LOTTS of LOVE
COUNSELING

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Date of intake: _____/______/______

CLIENT INFORMATION SHEET

Name ____ Date of birth _____/_____/_____ Age_____________

Client Social Security #: __________________Sex: Male/ Female Race/Ethnicity (optional) ________________________

Marital Status: Single Married Separated Divorced

Address ____

City/State/Zip ____ Home Phone _________________________________

Email Address____ Cell/Work Phone ____________________________

Occupation _________________________________Employers Name: ____

Name of your Primary Care Physician ____
PCP Phone: ______________________ PCP Fax____

Referred By: (please circle) Physician /Yellow Pages/ Friend/Family Other____________________________

May I contact or leave messages for the client or parent/Legal Guardian at the numbers listed above? Yes / No

If Client is under age 18 Please provide the Name of Parent/Legal Guardian Bringing Child to Appointment:
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Insurance Information

Insurance Company Name: _____________________Phone # for Mental Health Benefits/Services: _________________

Policyholder's Name: ______________________________________ Date of Birth: ____ /____/____ Sex: M / F

Policyholder's Address: ____

Policyholder's SSN: _______________________________________ Marital Status: _________________________________

Member ID Number/Medicaid#: ________________________________ Group/Plan/Policy#_____________________

Authorization for services may be required prior to treatment. Did you obtain authorization for services from your insurance company? Yes / No / Not required Authorization #: ______________________________# of sessions approved ___

Policyholders' Employer (Name & Address) ____
____

Other people living in the home:
Name Age Relationship to Client
____
____
____

Emergency Contact: ____ Relationship__________________________________

Complete Address: ____
Home Phone: ________________________Work Phone: _____________________ Cell Phone: ___________________
Spouse's Name (If not Emergency Contact): ____
Home Phone: _____________________Work Phone: ________________Cell Phone:_________________________

1. Authorization to Release Information to PCP

Communication between behavioral health providers and you're your primary care physician is important to ensure that you receive comprehensive and quality health care. I hereby authorize release of my protected health information related to my evaluation and treatment to my primary care physician. I understand this information my include diagnosis, treatment plan, progress and medication information if necessary. I understand that I may revoke this consent in writing at any time except to the extent that it has been relied upon.

____

Signature of Client/Legal Guardian/Legal Representative

2. Payment and Failed Appointments

I understand that all fees are due at the time of service. In other words, the full fee must be paid at the end of each session. The only exception to this is when insurance is being filed on my behalf; only the portion of the fee which the insurance is not expected to pay is due at the time of service, provided that all deductibles have been met.

I understand that Lotts of Love Counseling, LLC. has a 24 hour cancellation policy and I will be billed $50.00 for my missed appointment unless otherwise discussed with my therapist. I understand there will be a $35.00 service charge for all returned checks and that all additional collection expenses are my financial responsibility if the amount of the returned check plus $35.00 is not paid in cash within 30 days. **Outstanding accounts will be forwarded to a collection agency. I understand these charges are not reimbursable by my insurance and Lotts of Love Counseling, LLC. does accept some private insurances, cash, major credit-debit cards and checks.** I realize that my insurance policy is an agreement between me and my insurance company- not Lotts of Love Counseling, LLC. I take responsibility for all fees resulting from my treatment. I agree to pay any portion of the fee within 60 days and any collection costs encumbered should payment not be made promptly.

____
Signature of Client/Legal Guardian/Legal Representative

3. Client Rights and Responsibilities

Any person receiving services is entitled to:

1. Mental Health/Chemical Dependency services in accordance with standards of professional practice, appropriate to his/her needs and designed to give him/her a reasonable opportunity to improve his/her condition.
2. Humane care, protection from harm, and to be treated with dignity and respect.
3. The right to participate in the development and review of his/her treatment plan, including the known effects of receiving and not receiving such treatment, or alternative treatment, if any.
4. The right to receive treatment in the least restrictive settings.
5. The right to review his/her own record in the presence of the primary therapist, unless the primary therapist's professional judgment deems this to be potentially detrimental to the person.
6. The right to confidential maintenance of all his/her identifying treatment information; no disclosure of such information without his/her written authorization, except in cases of medical emergency, by court order, or when otherwise dictated by law.
7. The right to register complaints and to have his/her complaints heard and action taken, if required promptly.
8. The right to waive any of his/her rights, if the waiver is given voluntarily, knowingly, and in a competent state of mind. The waiver may be withdrawn at any time.

____ ________________________
Signature of Client/Legal Guardian/Legal Representative Date

4. Consent for Treatment Authorization

I authorize and request my therapist to carry out psychosocial assessments, treatment and/or diagnostic procedures that now, or during the course of my treatment become, advisable. I understand the purpose of these procedures will be explained to me upon request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my therapist can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that reactions will be worked on between my therapist and me. With these understandings, I hereby authorize treatment for myself. I give permission to The Wives Inc.-Natasha LaMarr to assist me in developing my treatment plan and provide treatment. In the event that I become ill or I am injured while on the premises, I authorize Lotts of Love Counseling, LLC Tracey Roberson to provide or obtain emergency medical services (i.e. call an ambulance).

____ ___________________________

Signature of Client/Legal Guardian/Legal Representative Date

5. Consumer Consent for Use/Disclosure of Health Care Information

I understand that the consumer's health information is private and confidential. I understand that Lotts of Love Counseling, LLC Tracey Roberson works very hard to protect the consumer's privacy and preserve the confidentiality of the consumer's personal health information. In general, there will be no uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. Examples would be if a consumer threatened to hurt someone of if child abuse is reported.

____ ________________________

Signature of Consumer/Legal Guardian/Legal Representative Date

6. Business Policies and Procedures and Notice of Privacy Policies.

Your signature below acknowledges that you have been given a copy of Lotts of Love Counseling, LLC. Informed Consent, Business Policies and Procedures and a Notice of Privacy Policies. It also acknowledges that you understand these policies.

____ _______________________________

Signature of Consumer/Legal Guardian/Legal Representative Date