***Intake Form***

***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 Name Phone # Relationship

Source of referral Reason for referral

How did you hear about Focus Therapy Clinic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL**

I understand that Focus Therapy Clinic, LLC 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

**OVER**

**Therapist Use Only** **Location Billing**

Therapist Name 🞎 Traverse City 🞎 Client Self Pay

Dx

Special Instructions 🞎 EAP – Bill EAP Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 # of Approved Visits \_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY INFORMATION**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **NAME** | **M/F** | **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.** |  |  |  |  |  |  |
| **6.** |  |  |  |  |  |  |
| **Others Living in Household** |
| **1.** |  |  |  |  |  |  |
| **2.** |  |  |  |  |  |  |
| **3.** |  |  |  |  |  |  |
| **4.** |  |  |  |  |  |  |
| **5.** |  |  |  |  |  |  |
| **6.** |  |  |  |  |  |  |

**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\_\_\_Anxiety\_\_\_Behavior Problems\_\_\_Changes in Appetite/Eating Habits\_\_\_Criminal Activity\_\_\_Decreased Energy\_\_\_Delusions\_\_\_Depressed Mood\_\_\_Disruption of Thought Process/Content\_\_\_Emotional/Physical/Sexual Trauma\_\_\_Excessive Crying \_\_\_Family Conflicts | \_\_\_Grief\_\_\_Guilt\_\_\_Hallucinations\_\_\_Hopelessness\_\_\_Hyperactivity\_\_\_Impulsiveness\_\_\_Interpersonal  Conflicts\_\_\_Irritability \_\_\_Manic \_\_\_Mood Swings\_\_\_Oppositional\_\_\_Panic Attacks | \_\_\_Paranoia\_\_\_Physical Aggression\_\_\_School/Work Problems\_\_\_Self Abusive Behavior\_\_\_Sleep Disturbance\_\_\_Somatic Complaints\_\_\_Suicidal Thoughts/Attempt\_\_\_Weight Gain\_\_\_Weight Loss\_\_\_Worthlessness\_\_\_Other (Specify)  |

How could your life be better?

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, medication referral, etc.)

b) Frequency of therapy sessions (weekly, biweekly, etc.)

c) Goals of therapy (what you hope to gain from this process.)

1. APPOINTMENTS: Each appointment is approximately 45-50 minutes. At the end of each appointment you can discuss

future appointments with your therapist.

1. 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.
2. 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. Charges for services in addition to therapy may be levied (i.e., involvement in

client litigation, document preparation, etc.). These fees will be negotiated individually with your therapist. We accept cash and check. Please make checks out to “Focus Therapy Clinic, LLC”.

1. 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 Focus Therapy Clinic are ultimately your responsibility. If your insurance company requires that outpatient mental health services be preauthorized, it is your responsibility to initiate the reauthorization process, i.e. contacting your primary care physician, insurance company, or a third party “gate keeper”. Failure to obtain required preauthorization for outpatient mental health services will result in you being held 100% responsible for all charges. Late charges of 2% per month will be added to balances existing for more than 30 days.

1. CONFIDENTIALITY: All information regarding the specific nature of your counseling or psychotherapy is maintained at

Focus Therapy Clinic and 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 MWCS and my primary care physician.

Patient(s):

Physician’s Name/Office and Phone Number

Signed: Date:

Signed: Date:

**Privacy Practices Form**

**CLIENT COPY – KEEP THIS FORM FOR YOUR RECORDS**

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