

# Living Water

## COUNSELING

Date \_\_\_\_\_

Name \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address \_\_\_\_\_

Primary phone: H W C \_\_\_\_\_ Secondary phone H W C \_\_\_\_\_

Email \_\_\_\_\_

(Circle) Single Married Divorced Separated Widowed Male Female

Occupation: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Name of Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**Insurance Information:** Policy # \_\_\_\_\_

Name of Policy Holder (PH): \_\_\_\_\_ Date of Birth -PH: \_\_\_\_\_

PH's Employer: \_\_\_\_\_ PH's Phone #: \_\_\_\_\_

Address of PH if different from above: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient's relationship to policy holder: \_\_\_\_\_

Insurance co: \_\_\_\_\_ Phone # of Insurance Co: \_\_\_\_\_

If I am using insurance to pay for treatment, I hereby authorize Living Water Counseling to release any information necessary to the above listed insurance company for treated and payment. I assign all benefits to which I am entitled to Living Water Counseling. This assignment will remain in

effect until revoked by me in writing. This information disclosed may be subject to re-disclosure by the recipient. A photocopy of this is considered as valid as the original.

I understand that it is my responsibility to know what my outpatient mental health benefits are as described by my insurance policy. Living Water Counseling will contact my insurance company to obtain these benefits as a courtesy only.

I understand that claim payment cannot be guaranteed at the time of service and that my insurance company will make the final determination upon receipt of claims. I agree to pay any legally collectable balance for fees that are incurred but that are not covered by insurance and/or are left unpaid by my insurance company. These fees may include copays, co-insurance, deductibles, missed appointment fees and other service fees.

Name: \_\_\_\_\_

Signature \_\_\_\_\_

**Why are you seeking treatment and what are your goals for treatment?**

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

How severe is the problem? \_\_\_\_\_Mild \_\_\_\_\_Moderate \_\_\_\_\_Severe \_\_\_\_\_Disabling

How long has it been troubling you? \_\_\_\_\_

Have any of your biological relatives ever had problems similar to those you are having? Please describe: \_\_\_\_\_

\_\_\_\_\_

**Please list any previous counseling, hospitalization, and substance abuse treatment:**

Date	Reason
_____	_____

In/Out Patient	Where	Provider
_____	_____	_____

\_\_\_\_\_ I have had no previous psychiatric or psychological treatment.

**Drug/Alcohol Abuse**

Substance	Amount	Route (Oral, inhale, inject)	Frequency	Last used

Have you ever had any medical consequences of alcohol abuse? (blackouts, shakes, DTs, hallucinations, hepatitis, pancreatitis, cirrhosis, seizures, other) If so, please list:

\_\_\_\_\_

Do you drink alcoholic beverages? Is so, what kind and how often?

**Client's Medical History**

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Arthritis    |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Thyroid Disease     | <input type="checkbox"/> Asthma       |
| <input type="checkbox"/> Head Trauma       | <input type="checkbox"/> Suicide Attempts    | <input type="checkbox"/> Other _____  |

**Surgeries/Injuries**

**Dates**

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

**Medications** (List prescriptions and over-the-counter drugs)

Current	Dose	Date of initial Rx	Prescribing MD

In an effort to provide services to as many individuals as possible in an efficient manner, the following conditions must be followed:

- You must give 24 hours notice before canceling an appointment. You will be charged \$20 for appointments that are not cancelled with 24 hours notice.
- I understand that my relationship with Living Water Counseling is protected by confidentiality. I also understand that there are legal limits to confidentiality as in cases of suspected child abuse or when there is a danger to self or others.

- I am NOT a forensic therapist, therefore, I do not do court work. If I am subpoenaed to appear in court on your behalf, I will do so but my fee is \$150/hour with a mandatory retainer of \$300.

I have read and understood the above. I also understand that my treatment at Living Water Counseling is completely voluntary and I consent to treatment under the terms above.

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Signature

Date

### Notice of Information Practices and Privacy Statement

I have read and understand the Notice of Information Practices and Privacy Statement.

Print Name: \_\_\_\_\_

Sign: \_\_\_\_\_

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