Journey Through Counseling LLC
We'll Journey Through Together

Service Intake Information Sheet

Todays date or first appointment
Date: ____________________

Name: _________________________________ Age: _____ Birthdate: _________________

Address____
Street State Zip

Home Number: _______________________ Cell Number: ___________________________

S.S.#________________________________ Gender: ___________________________

Marital Status: __________________ 1st 2nd 3rd 4th Widowed Divorced

Place of Employment: _______________________________ Work #: ________________

Shift: 1st 2nd 3rd Swing Homemaker Unemployed Disabled

Address____
Street State Zip

Emergency Contact Person: ____

Phone Number: ________________________ Relationship: ________________________

Address____

Street State Zip

Referral Source (check one): word of mouth _________ google_________ web site ________

Dr. Referral/ Dr. Name__________________________ other _________________________

Basic Medical Information

Reason(s) for seeking psychological help: ____

____

Name of Primer Care physician:______________________ Date of last exam:_____________________

Current Medications you are taking :____

____

Are you currently under a doctor's care: If yes, explain: _______________________________________

What is causing you stress? ____

Check any of the following that often apply to you:

_____Angry _____Fearful _____Happy _____Hopeful _____Bored _____Optimistic
_____Annoyed _____Panicked _____Conflicted_____Helpless _____Restless _____Tense
_____Sad _____Energetic _____Shameful _____Relaxed _____Lonely _____Shy
_____Envious _____Regretful _____Jealous _____Contented_____Anxious _____Unassertive
_____Guilty _____Hopeless _____Unhappy _____Excited _____Other feelings___________________

Informed Consent & Limits of Confidentiality

I_________________________________ (if the client is a minor, print the minor's name) consent to receive text messages from the practice and/or individual provider at my cell phone and any number forwarded or transferred to that number or emails to receive communication concerning, appointment reminders, feedback, health information, and, basic communication. I understand that this request to receive emails, text messages, and voice messages will apply to all future appointment reminders, feedback, health information, and basic communication unless I request a change in writing.

The **cell phone** number that I authorize to receive the aforementioned correspondence:

Text Reminders: ____

Voice Reminders (if different) ______________________________

The **email** that I authorize to receive email messages ____________________________@___________

The practice does not charge for this service. However, standard text messaging rates may apply as provided in your wireless plan.

Revocation

_____ I herby revoke my request for all future communication via email and/or text message.

_____ I herby revoke my request to receive any future communication via text message.

_____ I herby revoke my request to receive any future communication via email.

Missed/Canceled Appointments

Missed or canceled appointments for which you did not give at least 24-hour notice, **you will be charged $60 for the missed session.** Insurance companies do not pay for missed appointments. After 3 missed appointments your provided may discharge you from services.

By your signature below, you are indicating that **you read and understand this document, Practice and Polices Notice, Client's Rights, and Informed Consent & Limits of Confidentiality**. Any questions you had about these document were answered to your satisfaction and that you were offered a copy.

____ ______________
Minor Child Date

____ ______________
Signature of Client/Custodial Parent or Legal Guardian Date

Todays date or first appointment
Date: ______________________

Name: ___________________________________ Age: _____ Birthdate: ___________________

Address____

Street State Zip

Home Number: _________________________ Cell Number: _____________________________

S.S.#__________________________________ Gender: _____________________________

Marital Status: ____________________ 1st 2nd 3rd 4th Widowed Divorced

Place of Employment: _________________________________ Work #: __________________

Insurance Information

____

Policyholder's name Employer Policyholder's birthdate

____

Insurance Company Policyholder's SS# Policy Number

Responsible Party (if other than client): ____

ASSIGNMENT OF BENEFITS: I request that payment of private insurance and/or government benefits for my treatment be made to Journey Through Counseling LLC.
Signature of client or his/her representative____

CONSENT FOR TREATMENT: I consent that I, or the person whom I represent, receive treatment from Journey Through Counseling, LLC
Signature of client or his/her Representative: ___________________________ Date: __________