LivingWater COUNSELING

Date__________________

Client name _____________________________________Date of birth: _____________

Address ____

Primary phone: H W C ____________________ Secondary phone H W C ___________

Circle: Male Female School attending: _____________________________________

Name of Parent/Guardian : _________________________________

P/G's Phone: ______________________P/G's email: ___________________________

Family Physician: ________________________________ Phone: ________________

Insurance Information: Policy #___________________

Name of Policy Holder (PH): __________________________DOB of 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 Frequency Last used
(Oral, inhale, inject)

____

____

____

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

____ Diabetes
____ Cancer
____ Epilepsy/Seizures
____ Head Trauma
____ Heart Disease
____ Headaches/Migraines
____ Thyroid Disease
____ Suicide Attempts
____ Hypertension
____ Arthritis
____ Asthma
____ 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.

Signature of parent Date