DATE _____ Counselors Name _____

Client's Name _____ DOB_____ Age_____

Sex - Male or Female Home Address _____

City_____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Emergency Phone_____

Employer/School #_____ Email Address: _____

Race: Caucasian African-American Asian, Hispanic-American Other _____

Marital Status: Married Single / Cohabiting / Divorced / Widowed /

Name of Spouse or Significant Other _____ Age_____ Years Married _____

Spouse's Age _____ Spouse's Employer _____

# of Children at home _____ # of Boys and Ages_____ # Girls and Ages_____

Children living outside the home _____ # of Boys and Ages_____# Girls and Ages_____

Others living with you _____

Do you attend church? Yes or No If yes, where?_____

Current Concerns

The following are problems or complaints that people frequently have which may apply to you. For each problem please indicate how much that problem has bothered or distressed you during the past seven days, including today.

Please answer each of the following with **None / Some / Moderate / Extreme**

1. Nervousness or shakiness_____ 2. Feeling lonely_____

3. Feeling sad or blue _____ 4. Heart pounding or racing _____

5. Feeling hopeless about the future _____ 6. Feeling everything is an effort _____

7. Spells of terror or panic _____ 8. Feelings of worthlessness _____

9. Feeling no interest in things. _____ 10. Talking Down To yourself _____

In your own words, Why are you coming to counseling **now**?

_____

Please circle "ALL" words, which feel descriptive of your situation:

If you are filling out for a minor please describe their behavior.

Alcohol Abuse (Self/Others) / Anger- Rage / Anxiety / Fear / Worry / Blackouts Blended or Step-Family Issues / Career-Occupational Issues / Depression- Sadness / Divorce Life Adjustments / Divorce Preparation / Drugs Abuse / Eating Disorder/ Weight Loss / Excessive Crying / Excessive Sleeping Family Issues / Fear of Death / Financial Issues / Grief- Mourning or Loss / Guilt-Shame / Hallucinations / Head Injury / Legal Problems / Marriage Problems / Memory Loss / Nightmares / Phobia? _____ Obsessive Or Repetitive Thoughts / Panic Attacks / Parenting Issues / Physical Abuse / Pornography Pre-Marital Issues / Physical Health / Rape or Sexual Abuse / Relationship Problems / School /Grades / Problems with Peers / Self-mutilation / Sexual Addiction / Stress Regulation, Abortion Regret / General

In the past 30 days, to what extent have the problems which led you to seek help interfered with your life and in what way?_____

_____

List any disturbing behavior(s)or thoughts which you have concerns about or feel free to give more info about selections above._____

_____

Are you having trouble with any of the following? **If Yes, how much? Some / Moderate / A Lot**

1. Family life _____ if you care to specify who?_____
2. Social life _____, if you care to specify how?_____
3. Work, schoolwork_____, If you care to specify how?_____
4. Housework _____, if you care to specify how?_____
5. How is your Health and physical well-being **on a 1 to 10 scale?** Physical _____Mental_____

Have you been in physical pain in the past 30 days? If Yes, How Bad? **Please circle one…**

Some / Moderate to Mild / It bothers me but I Am used to It / It Bothers Me A Lot

If you care to specify what type of pain _____

Primary Client Medical Information

Name and location of your Doctor _____

Date of last physical _____ Last visit _____ Reason _____

Current medications_____

Describe any health problems_____

_____

Medical Information (Secondary Client): example spouse parent or child)

Name and address of your Doctor _____

Date of last physical _____ Date of Last visit _____

Reason For Doctors Visist _____

Current Medications_____

Describe any health problems _____

_____

Addiction Assessment Be Honest We Are Here to Help Not Judge! **Circle Yes or No**

1. Have you had a drink in the past 30 days? Yes or No

If "Yes," how many drinks (glasses, bottles, cans and/or shots) a day do you drink? _____

Do you drink caffeine? Cups Per Day____Have you done drugs in the last 30 days? Yes or No

Please be honest about which ones. , Alcohol / Marijuana / Amphetamines / Pain Killers

2. Have you ever used alcohol/drugs or other additives to relieve emotional discomfort such as anger, sadness or boredom? Yes or No If Yes How Often **Some / Often / Dailey**

3. Do you have a history of substance/alcohol abuse causing life or family issues? Yes or No

4. In the past 30 days have you felt the need to reduce your drinking or drug use? Yes or No

Counseling History

Have you ever seen a counselor before? Yes or No _____ Last Visit Date_____

Have you ever been hospitalized for emotional and/or mental health reasons? Is so why and

approximatedates:_____

What Age Did This First Occur: _____ Have you ever attempted suicide? Circle Yes or No

If yes, when and how did you attempt it? _____

This space is reserved for you to tell us anything you would like that you do not feel you were able to express up to this point that may help us help you or the family member you have brought.

_____

_____

_____

_____

How did you hear about us / Referral Name? _____

Insurance Information (Circle Those That Apply) (If you have Insurance Get Out Your Card).

Employee Assistance Program / Medicaid / Private Insurance / No Insurance or Self-payment

Insurance Company Name _____ Policy #_____

Address Shown on Insurance Card_____

Primary Policy Holder Name? _____

Insured's DOB_____/_____/_____ Relationship to client if family member?_____

Employer Name _____City_____

Please Print, Date and Sign Below confirming the information provided is correct to the best of your knowledge. This intake form is not a contract for service. See additional forms at time of first date or service including financial, consent to treat and communication preferences. We may send these to you via email as well if you wish.

Client Name (please print):_____Date: _____

Primary Client Signature: _____**Secondary Client Signature** _____

If under 18 years of age, parent/guardian must sign.) Name of child_____

Counselor Signature: _____ **Date Submitted**_____

WELCOME! We have faith that your experiences at Christian Counseling Center will be worthwhile and beneficial for you and your family. Please read this carefully so that all of your questions regarding our policies can be answered. Please feel free to ask any questions after completing the intake to the best of your ability. **Being Open and Honest is the most important thing in this confidential process.**

NON-DISCRIMINATION POLICY: Christian Counseling Center will not tolerate any discriminatory acts or procedures as defined in Admin. Code 8 CSR 60-3.010 (1): "Discrimination in public accommodations because of race color, religion, national origin, ancestry, sex or handicap is prohibited by law in Missouri." Immediate action will be taken if any such act occurs. I understand and agree with the above Non-Discrimination Policy.

PHYSICAL EXAMINATION: If possible, it is strongly recommended that you be current on your physical examinations from your personal physician. This is important to make sure that none of the problems discussed are the result of physical health difficulties. Because **we are not physicians,** we cannot know if you have a physical condition that might be related to your situation.

TIME OF APPOINTMENTS: Each appointment will last fifty (50) minutes. The session will begin at the time it is scheduled. If the counselor causes a late start, the session will last fifty (50) minutes or be prorated. If you arrive late for your appointment, the session will end at the regularly scheduled time and the charge will be for the full amount of the appointment fee. **You will be billed for the regular cost of an appointment if you cancel with less than a 24-hour notice.** Missed appointments or frequent rescheduling may result in termination of the counseling relationship. In this case, a referral to another mental health professional will be made.

CONFIDENTIALITY: As a client you have the right to confidentiality. Counselors are bound by ethical codes for their profession and under The Privacy Act as pertaining to the laws of the state of Missouri. Information shared with a counselor will only be given to others upon request and with your written consent*. Some limits on maintaining confidentiality are: Duty to warn the proper authorities regarding homicidal or suicidal ideation; Duty to warn of danger to others; Subpoena of records by a court of law; or Laws mandating reporting of child or vulnerable adult abuse.

***An individual of CIT/PLPC status is also allowed to disclose information to his/her supervisor.**

I hereby acknowledge that I have been offered a copy of Mental Health HIPAA Privacy Practices as provided by the Missouri Department of Mental Health. I agree that Christian Counseling Center may contact me in the following ways regarding my appointments… (Please check one or more)

- ☐ Leave messages on my voicemail or answering machine regarding scheduling changes, appointment confirmations, etc.,
- ☐ Send Email regarding scheduling changes, appointment confirmations, etc.,
- ☐ Send Text Messages regarding scheduling changes, appointment confirmations, etc.,
- ☐ or other:_____

Name(please print):_____ Date:_____

Signature:_____

If under 18 years of age, parent/guardian must sign.) Name of child_____

Counselor Signature: _____ Date Reviewed_____

Financial Responsibility

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. Client is responsible for the full fee for service regardless of insurance status. Payment is expected at the end of each session by check or cash except for in the case of pre verified insurance coverage.

COST Per Session Outlined: Initial intake session is One Hundred and Seventy Five Dollars ($175) For individuals, couples or groups, or self pay is just $95. The cost for each additional fifty-minute session is One Hundred and Fifty Dollars ($150.00), or ninety-five Dollars ($95.00) for self-pay clients using cash, credit card, or check. **Telephone Consultation:** At times it may be necessary to speak to your counselor by phone for which there is no charge at the time of service, however when the next counseling session occurs, there will be a charge of Nineteen Dollars ($19.00) per ten-minute period added to your session fee. If no session is scheduled, you will be contacted by our team to collect for telephone sessions after 30 days.

Please Initial The Option That Works Best For You.

Payment Option 1

Cash, Credit or Debit Card, or Checks are accepted. Bounced checks or chargebacks incur a $35 fee and must be paid for before additional sessions will be scheduled. Opt 1_____

Payment Option 2

Full payment is paid by the patient at the time of service. Then a non-assigned insurance claim will be filed for the client, so the client can be reimbursed by the insurance company directly. Opt 2_____

Payment Option 3: Preverified Insurance Coverage

- When insurance benefits are verified prior to treatment then all Applicable deductibles and copayments are due at the time of service only.
- An assigned insurance claim will be electronically filed for the client after each visit..
- Counselors may agree to take any fee reduction set by the insurance carrier ONLY if the counselor has a written agreement with that carrier. If insurance agrees to pay an amount less the counselor is willing to accept, the counselor reserves the right to charge the difference at the time of service or after.
- Any amount not covered by the insurance carrier is due from the client no later than thirty (30) days from receipt of the first statement.
- If full payment is not received within thirty (30) days, a finance charge may be assessed.
- Client is responsible for any cost of collection, including, but not limited to, reasonable attorney's fees.

Opt 3_____

Payment Option 4 (Claim Financial Hardship)

This office uses the U.S. Department of Health and Human Services Poverty Guidelines for assessing financial hardship. Opt 4_____

I have read and understand the above Financial Policy. I have read, understand and agree to the Option indicated above by my initials and the initials of my counselor. I have read the foregoing document, which sets forth the nature of counseling and Confidentiality Policy of Christian Counseling Center. I understand the contents of this document. I have been given an opportunity to ask any questions about the contents of this document and my questions have been answered to my satisfaction or I have no questions. I hereby consent to the contents of the foregoing document and do knowingly and willingly waive the confidentiality of my communication with any counselor associated with Christian Counseling Center under the two exceptional circumstances stated above.

Client Name _____, Signature _____ Date, _____

Counselor Name _____, Signature _____ Date, _____

If under 18 years of age, parents/guardians must sign.) Name of child_____

Permission to Treat, Insurance Assignment, and Permission For Electronic Filing

By my initials and signature below, I agree to participate in counseling services with Christian Counseling Center. I hereby authorize the release of medical information which my counselor, which in his/her sole consideration, deems necessary for the purpose of treatment, payment, or any other pertinent healthcare matter. I agree and hereby authorize and give my permission for electronic filing of my insurance and assign payment of any insurance benefits to Christian Counseling Center. I understand that Christian Counseling Center (CCC) offers counseling from a holistic perspective and embraces the spiritual Christian perspective. The interventions will focus on spiritual, physical, intellectual, emotional and social realms from a Christian worldview.

Initial _____

Confidentiality Policy: I understand that the counselor is a Licensed Professional Counselor. I understand the information given or received as part of the counseling service, including but not limited to names, dates, times, situations causes, histories, diagnosis, treatment, content, conversations, discussions, identifying information which may compromise the identity of an individual seeking counseling, testing, guidance, personal information or other information which by its very nature is confidential, will be considered as confidential information by Christian Counseling Center. However, **the confidentiality of the communication is hereby waived by the counselor when, in the sole absolute discretion of the counselor, information received falls within one or two categories:**

#1 Harm to Self: When the counselor receives information which causes the counselor to believe the client is in a state of mind where the client poses a threat of harm to self, the counselor will take reasonable steps to prevent such harm, including disclosure of information which would otherwise be considered confidential, to appropriate authorities or professionals.

#2 Harm to Others: When the counselor receives information which causes the counselor to believe the client is in a state of mind where the client poses a threat to a person other than the client, or information is given to the counselor causing the counselor to determine that the client poses a threat of harm defined as child abuse or neglect, elder abuse or neglect, or dependent adult abuse or neglect is suspected to a person other than the client, the counselor will take reasonable steps to prevent such harm, including disclosure of information, which would otherwise be considered confidential, to appropriate authorities or professionals.

Initial _____

Patient Name _____, Signature _____ Date, _____

Counselor Name _____, Signature _____ Date, _____

If under 18 years of age, parents/guardians must sign.) Name of child_____

Would you like for us to pray for you? Yes or No