Complete Counseling Group
2 Corporate Drive, Suite 209
Trumbull, CT 06611
203-309-6052
www.completecounselinggroup.com

Client Intake Form

Date: _____
Name: _____
Date of Birth: _____
Street Address: _____
City, State, Zip:_____
Cell phone: _____
Home phone: _____
Work phone: _____
Email: _____
Social Sec. #: _____
Emergency Contact (name, relationship, contact information):_____
_____
Referred by: _____

Insurance (ONLY if you have not presented your insurance card for copy):
Insurance: _____
Group #: _____
ID#: _____
Telephone #: _____
Name on card if not client's: _____

Brief Description of the Presenting Problem:
_____
_____
_____
_____

Previous Treatment:
_____
_____
_____
_____

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What problems do you wish to solve in counseling?

_____
_____
_____
_____

Do you have any physical health concerns?

_____
_____

Please list all medications taken by the client:

_____
_____
_____
_____

Current court involvement?

_____
_____

Marital status: _____ **Highest Grade Completed**: _____
Employer/School: _____ **Race/ Ethnicity**: _____
Primary Language: _____ **Spiritual Preference**: _____

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Financial Practices

Services and Fees: Sessions are 50-55 minutes in length and are $150 per session. If insurance benefits are used, ***you are responsible for all co-pays at the time of services rendered***. If an appointment needs to be rescheduled, please give at least twenty-four hours notice by email or telephone. Late cancellations and no-shows will be charged a fee of $75.00. After three missed/late cancelled appointments, it may result in the client not being able to continue seeking services with the practice. If there is an emergency and you cannot reach your therapist, please call 911.

Payment for Services: Client payment obligations are due, in full, at the time of service, unless you have made payment arrangements in advance with your therapist. Fees can be paid by cash, credit card (Visa, Mastercard, Discover and American Express) or check; please make checks payable to "Complete Counseling Group". You are responsible for the full fee of any returned checks submitted to Complete Counseling Group for services provided to you. Regardless of your medical coverage, you are responsible for payment of your clinical services. If payment is late and the client does not communicate with their therapist the reason for the unpaid balance, you will not be able to schedule follow up visits until all balances are paid off or payment arrangement is made.

Insurance Coverage: Complete Counseling Group will submit insurance claims for coverage. You are responsible for reporting any changes to your insurance information, including coverage changes. If you fail to inform your therapist, you may be responsible for payment in full for your professional services. You are responsible for costs or professional services regardless of coverage. By signing this form you are authorizing insurance carriers to make payments to Complete Counseling Group. If your insurance carrier will only submit payment directly to the client, you are responsible for forwarding payment in full to Complete Counseling Group.

Acknowledgement and Agreement of Financial Practices and Fees:
I hereby have read and understand the above Financial Practices. I guarantee payment of all charges incurred for the account of the below client. I further agree to indemnify, defend and hold Complete Counseling Group harmless from and against all liabilities and will advance, reimburse and pay any attorney's fees, costs, expenses and liabilities. I also agree that any due and outstanding payment obligations not paid within forty-five (45) days of issuance shall accrue interest, which I hereby agree to pay, at the rate of 12% per year.

_____ _____

Client/Guardian Signature Date

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THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

I am required by law to maintain the privacy of your health information and to provide you with notice of my legal duties and privacy practices. I reserve the right to change my privacy policies as permitted by law and will notify you of any significant changes.

Treatment: I may use and disclose your health information to provide you with treatment and coordinate care (i.e. by communicating with physicans, psychiatrists, therapists, school or other professionals involved in your care). This information will only be shared with your written consent to do so.

To Avert a Serious Threat to Health or Safety: When necessary to prevent a serious threat to the health or safety of yourself, the public, or another person, I may use or disclose your health information to individual(s) able to lessen or prevent the threatened harm.

Reporting Suspected Federal Violations and Child Abuse: Suspected Federal violationg may be reported to the appropriate authorities in accordance with Federal regulations. Federal laws and regulations to no protect any information about suspected child or elder abuse or neglect from being reported under State Law to appropriate State or local authorities.

Special conditions regarding disclosure of psychiatric, substance abuse, and HIV related information

For disclosures concerning health information relating to care for psychiatric conditions, substance abuse or HIV-related information, special restrictions may apply. I generally may not disclose this information in response to a subpoena, unless you sign an authorization to do so or a judge orders the disclosure.

I consent to the use or disclosure of my protected health information by Complete Counseling Group to any organization or person for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operation.

By signing the below, I understand and acknowledge that I have read and understand this consent:

_____

Print Name of Individual or Guardian

_____

Signature of Individual or Guardian Date

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Missed Appointments and Unpaid Balance Payment Agreement

We request twenty-four (24) hours notification of any cancelled appointments. If my appointment is missed or not cancelled with 24 hours notification, there is a seventy-five ($75) fee for each missed appointment. Per my understanding of the signed Financial Practices Agreement, I authorize Complete Counseling Group to charge my credit or debit card (whichever is supplied below and copy of same has been taken in lieu of having the physical card) in the amount of seventy-five ($75.00) on or about the day of my missed appointment.

I also authorize charges related to any and all fees due on my account that remain unpaid after fourty-five (45) calendar days from the date submitted to insurance or date of service if insurance is not being used that I am responsible for including (but not limited to): co-pays, co insurance, unmet deductibles, failure to complete coordination of benefit (COB) forms or if the insurance company deems me as "ineligible" for benefits (i.e., I am not covered). This information is often printed on insurance company's EOB (Explanation of Benefits) sent to both the provider and the insured party after the insurance company is billed for the visit.

At no time will this credit or debit card number (without card present to be swiped) be used routinely to pay for my bill, unless agreed upon. This agreement applies **only** in the event the client below has not given twenty-four (24) hours notice prior to a scheduled appointment as agreed to and/or attemps to collect payment in a timely manner described above have failed.

In the event a credit card authorization is not duly executed, or if my credit card is declined for any reason and I fail to provide an updated credit card authorization, I hereby acknowledge and agree Complete Counseling Group may refuse to schedule and otherwise cancel any pending or future appointments unless and until I fully discharge payment obligations.

Signature: _____ Date: _____

Printed name: _____

Name as it appears on card: _____

Billing address including zip code where credit/debit card or bank statement is received:

_____

Credit card: Visa Mastercard American Express Discover (circle one)

Card type: Credit Debit (circle one)

Card number: _____

Expiration date: _____

Security code (three digits on back of card): _____

Communication

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It is at the therapist's discretion how much or how little they communicate via telephone, text messaging, or emailing. In any emergency situation please call 911 or 211. Communication with your therapist outside of session is mostly meant for scheduling needs, but if a mutually selected time is chosen for a phone discussion, conversations are meant to be less than 15 minutes long. If the phone discussion is longer than 15 minutes, the therapist may choose to charge you for an hour long phone call.

I give permission for Complete Counseling Group to get in touch with me via the following methods:

	Yes	No		Yes	No
Cell phone:	_____	_____	Can we leave a message?	_____	_____
			Can we text you?	_____	_____
Home phone:	_____	_____	Can we leave a message?	_____	_____
Work phone:	_____	_____	Can we leave a message?	_____	_____
Email:	_____	_____			

PREFERRED METHOD OF CONTACT: _____

I understand that text messaging and email may not be secure forms of communication. I acknowledge the above "Communication Consent Form" in its entirety.

_____ _____

Client/Guardian Signature Date