CONFIDENTIAL CLIENT INTAKE
Debbie Devine, LPC

Date: _________________________

CLIENT INFORMATION:

Client Name____ Spouse______________________________

Address to send mail to from Debbie: _________________________________ City________________

ZIP_____________________

Phone: Home ( ) _______-_______________ OK to call/leave message? YES NO

Cell ( ) ______-______________ OK to call/leave message? YES NO

E-Mail: ____ OK for communication? YES NO

Date of Birth: ____/_____/________ Age: ____ Sex: M F

Marital Status: Single Married Divorced Widowed Committed Relationship

Employer: ______________________________ Job Title: ______________________________________

How did you hear about me? ____

MEDICAL DATA: Physician: ____ City_______________

Month/Year of last complete Physical: ____

May I notify your doctor of my findings (Coordination of Care?) YES NO

Are you currently being prescribed medication? YES NO

If yes, please list medications and condition:

____

____

Have you been in counseling before? Yes NO Year______ Therapist's name: ___________________

Please list any substance abuse treatment or inpatient psychiatric hospitalization:

Facility name: ____ Mo/Yr_______________

EMERGENCY CONTACT:

Name____ Relationship:________________________

Phone____

(NOTE: An emergency is defined as medical distress or imminent danger to yourself or someone else)

Please complete both sides of the form

POLICIES and PAYMENT

APPOINTMENTS: Your appointment time is reserved exclusively for you. Appointments cancelled with less than 24 hours notice will be charged to your credit card at the regular session rate:

I authorize Debbie Devine LPC to charge my card for my late cancellations or therapy services:

CARD NUMBER: ____

Expiration date: _____________ TYPE: Visa Mastercard

Name as it appears on card: ____

Signature____

(OPTION: Leave a one time cash payment for which you will be given a receipt. It will be returned to you at termination of therapy if unused.)

Payment for services is due at the time of service and is the responsibility of the client. Due to the wide variety of insurance policies, I cannot guarantee that, should you choose to use insurance, your insurance company will pay. You are ultimately responsible for payment since the services are provided to you and not the insurance company. If you fall behind on payment, I have the right to discontinue services until payment for prior services is received. **INITIAL HERE: _______**

RETURNED CHECKS will be charged a $25 fee.

Debbie Devine, LPC does not testify in court cases. I agree not to involve her in same.

IF USING INSURANCE:
If I choose to file my counseling charges for reimbursement, I authorize the release of any information necessary to process the insurance claims. I understand that my choice to use insurance means that Debbie Devine, LPC may have to release my session content to the insurance company. This becomes part of my Medical Records. I understand that use of insurance for counseling *is NOT ADVISED* by Debbie Devine, as it can be used to ***rate me at a higher risk with future prospective employers or when applying for life or health insurance in the future.***

DUTY TO WARN:
Receiving counseling from a qualified professional is a confidential process. Your identity will not be revealed to ANYONE without your written consent. HOWEVER:
Some courts have held that if a client intends to take harmful or dangerous action against another human being or against him/herself, a therapist has a Duty to Warn the intended victim and/or state/local law enforcement. In cases of suspected child or elder abuse, I am required by law to notify appropriate state agencies.
If you become involved in legal action, a court of law may subpoena my testimony or your records. I will, when expedient, notify you of these actions if they become necessary.

TEXAS NOTICE FORM: All HIPA privacy rights are posted in the waiting room. A paper copy is available on request.

I have read this page of information and agree to abide by the policies and procedures described.

DATE: ______________________

CLIENT SIGNATURE:

____

SIGNATURE OF RESPONSIBLE PARTY, IF DIFFERENT:

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