Changing Perceptions Counseling

NEW CLIENT INTAKE FORM

Today's Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Occupation: _____ Date of Birth: _____

In case of emergency notify: _____

Phone: _____ Relation to you: _____

Present (Main) Complaint: _____

_____

_____

_____

Onset & Duration: _____

How did you hear of me? _____

What prior experiences have you had with counseling or therapy? _____

_____

_____

What do you do to relax? _____

_____

Consent for Therapy:

I, the undersigned, understand counseling is a collaborative process where I as the client, and the counselor, will work together to foster trust and understanding. I further understand the counseling relationship is based upon mutual trust, dignity, and confidentiality. While developing and maintaining this relationship, we will explore and define present situations, create attainable goals to properly address present situations, promote future growth and development, and monitor and adjust strategies to meet all objectives. I accept that no guarantee is made as to the use of therapy, and that I may discontinue treatment at any time. I hereby certify that all information provided to you is true.

I understand that the therapist does not diagnose illness, disease or any other physical disorder. The therapist does not prescribe medical treatment or pharmaceuticals. I have stated all my known medical conditions and take it upon myself to keep the therapist updated on my physical health.

I, the undersigned, acknowledge that I received a copy of the HIPPA, Notice of Privacy Practices notice and understand that my private health information is protected by federal law.

I, _____, hereby acknowledge that I have been provided with the above information, have read such, and have received a copy of this disclosure.

Signature: _____ Today's Date: _____

INSURANCE INFORMATION

Client Name: _____ Birth Date: _____

Person responsible for bill: _____ Phone: _____

Address (if different): _____

Email: _____ Venmo ID: _____

Occupation: _____ Work phone: _____

Work Address: _____

Insurance Company: _____

Member ID No: _____ Group No: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Client's relationship to subscriber: _____ Self _____Spouse _____ Child _____Other

THIS FORM IS MANDATORY IN ORDER TO RECEIVE SERVICES WITH SHARON NORMAND, LPC-S, LAC, CCS dba CHANGING PERCEPTIONS COUNSELING.

I, _____ am authorizing Sharon Normand to charge my credit card in the event I fail to show up for my scheduled appointment and do not notify Sharon Normand of my inability to attend a scheduled appointment at least 24 business hours in advance. I agree to pay $100 for any session cancelled without 24 business hours in advance. I will not dispute the charges for the sessions I have received or that I have not cancelled less than 24 business hours in advance.

Card Type: _____ Visa _____ Mastercard

Full Name on Card: _____

16 Digit Card Number: _____ exp date: _____

Verification/Security Code: _____ (3-digit code on back by signature line)

Full CC Billing Address: _____

E-Mail Address: _____

Please note: This form will be securely stored in your clinical file and may be updated upon request at any time. Your credit card will not be charged unless the following conditions apply: No show for scheduled appointment, cancellation less than 24 business hours in advance, or outstanding unpaid balance for services received that insurance did not cover. If your insurance is accepted, claims will be filed on your behalf and you agree to pay for services that are not covered by your insurance due to cancellation of insurance, uncovered services or unmet deductibles.

I agree to pay Sharon Normand $ _____ per 60-minute session if not covered by insurance.

Signature: _____ Date: _____