ADULT INTAKE

CLIENT INFORMATION		SPOUSE INFORMATION	
NAME	______	NAME	______
PREFERRED NAME	______	PREFERRED NAME	______
DOB	______	DOB	______
ADDRESS	______	ADDRESS	______
CITY, ZIP	______	CITY, ZIP	______
MOBILE PHONE	______	MOBILE PHONE	______
HOME PHONE	______	HOME PHONE	______
EMAIL	______	EMAIL	______
EMPLOYER	______	EMPLOYER	______
OCCUPATION	______	OCCUPATION	______

INSURANCE ______

POLICY HOLDER ______

EMERGENCY CONTACT ______

CONTACT PHONE ______

SUMMARY OF CIRCUMSTANCES THAT BRING YOU TO CHRISTIAN LIFE COUNSELING

______

______

______

HAVE YOU RECEIVED COUNSELING BEFORE? YES NO

PREVIOUS THERAPIST/DATES/REASONS FOR PRIOR THERAPY?

______

______

______

MEDICAL HISTORY

SERIOUS ILLNESSES

____

____

____

SERIOUS INJURIES OR ACCIDENTS

____

____

____

NAME AND DATE OF ANY OPERATIONS AND/OR HOSPITALIZATIONS

____

____

____

ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS?

(PLEASE INCLUDE NAME AND DOSAGE)

ASPIRIN, BUFFERIN, ANACIN	________________	ANTIDEPRESSANTS	________________
BLOOD PRESSURE PILLS	________________	TRANQUILIZERS	________________
CORTISONE	________________	WEIGHT REDUCERS	________________
COUGH MEDICINE	________________	BLOOD THINNING	________________
DIGITALIS	________________	DILANTIN	________________
HORMONES	________________	INJECTIONS	________________
INSULIN OR DIABETIC PILLS	________________	WATER PILLS	________________
IRON OR POOR BLOOD PILLS	________________	ANTIBIOTICS	________________
LAXATIVES	________________	BARBITURATES	________________
SLEEPING PILLS	________________	BIRTH CONTROL	________________
THYROID MEDS	________________	PHENOBARBITAL	________________
ULCER MEDS	________________	OTHER	________________

Marital Status

☐ SINGLE ☐ MARRIED DATE MARRIED ____________________

☐ DIVORCED DATE ________________

☐ WIDOWED DATE ________________

PREVIOUS MARRIAGE FROM ________________ TO ____________________

☐ DIVORCED DATE ________________

☐ WIDOWED DATE ________________

Children

Name	Sex	DOB	Health	Grade/School

Family Members

Members	Sex	DOB	Health/Mental Illness	Date of Death	Cause
Father					
Mother					
Spouse					
Brother					
Sister					

Personal History

What is your last grade/degree completed? ____________________

Do you smoke? YES NO

If so, number of years CIGARETTES ________ PIPE ________ CIGARS ________

Do you drink caffeinated beverages? YES NO

How many cups each day? COFFEE ______ TEA ________ SODA ______

Do you drink alcohol? YES NO

Number of times per DAY ________ WEEK ________ MONTH ______

Other chemicals or illegal drugs? YES NO

If so, please identify ____________________

Do you have difficulty falling asleep? YES NO

Do you wake in the middle of the night? YES NO

Have you experienced a change in appetite? YES NO

Have you lost or gained weight in the last year? YES NO

LOST ______________ GAINED ____________

Are you currently having thoughts of suicide? YES NO

If so, please explain

____

____

Have you had previous suicide thoughts and/or attempts in the past? YES NO

Have you ever been hospitalized for mental health reasons?

If so, please explain and provide dates/reasons

____

____

____________________ SIGNATURE

____________________ DATE

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CLIENT CONTACT PREFERENCES

PLEASE PROVIDE CONTACT METHODS BELOW AND MARK THE BOXES ACCORDING TO YOUR PREFERENCES

METHOD OF CONTACT	CHRISTIAN LIFE COUNSELING MAY LEAVE A DETAILED MESSAGE	APPOINTMENT REMINDERS
EMAIL		
CELL PHONE		
CELL PHONE		
LANDLINE		N/A

REGARDING BILLING AND SCHEDULING

PLEASE IDENTIFY INDIVIDUAL(S), OTHER THAN YOURSELF, WITH WHOM CHRISTIAN LIFE COUNSELING MAY SPEAK

NAME	NAME
NAME	NAME
NAME	NAME

I UNDERSTAND AND AGREE TO THE NATURE OF THIS RELEASE.

I WILL PROMPTLY NOTIFY CHRISTIAN LIFE COUNSELING OF ANY CHANGES TO MY INFORMATION OR PREFERENCES.

__________________	__________________	__________
CLIENT NAME	CLIENT SIGNATURE	DATE
PARENT/GUARDIAN SIGNATURE	RELATIONSHIP TO CLIENT	DATE

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Fee Schedule & Late Cancellation/No-Show Policy

Psychotherapists

Service	Fee
90791 Intake	$225.00
90847 38-52 min	$220.00
90837 53-89 min	$200.00
90834 38-52 min	$150.00
90832 16-37 min	$100.00
90853 Group 60 min	$100.00
Late Cancel Charge	$75.00

Psychologist

Service	Fee
90791 Intake	$275.00
90847 38-52 min	$270.00
90837 53-89 min	$250.00
90834 38-52 min	$200.00
90832 16-37 min	$150.00
96101 Testing 60 min	$250.00
No-Show Charge	$100.00

Service	Fee
Written/Standard Reports & Letters Exchanging Client Information 60 min	$200.00
Records Release to Client (per sheet)	$0.10
Required/Requested Provider Appearances (per hour, plus mileage)	$200.00

*The above charge amounts are billed to the insurance companies. If you are not using insurance, your therapist will discuss a suitable Private Pay agreement with you.

We understand there are times when you must miss an appointment due to emergencies or obligations to work or family. However, if you do not notify the office you are unable to make an appointment, you are interfering with our ability to schedule with another client. Therefore, if an appointment is not cancelled at least 24 hours in advance, you will be charged a $75.00 fee. A $100.00 fee will be charged if you fail to show for a scheduled appointment and do not call.

Late cancellation and no-show fees are not covered by insurance companies.

I will be charged:

- $75.00 if I do not cancel a scheduled appointment at least 24 hours in advance.
- $100.00 if I fail to show for a scheduled appointment and do not call.

I have read the Fee Schedule & Late Cancellation/No-Show Policy. I understand and agree to the policy.

______________________	______________________	______________
Client	Client Signature	Date
Parent/Guardian	Parent/Guardian Signature	Date

We strongly encourage clients to leave a credit card on file for sessions. Only the last four digits will appear in the system.

Client Acknowledgement and Authorization

- I have reviewed the *Client Rights* document available on the website (a copy will be provided upon request).
- I have reviewed the *Consent to Treatment* document available on the website (a copy will be provided upon request).
- I have reviewed the *Fee Schedule*.
- I understand if I have any questions regarding my privacy rights, I may contact:
  Tanya Gerhard at (262) 785-1008.
- I authorize you to use and disclose my personal health information to my insurance company. I also authorize the cost of treatment be made directly to Christian Life Counseling.
- I understand Christian Life Counseling and its billing company will be contacting my insurance regarding benefits/eligibility and/or claims information.
- I understand any treatment charges not covered by my insurance plan will be my responsibility.
- I understand I will be charged up to the normal fee for appointments missed without 24-hour notice. I also understand my insurance company will not pay for missed appointments.
- I understand Psychotherapy is best done in person, therefore, anticipate my therapist may suggest I meet with them if I call or email with a non-critical problem. Christian Life Counseling understands, however, some circumstances may require immediate attention. If this occurs, I can expect charges for these services, which are not often reimbursed by insurance companies. I understand email is not to be used for immediate attention or emergency care.
- I understand recording of sessions is forbidden.

It is our policy to be as responsive to clients as possible, particularly during times of crisis. Your therapist, however, will always not be available. Each therapist has a confidential voicemail upon which you may leave a message. Your therapist will check his/her voicemail at least once each day and will return your call as soon as possible.

If you have an emergency, please contact your primary physician, an emergency crisis line, or 911.

Client	Client Signature	Date
Parent/Guardian	Parent/Guardian Signature	Date

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