

# Inner Reflections Counseling Center, LLC

## COUNSELING INTAKE FORM

CLIENT INFORMATION		
NAME	TODAY'S DATE	
RELATIONSHIP STATUS	DATE OF BIRTH	
AGE	SOCIAL SECURITY NUMBER	
NUMBER OF LEGAL DEPENDENTS (include yourself)	Legal assigned sex at birth:	RACE/ETHNICITY
HOME/MOBILE NUMBER	IS IT OKAY TO LEAVE A MESSAGE FOR YOU AT THIS NUMBER? Y / N	
WORK PHONE	IS IT OKAY TO LEAVE A MESSAGE FOR YOU AT THIS NUMBER? Y / N	
EMAIL:	OKAY TO DISCUSS SCHEDULING VIA EMAIL Y / N OKAY TO SEND RECEIPTS/STATEMENTS VIA EMAIL Y / N	
SPIRITUAL PREFERENCE	Primary Spoken Language: 0 English 0 Other: Secondary Spoke Language: 0 English 0 Other: Primary Written Language: 0 English 0 Other:  Do you require an interpreter Yes   No	
PHYSICAL ADDRESS	CITY:	STATE/ZIP CODE:
MAILING ADDRESS IF DIFFERENT		
OCCUPATIONAL STATUS: F/T P/T SELF-EMPLOYED DISABLED Student		
If text reminder is available, what number would you like appointment reminders/cancelations sent to:		
EMERGENCY CONTACT – Must be filled out		
NAME	PHONE	RELATIONSHIP
My signature below confirms my consent granting Inner Reflections Counseling Center permission to contact the person listed above in the case of a mental health emergency or crisis. I understand this can be updated, changed or revoked at any time in writing.		
Signature _____		
RESPONSIBLE PARTY (IF DIFFERENT THAN CLIENT)		
RESPONSIBLE PARTY NAME	RELATIONSHIP TO CLIENT	
BILLING ADDRESS	CITY/STATE/ZIP	
BILLING PHONE	OKAY TO LEAVE MSG? YES NO	
INSURANCE INFORMATION COPY OF BOTH SIDES OF INSURANCE CARD(S) NEEDED AT INTAKE		
<b>*note – billing insurance is a courtesy separate of financial obligation.</b> If your insurance will not pay, termed or denies for any reason at any point, you are still responsible for services. Please contact your insurance provider for any billing questions. We are not responsible for their decisions or denials. We can only go off explanation of benefits received by your insurance provider, and this can take up to 90 days or more for us to receive.		
INSURED'S NAME	INSURED'S DOB	SSN
INSURED'S EMPLOYER	PRIMARY INSURANCE COMPANY	
GROUP#	ID#	Employer
Secondary Insurance Policy Holder Name and Policy	Secondary Policy Holder's DOB	
Group #	ID#	Employer

# Inner Reflections Counseling Center, LLC

IMPORTANT SIGNATURES FOR TREATMENT AND SERVICES		
Client full name	Date of birth	
<i>If client is a minor, or has a legal guardian, please print the name of the parent/guardian(s) signing on behalf of the client:</i>		
Print full name	Relationship to client	Contact information
Print full name	Relationship to client	Contact information
INSURANCE BILLING		
<p>I authorize INNER REFLECTIONS COUNSELING CENTER, LLC, herein referred to as IRCC, to release any medical information to my insurance company which may be deemed necessary in order to process an insurance claim any information necessary to process claims or superbills, including but not limited to the release of session notes, diagnoses, test results, and treatment plans. I also authorize my therapist to release information to the health plan for a telephonic treatment review, if requested by the plan. I authorize my insurance company to assign benefits to IRCC. I understand that I am responsible for payment for services rendered by IRCC regardless of reimbursement for these services by the insurance company and that any inaccuracy in information I provide may result in nonpayment by my insurance company. I agree to notify IRCC immediately whenever I have changes in my health plan coverage or other changes that may affect my treatment, billing and IRCC's ability to receive or retain payment for services I receive(d).</p>		
Client/Guardian Signature _____		Date _____
ACCOUNT RESPONSIBILITY		
<p>I am responsible for payment to INNER REFLECTIONS COUNSELING CENTER, LLC, herein referred to as IRCC, for all services rendered, due at the time of the visit. I understand that billing insurance is a courtesy, and I am responsible for any balance due including balances due for insurance denial or disallow, including post-payment disallow and that IRCC has no control over what my insurance determines or my insurance's timeliness. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable unless other arrangements have been made in writing ahead of time. If I default on any payment obligations as called for in this agreement, IRCC, reserves the right to forward my information to a professional collection agency and I understand any additional fee or interest that may be assessed by the collection agency is my obligation. There will be no obligation to provide continuing services to any client who names IRCC, as a creditor in any bankruptcy filing or any account that exceeds 90 days past due or a balance past due of greater than \$400. My signature confirms I understand and consent to these terms.</p>		
Client/Guardian Signature _____		Date _____
<p>I understand I am financially responsible for my attendance at all scheduled appointments, unless cancelled with <u>at least</u> 24-hour notice. I understand that charges may be applied to my account for late cancel and no-show. I understand this charge is not covered by insurance and is the financial responsibility of the person receiving services and/or identified responsible party.</p>		
Client/Guardian Signature _____		Date _____
LITIGATION LIMITATION		
<p>Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.) Neither you (client) nor your attorney, nor anyone else acting on your behalf will call on your therapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested. INNER REFLECTIONS COUNSELING CENTER, LLC retains full rights to assess and determine if disclosure is to occur, within legal guidelines.</p>		
Client/guardian signature _____		date _____
CLINICAL STAFF AND CONSULTATION RELEASE		
<p>I understand that as a part of professional clinical care at Inner Reflections Counseling Center, LLC, my situation may be reviewed using general clinical information, and that my therapist will only disclose information with the intent of case consultation, or education for continued access to services, or insurance compliance, which will help better the care received and/or access to behavioral health/substance use services and care.</p>		
Client/Guardian Signature _____		Date _____
INFORMED CONSENT AND NOTICE OF PRIVACY PRACTICES		
<p>I AM CONSENTING TO THE TREATMENT AND HAVE RECEIVED AND UNDERSTAND THE CONTENTS OF THE COUNSELING POLICIES, INCLUDING THE NOTICE OF PRIVACY PRACTICES (HIPPA) AND INFORMED CONSENT.</p>		
<i>My signature below indicates that I have been provided a copy of, and that I fully understand and agree to all of the terms and conditions of the counseling policies and informed consent. If I have questions, the information has been explained and/or summarized for me.</i>		
Signature (client or legal guardian)		Date
Printed name		