LivingWater
COUNSELING

Date_____

Name _____ Date of birth: _____

Street/City/State/Zip _____

Primary phone: H W C _____ OK to leave messages/texts? Y or N
Secondary phone H W C _____ OK to leave messages/texts? Y or N

Email_____

(Circle) Single Married Divorced Separated Widowed Male Female

Occupation: _____

Name of Employer: _____

Name of Emergency contact:_____ Phone: _____

Family Physician: _____ Phone: _____ Do you want me to tell your doctor that you are receiving treatment from me? Y or N

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

____ Diabetes	____ Heart Disease	____ Hypertension
____ Cancer	____ Headaches/Migraines	____ Arthritis
____ Epilepsy/Seizures	____ Thyroid Disease	____ Asthma
____ Head Trauma	____ Suicide Attempts	____ 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 $50 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 therapists, 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 will write letters if requested. There will be a fee of $50/half hour.**

- **If I refuse to follow recommended medical advice, my therapist may terminate our therapeutic relationship.**

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 Date

(Please refer to our HIPAA Notice on the dropdown link.)

Notice of Information Practices and Privacy Statement

I have read and understand the Notice of Information Practices and Privacy Statement.
(See HIPAA Notice of Privacy Practices in DE statement.)

Print Name: _____

Sign: _____

Date: _____