|  | **I will use my insurance benefits.** I understand that I am responsible for all co-payments, cost share payments, or out of pocket payments for services provided to me. I authorize the release of information for claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan. |
|  | **I understand that I am responsible for any fees denied or not covered by my insurance company.** |
|  | **I will pay for services out of pocket and will not use insurance or will submit my own receipts for out of network reimbursement**. I understand that I am responsible for all fees for services provided to me. |

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| **I have read and understand the conditions outlined above:** | | | |
| Client signature: | Handwritten signature not required if signing electronically | Date: |  |
| Parent/Guardian (if applicable) Signature: | Handwritten signature not required if signing electronically | Date: |  |