Counseling Intake Form

Client Registration

First Name Last Name

Insurance Information

Insurance Company Member ID

Group # Plan Code

Please submit a copy of the front and back of your insurance card with completed paperwork.

Name of Financially Responsible Party (Write "Self" if it is you)

First Name Last Name

Relationship to client Social Security #

Street Address

Street Address Line 2

Area Code Phone Number

Employer Occupation

Brief Description of Concerns and Goals

Client Acknowledgements/Consents

1. I agree to be evaluated by Salathiel Reagan, LMHC. Following the evaluation, I will be asked to consent to specific treatment recommendations as stated in the treatment plan.
2. I understand these services are voluntary and that I may revoke consent at any time.
3. I have received a copy of my Rights and Responsibilities in regard to services being provided. Salathiel has reviewed and explained these rights to me and to my family/advocate/representative.
4. I have received a copy of Salathiel's Notice of Privacy Practices ***I acknowledge the above statements and information have been explained and reviewed with me, and I understand the statements. My signature below indicates that the results of the assessment, treatment recommendation and proposed interventions have been explained to me. I voluntarily consent to participate in this plan of care. I am aware that similar services are available from other provider organizations and agencies. I choose to receive services through Salathiel Reagan, LMHC/Reagan Counseling LLC.

Date

Month Day Year

Signature (please include relationship to client)

Financial Agreement

I understand that if I choose not to use my insurance benefits ("self pay") or if Salathiel is not a participating provider with my insurance plan ("out of network"), I will pay in full, at the time of service, for all services rendered on my behalf. I understand that if Salathiel is a participating provider ("in network") I will pay the copay at the time of service and Salathiel will submit my claim to my insurance provider. I hereby give consent to Salathiel to release any required health information to my health care insurance provider to assist in the processing of claims, including protected health care information in accordance with the Health Insurance Portability and Accountability Act (HIPAA). I also acknowledge that I am responsible for any changes not covered by my health insurance. I understand that 24 hours notice is required to avoid a $50 charge for missed appointments. I also understand that I may be charged a late fee if I arrive more than 15 minutes late to my appointment. I understand that missed appointment fees and late fees are not covered by my insurance plans. In the event my account is sent to collections, I agree to pay for all charges incurred, court costs, interest, and reasonable attorney's fees. Your signature indicates you have read and agree to the financial agreement.

Signature of Financial Responsibilty

Missed/Canceled Appointments (Attendance Policy)

I understand that my attendance is critical to the therapy process and will have a direct impact on my treatment and progress; therefore I understand the importance of attendance and the likely negative impact of repeated missed/canceled appointments. I also understand that routine cancellations or missed appointments may result in fees, as well as a referral to another agency for ongoing services. In the event that I miss or cancel multiple appointments, I accept that I may be referred to another facility that may be able to accommodate a more irregular therapy schedule.

Signature Consenting to Attendance Policy

Authorization for Messages (Communications)

I authorize email messages regarding my appointment time may be sent to the email I have listed.

- ○ Yes
- ○ No

I authorize voicemail messages may be left at the phone number I have listed.

- ○ Yes
- ○ No

I authorize I can receive text messages at the phone number I have listed.

- ○ Yes
- ○ No

I hereby consent and agree to receiving emails from Salathiel Reagan, LMHC/Reagan Counseling LLC for appointment reminders. I understand the risk of Protected Health Information (PHI) through email, and with this agreement I am accepting these risks to my PHI. I accept Salathiel will not be responsible for any exposure of email communications at my home or place of employment, depending on the location of my email address. I also agree to never use email communications for emergency situations, and to call the office phone number provided to me with any emergencies. I understand that I can terminate this agreement at any time by informing Salathiel Reagan, LMHC/Reagan Counseling LLC in writing with my signature.

Signature for Authorization of Communications

Insurance and Medical Information Release Authorization

I authorize release of any and all information required for insurance and payment purposes. I authorize Salathiel Reagan, LMHC/Reagan Counseling LLC to release necessary medical information to appropriate third parties for reimbursement purposes and/or to person authorized to conduct service utilization reviews. I understand that a photocopy of this authorization is as authentic as the original signed authorization.

Signature for Medical Information Release