Personal Solutions Counseling **Provider:** _____

Initial Appointment date: / /2018 **Day:** M T W Th F S S **Time:** _____

CLIENT INFORMATION

First Name: _____ **Initial:** _____ **Last Name:**_____

Gender: M F **Date of Birth:** _____ **SSN:** _____

Marital Status: _____ **Email:** _____

Address: _____ **City:** _____ **Zip:** _____

Employer: _____ **(Circle): Full Time Part Time**

School: _____ **(Circle): Full Time Part Time**

Home Phone: (_____ **)** _____ **Cell phone: (** _____ **)** _____

I found you through _____ **Do we have permission to text you? Y**_____ **N** _____

INSURANCE SUBSCRIBER INFORMATION

(subscriber is the family member who purchases the insurance policy)

We will need a copy of your driver's license and insurance card

Name of Subscriber as it appears on Insurance Card: _____

Insured's DOB:_____ **Gender:** M F **SSN:** _____

Address of Insured: _____ **City:** _____ **Zip:** _____

Insured's relationship to the client: Self Spouse Child Step parent Other: _____

Insured Party's Employer: _____

Home phone: (_____ **)** _____ **Cell Phone: (** _____ **)** _____

Is there a secondary insurance policy: yes no I don' know **If Yes, we need copy of card.**

You have the right to request confidential communications or that a communication of your Private Healthcare Information (PHI) **be made by alternative means**, such as sending correspondence to your office instead of your home, or calling your cell phone instead of your work or home phone. Privacy requests do not apply to collection attempts for unpaid bills. **Write down preferences below. If you leave it blank, then we will use contact information provided above**:

_____

_____

_____

Personal Solutions Counseling, PC

INFORMED CONSENT FOR SERVICES

BY SIGNING THIS DOCUMENT, I _____ AM INDICATING THAT I AGREE TO PARTICIPATE IN THE FOLLOWING SERVICES WITH PERSONAL SOLUTIONS COUNSELING:

Initial all that apply:

____ Clinical Assessment for myself (first appointment)
____ Individual Psychotherapy for myself
____ Clinical Assessment for my child (first appointment)
____ Psychotherapy for my child
____ Family Therapy for (circle:) myself my child
____ Couple or Marital Therapy
____ EAP Assessment & Referral only
____ EAP Assessment & Short-Term EAP Counseling
____ To participate as a collateral in therapy or EAP counseling with my
____ Group Therapy:
____ Other: _____

I understand that this agreement is valid for the duration of time that I am participating in services with Personal Solutions Counseling (hereinafter, PSC). By signing below, I acknowledge that I have received a copy of the Privacy Policy and the Informed Consent for Counseling Services, and I understand and agree to the entire contents of these documents. I acknowledge that I have had an opportunity to have answered any questions, comments, or concerns that I might have had prior to signing this consent and participating in services. PSC reserves the right to change the Privacy Policy and Informed Consent for Counseling Services and changes will be available at the office of PSC and on the PSC website at www.PersonalSolutionsCounseling.com. I can request a copy of changes at any time at no charge. Any changes that PSC makes are effective immediately unless otherwise indicated.

_____ _____

CLIENT SIGNATURE (18 and older) DATE

_____ _____

SIGNATURE OF PARENT OR SPOUSE
(for a child age 17 and younger) DATE

Agreement Regarding Fees, Insurance, and Collections

FEES: I will be charged $175 for my first meeting (evaluation), $105 for each 45-minute individual meeting, $150 for each 60-minute meeting, $110 for marriage or family meeting, $75 for each 20-35 minute meeting, and $150 for crisis intervention per hour. Phone consultations are $75 per hour pro-rated in 10 minute increments, and $95 per hour for report writing or in-person meetings pro-rated in 10 minute increments including travel-time and are not billed to insurance**. If I do not give at least 24 hours notice of cancellation, a $60 fee will be applied. If there are repeated missed sessions, a $60 fee will be applied regardless of notice. If I do not attend a scheduled appointment and do not give any notice, a fee will be incurred that may range up to the full session rate (negotiated by my insurance company) at the therapist's discretion.**

INSURANCE: If PSC is an in-network provider for my insurance company then I am only responsible for the PSC contracted rate with that company which may be the same or less than the rates for services listed above. If PSC is an out-of-network provider, I may be responsible for the difference between what my insurance company pays and what PSC charges even if the insurance company "adjusts" the rates. I am aware that there is no guarantee that my insurance company will cover services, and that I am fully responsible for all fees not covered by my insurance company. A quote of coverage is not a guarantee of payment and we cannot be certain of your exact coverage until we receive an Explanation of Benefits from your insurance company after we send them a bill. I am aware that State and federal laws require PSC to collect co-payments, co-insurance and deductibles in full. I am responsible for paying my co-payment, coinsurance, or deductible at the time of each session.

We received the following quote of benefits: Copayment $ _____ Coinsurance $ _____Deductible $ _____

PAYMENT: If I am unable to pay my balance due, I may request a payment plan. After receiving an Explanation of Benefits from my insurance company, or if I am paying privately, if my balance exceeds $200, my counselor may stop providing services until my balance is paid down to a reasonable amount given my circumstances.

COLLECTIONS: I understand that if my account is sent to a collection agency or attorney for collection, that I will be responsible for my full balance plus a collection fee of 33% of my principle balance. I understand that my counselor may not be able to provide services to me if my account is sent to collections. You could avoid collections by adhering to a payment plan.

AMENDMENTS: I agree that PSC reserves the right to amend this agreement and may provide me with a notice at which time I will have 14 days to decide if I will continue services with PSC under the amended agreement.

X _____ _____

Signature of Client, Parent, or Guardian **Today's Date**

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION: I authorize any and all of my medical information necessary to process insurance claims to be released to _____ for the purpose of processing claims. This authorization to release information shall be valid through December 31, 2019. I authorize assignment of benefits directly to PSC for services provided.

X _____ _____

Signature of Client or Parent **Today's Date**

STATUS & HISTORY:

Have you seen a counselor, therapist, psychologist or psychiatrist in the past? Yes No
If yes, what month/year and for what reason? _____

_____

If you have had substance abuse treatment, please write down the month/year and type here: _____

_____

Are you currently receiving treatment for an illness, injury, or chronic medical condition? Yes No
If yes, what is the diagnosis and what are the treatments:_____

_____

Write down all prescription medications, over-the-counter medications (OTC), or illegal drugs below:

Med or Drug name	Month & Year Started	Daily Dosage	Prescribed by And Reason for taking

Doctor's Name:_____ Type of Doctor:_____
Clinic or Facility:_____
Address:_____ City: _____
Office Phone: (_____) _____
Do you want us to contact your doctor? Yes No Last exam date?_____

Legal Issues & History. Please tell us if you have any current legal issues (arrests, convictions, civil or criminal lawsuits, judgments, order of protection, bankruptcy, juvenile delinquency, parole, probation): _____

_____

_____

Please list stressors in your life: _____

_____

_____

Employment: Unemployed Employed (circle): Full-Time Part-Time Homemaker

Education: None 6th 8th High School 1-2 yrs college Bachelor Master PhD MD

History of Learning problems: yes no

Lifestyle (*circle things you do **daily** or **weekly**—average):* eat fast food drink pop drink coffee smoke drink alcohol take vitamins surf the web exercise watch TV read books socialize gamble use drugs play computer/video games eat junk food/snacks hobbies eat healthy snacks shop self educate play with kids practice something take college courses volunteer

How many hours of sleep do you average per night in the last month:_____

Do you take naps: yes no If yes, how often and how many hours at a time:_____

Your Relationship to Client: Self Parent Spouse Other Relative

_____ _____
Signature of Person Completing this Page Date