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| Contact Information |

Please fill out this form with complete and accurate information. If you have any questions, we would be happy to assist you!

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| --- | --- |
| First Name:      Middle Initial:       Last Name:        | Date of Birth:      |
| **Street Address:** |

|  |  |  |
| --- | --- | --- |
| City:      | State:        | Zip Code:       |
| **Primary Phone Number: (****)****Secondary Phone Number : (****)** | **E-Mail Address:** |
| **Can we leave a message at the above number? [** **[ ]  ] Yes [** **[ ]  ]No** | **Can we leave a message at the above e-mail? [** **[ ]  ] Yes [** **[ ]  ]No** |
| **Social Security Number:** | **Marital Status: [ ] Single [ ] Married/Union [ ] Divorced [ ] Widowed** |

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| [[ ]  ]Employed [ [ ]  ]Retired [[ ]  ]Unemployed [ [ ]  ] Other explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Employer:**  | **Work Number: (** **)** |
| Primary Physician:      | Physician Phone Number: (     )      |
| **Other Care Provider:** | **Contact Number: (****)** |

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| Insurance |

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| Insurance Company:      |
| **Policy Number:** | **Group Number:** |

|  |  |
| --- | --- |
| Name of Insured:      | Relationship to You: [[ ] ]Self [[ ] ]Spouse/Partner [[ ] ]Parent |

|  |
| --- |
| **Insured Employer:** |
| Insured Employer’s Address:      |

|  |  |
| --- | --- |
| Insured Date of Birth:      | Insured Social Security Number:      |

 Pre-Certification Number on the Back of the Insurance Card:      |
|  **SELF-PAY OPTION: [****[ ] ] Check if you would prefer to not utilize insurance benefits and pay for services directly.** |

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| Mental Health and Medical Information |

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| Do you have a diagnosis (or suspected diagnosis) given to you by another professionals? [[ ] ] Yes [[ ] ] No [[ ] ] Uncertain |
| **IF YES: Please list diagnosis….** |

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| IF YES: Who gave you that diagnosis and when?      |

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| Please describe any past mental health treatment:       |
| **Please share family mental health history:** |
| Briefly describe any current medical/physical concerns with self (include recent surgeries):      |

 **List family illness:** |
|  **Please list ALL current medications** |
| **Please fill out symptom survey on the backside, read agreement and sign form.** |

Please check as many of the symptoms you have experienced in the **last 60 days….**

[[ ] ] Depressed Mood [[ ] ] Irritable Mood [[ ] ] Anger /Rage Episodes [[ ] ] Feelings of Worry

[[ ] ] Suicidal Thoughts [[ ] ] Suicidal Attempt [[ ] ] Homicidal Thoughts [[ ] ] Homicidal/Physical Harm

[[ ] ] Hallucinations [[ ] ] Blackouts [[ ] ] Panic Attacks [[ ] ] High Stress

[[ ] ] Night Sweats [[ ] ] Nightmare/Night terrors [[ ] ] Difficulty Falling Asleep [[ ] ] Difficulty Staying Asleep

[[ ] ] Recent Weight Gain [[ ] ] Recent Weight Loss [[ ] ] Increased Appetite [[ ]  ] Decreased Appetite

AGREEMENT FOR TREATMENT:

*First review the Fee Schedule/Payment Policy and the Notice of Privacy and Confidentiality Policies*.

Please read carefully and initial each statement indicating your understanding and agreement to the following:

      I have provided and will continue to provide accurate information to the best of my ability.

      I give permission to Strength Renewed Counseling Services, LLC to administer assessments, treatments and procedures as deemed necessary.

      I have received Privacy Rules and notification of my rights of confidentiality of alcohol and drug abuse records. I

understand that disclosure of information will not be released to others without my signed consent, except in cases of

Emergency or when required by law (child abuse or neglect, imminent danger to yourself or others)

      As authorizing signature, I guarantee to assume sole financial responsibility for services rendered for myself or my minor,

including services not paid for by my verified and assigned insurance within 60 days. In cases of minors of divorced or legally separated parents, payment for services if the responsibility of the parent who schedules the appointment for the child. When legal agreements specify percentages to be paid by each parent, it is the responsibility of the custodial parent to coordinate and provide full payment

      I understand that there is a 24 cancellation policy and that I may be charged for a full-session for appointment. In case of

Emergency or extenuating circumstances I will contact the office with 48 hour to reschedule session and verify why the

Appointment was missed.

      I authorize Strength Renewed Counseling Services, LLC and their staff to release all or any part of my medical records to my insurance company (s) and assign all insurance benefits to be paid to Strength Renewed Counseling that would have been otherwise payable to me.

      I understand that the office phone or fax may be answered by the staff of Indy Counseling Professionals, the adjoining company in the office. If a phone call I can chose to leave a message with them or inform them that I will call back and leave a message on the Strength Renewed Counseling Services Voice Mail.

**I understand and agree the above statements:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/Date:\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/Date: \_\_\_\_\_\_\_\_\_\_\_\_

 Client Signature Parent/Legal Guardian Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Client PRINTED Name Parent/Legal Guardian PRINTED Name

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Witness Signature