Pathway Counseling Services, LLC
Stacy S. Fortenberry, MS, LPC
5 Orleans Drive, Suite 2, Hattiesburg, MS. 39402
Phone: (601) 550-7383 Email: stcyfortenberry@yahoo.com

CLIENT INTAKE FORM

(Please Print)

Today's Date _____/_____/_____

CLIENT INFORMATION

Client's Last Name	First	Middle	❑ Mr. ❑ Ms.	❑ Single ❑ Married ❑ Divorced ❑ Widowed How Long? _____ Years

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Address	City	State	Zip Code	Home Phone No. ( )
Occupation	Employer			Cell Phone No. ( )
Email Address				Work Phone No. ( )

Referred to Provider by (Please check one box & list) ❑ Dr. _____ ❑ Insurance Plan ❑ Website
❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other _____

INSURANCE INFORMATION (I WILL NEED A PHOTO COPY OF YOUR INSURANCE CARD)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Email Address:			Cell Phone No. ( )

Occupation	Employer	Employer Address	Work Phone No. ( )

Is this client covered by insurance? ❑ Yes ❑ No	Is this an EAP visit? ❑ Yes ❑ No	Total Annual EAPs allowed? _____

Please Select Your Primary Insurance Provider

❑ Blue Cross/Blue Shield ❑ Other _____

What is the authorization number? ❑ Self Pay

Insured's Name	Birth Date / /	Group #	Policy #	Co-Payment $

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if any)	Insured's Name	Group #	Policy #

Client's Relationship to Insured ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.

SPOUSE'S INFORMATION

Spouse's Last Name	First	Middle	❑ Mr. ❑ Ms.	

Home Phone No.	Cell Phone No.	Work Phone No.	Birth Date	Age	Sex
( )	( )	( )	/ /		❑ M ❑ F

Address	City	State	Zip Code

Occupation	Employer	

CHILDREN'S INFORMATION

Child's Name	Birth Date	Age	Sex	Lives w/You
	/ /		❑ M ❑ F	❑ Yes ❑ No
Child's Name	Birth Date / /	Age	Sex ❑ M ❑ F	Lives w/You ❑ Yes ❑ No
Child's Name	Birth Date / /	Age	Sex ❑ M ❑ F	Lives w/You ❑ Yes ❑ No
Child's Name	Birth Date / /	Age	Sex ❑ M ❑ F	Lives w/You ❑ Yes ❑ No

PRESENTING PROBLEM (What brings you here today)

CURRENT SYMPTOMS (Check all that apply)

❑ Anxiety	❑ Appetite Issues	❑ Avoidance	❑ Crying Spells
❑ Depression	❑ Excessive Energy	❑ Fatigue	❑ Guilt
❑ Hallucinations	❑ Impulsivity	❑ Irritability	❑ Libido Changes
❑ Loss of Interest	❑ Panic Attack	❑ Racing Thoughts	❑ Risky Activity
❑ Sleep Changes	❑ Suspiciousness	❑ Thoughts of Suicide	❑

MEDICAL INFORMATION

Doctor's Name	Phone No. ( )

Address	City	State	Zip

MEDICATIONS

Name	Dosage	Name	Dosage	Name	Dosage
Name	Dosage	Name	Dosage	Name	Dosage

FAMILY HISTORY OF MENTAL HEALTH (Please explain)

Do you have thoughts or plans of suicide? History of suicide thoughts or plans?

How much, if any, alcohol do you consume per week? Your spouse? Please be specific?

Stacy S Fortenberry MS., LPC
Policies and Procedures

Thank you for choosing ***Pathway Counseling Services**, LLC*. Please feel free to ask any questions about my counseling services. The following is some of the information you need to know. **Fees are $130.00 per 50 minute session and $189.00 per 60 minute session. Payment is required at the time of service. At this time, Pathway Counseling Services accepts the following forms of payments; cash, checks, and credit cards (VISA & Master Card only).** Sessions are typically 50 minutes or 60 minutes. Marital/couple sessions are typically longer and fees are usually $32.50 for each increment of additional 15 minutes. Please contact me between sessions only as necessary. Phone calls between sessions that include therapy will be charged as a session. This will also be calculated by 15 minute increments. If you cannot be present for an appointment, please contact me prior to the session; missed sessions without prior cancellation will be assessed fees. If you cannot contact me and feel as if you are in urgent need of immediate care, please go to your local emergency room for care and services. Please note that I am trained as a Licensed Professional Counselor and I am not trained to provide assistance in the legal system; I cannot assist you in legal matters. If subpoenaed regarding counseling services, I will assess fees for my time.

I do file Blue Cross Blue Shield insurance forms. At this time, this is the only insurance I file. All other payments are listed above and must be paid at the beginning of the session. There is no guarantee that your provider will pay for these services; I recommend that you check with your provider as soon as possible.

Any *medications* that are being taken need to be revealed to the therapist at the initial session. If there is a need for the therapist to speak with the prescribing doctor, a release form will need to be signed. Therapy is more successful when your counselor and physician are working together to provide the proper care needed.

All sessions are *confidential.* The only exceptions to my professional policy of confidentiality will be if there is a threat of harm to a minor and/or the client or another involved party. The law requires that the therapist report such threats.

As your professional counselor, confidentiality and ethics require that I maintain a professional relationship with you free of any social media contacts such as Facebook, Twitter, etc.

I _____, understand and agree to the above statements.
(Please print.)

Signature:_____ Date:_____

PLEASE READ THE FOLLOWING CAREFULLY

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. _____ will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

I hereby consent to treatment by specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

X _____

CLIENT/GUARDIAN SIGNATURE DATE

I authorize the payment of medical benefits to the provider of services.

X _____

CLIENT/GUARDIAN SIGNATURE DATE