



ADULT INTAKE

Appointment Date _____

Name _____ Gender: M F
FIRST MIDDLE INITIAL LAST

Date of Birth _____ Age _____ Social Security # _____

Address _____ City, State, Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Primary Care Physician _____ Phone # _____

How did you hear about us? _____

PAYMENT INFORMATION: Who will be responsible for payment of this account?

Name _____ Social Security # _____

Address _____ Phone # _____

Signature _____ Date _____

CANNOT SIGN FOR SOMEONE ELSE

AGREEMENT TO ALLOW DIRECT INSURANCE PAYMENT

I authorize medical payments from _____
NAME OF INSURANCE COMPANY

to the Life Enrichment Center of Virginia and its affiliated clinicians for services rendered.

Name of Insured _____ Insured's Date of Birth _____

Insurance ID# _____ Group # _____

Employer of Insured _____ Co-pay amount _____

Signature _____ Date _____

DEMOGRAPHIC INFORMATION

Marital Status: S M Sep D W **Education level** _____

Occupation _____ **Place of Employment** _____

Name of Emergency Contact _____ **Phone #** _____

Relationship to you _____

Current Medications _____

Current or past illnesses, injuries, health problems _____

Previous mental health treatment (therapy, hospitalizations, drug/alcohol rehab., etc.)

Briefly describe why you are seeking counseling and what you hope to get out of it _____

Please place a check by any symptoms or problems that you are currently experiencing

- | | | |
|--|--|---|
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> ANXIETY | <input type="checkbox"/> SCHOOL/WORK PROBLEMS |
| <input type="checkbox"/> INSOMNIA | <input type="checkbox"/> FEEL TENSE | <input type="checkbox"/> FINANCIAL PROBLEMS |
| <input type="checkbox"/> NO APPETITE | <input type="checkbox"/> CONSTANT WORRYING | <input type="checkbox"/> LEGAL PROBLEMS |
| <input type="checkbox"/> FATIGUE/LOW ENERGY | <input type="checkbox"/> PANIC ATTACKS | <input type="checkbox"/> MARITAL/FAMILY PROBLEMS |
| <input type="checkbox"/> IRRITABILITY | <input type="checkbox"/> EXCESSIVE FEARS | <input type="checkbox"/> PHYSICAL ABUSE BY PARTNER |
| <input type="checkbox"/> CAN'T MAKE DECISIONS | <input type="checkbox"/> WITHDRAWN | <input type="checkbox"/> EMOTIONAL ABUSE BY PARTNER |
| <input type="checkbox"/> LOW SELF-ESTEEM | <input type="checkbox"/> EXCESSIVE GUILT | <input type="checkbox"/> PHYSICAL ABUSE IN CHILDHOOD |
| <input type="checkbox"/> MOOD SWINGS | <input type="checkbox"/> FLASHBACKS | <input type="checkbox"/> EMOTIONAL ABUSE IN CHILDHOOD |
| <input type="checkbox"/> ANGER PROBLEMS | <input type="checkbox"/> NIGHTMARES | <input type="checkbox"/> SEXUAL ABUSE IN CHILDHOOD |
| <input type="checkbox"/> INCREASED APPETITE | <input type="checkbox"/> HEADACHES | <input type="checkbox"/> RECENT LOSS |
| <input type="checkbox"/> SEXUAL PROBLEMS | <input type="checkbox"/> STOMACH PROBLEMS | <input type="checkbox"/> ABUSING ALCOHOL |
| <input type="checkbox"/> SUICIDAL THOUGHTS | <input type="checkbox"/> HALLUCINATIONS | <input type="checkbox"/> ABUSING DRUGS |
| <input type="checkbox"/> PAST SUICIDE ATTEMPT(S) | <input type="checkbox"/> MEMORY PROBLEMS | <input type="checkbox"/> OVERLY SUSPICIOUS/PARANOID |
| <input type="checkbox"/> OTHER _____ | | |

OFFICE POLICIES

FEES			
Initial Evaluation (60 minutes).....	\$125	Telephone sessions.....	\$25 per 15 minutes
Psychotherapy (45 minutes).....	\$100	Letters or reports.....	\$25 per 15 minutes
Psychotherapy (25 minutes).....	\$65	Group Therapy.....	variable
Missed Session/Late Cancel.....	full fee	Returned check fee.....	\$25
Court Appearance.....	\$500 minimum for the first 3 hours; \$150 per hour thereafter		

1. **Payment:** All fees, co-pays, etc. are due on the date services are rendered. If you should choose to use your insurance, we will file the claim as a courtesy to you. Please be aware that you, not the insurance company, are ultimately responsible for payment of all charges. Please note that there are limits to what information is kept confidential when you use insurance to pay for your treatment. Typical information required by managed care organizations includes dates of treatment, type of treatment, a mental health diagnosis, and may include treatment plans and/or periodic review of client records.
2. **Cancellation Policy:** Your appointment time is reserved for you. If you need to change your appointment, please give at least 24 hours notice; otherwise you will be charged the full fee for the missed session.
3. **Confidentiality:** The information you discuss in therapy is strictly confidential and will not be shared with anyone without your written consent. There are some legal exceptions to this rule, however. Your therapist is legally bound to break confidentiality in cases where the client may be in danger of harming themselves or another person, a client is gravely disabled, there is suspicion of child or elder abuse, and by order of the court. The HIPAA Notice of Privacy Practices and Policies given to you explains in detail the ways in which your protected health information may be used and disclosed.
4. **In Case of Emergency:** If you are experiencing a mental health emergency, you may contact your therapist via emergency pager. In the unlikely event that your therapist does not respond within a reasonable time period (usually within one hour), please call the crisis number that corresponds to the county in which you live or call 911. Chesterfield Crisis: 748-6356; District 19 Crisis (for Hopewell, Petersburg, Colonial Heights): 862-8000.
5. **Collections:** If your account is more than 30 days delinquent and prior arrangements have not been made, Life Enrichment Center of Virginia reserves the right to use legal means to secure payment. The cost of any collection services, up to 33.33% of the amount owed, will be added to your balance. Additionally, these actions will require disclosure of otherwise confidential information to outside collection agencies.

If you have any questions about the above policies, please discuss them with your therapist.

I have read and understand the above policies and agree to abide by the conditions outlined. I have also received a copy of the HIPAA Notice described above.

Signature

Date

PERMISSION TO NOTIFY PRIMARY CARE PHYSICIAN OF TREATMENT

If you would like your therapist to inform your primary care physician (PCP) that you are receiving counseling services, please complete the information below and sign and date the form.

If you would prefer that your PCP NOT be notified, please sign under “DECLINE”.

If you do not have a preference, please sign under “DECLINE”.

Your decision will in no way affect your treatment at the Life Enrichment Center. It is simply a courtesy we offer to our clients to enhance coordination of care.

I hereby GIVE my consent for _____ (therapist’s name) to inform my primary care physician that I am receiving treatment and the reasons for treatment. This release is valid for one year unless noted otherwise. I have the right to revoke this authorization at any time by notifying my therapist in writing. However, my revocation will not be effective to the extent that my therapist has already taken action in reliance on the authorization.

Signature _____ Date _____

Printed Name _____ Date of Birth _____

Primary Care Physician Name _____

OR

I hereby DECLINE my consent for my therapist to inform my primary care physician that I am receiving treatment.

Signature _____ Date _____