

Integrity Counseling & Coaching
CLIENT INFORMATION FORM

NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____ ZIP: _____

HOME # _____ WORK #: _____ CELL #: _____

MAY WE LEAVE DISCREET MESSAGES AS NEEDED AT ABOVE LISTED NUMBERS? YES _____ NO _____

EMAIL ADDRESS: _____ MAY WE CONTACT YOU AT THIS ADDRESS? YES ___ NO ___

SOCIAL SECURITY NUMBER: _____ DOB: _____ AGE: _____

NAME AND NUMBER OF EMERGENCY CONTACT PERSON: _____

HOW DID YOU HEAR ABOUT INTEGRITY COUNSELING? _____

BRIEFLY DESCRIBE THE ISSUES/PROBLEMS THAT LED YOU TO SEEK THERAPY TODAY: _____

WHAT GOALS WOULD YOU LIKE TO ACHIEVE IN THERAPY? _____

DESCRIBE ANY HEALTH PROBLEMS, MEDICAL CONDITIONS, OR RECENT OPERATIONS:

ALLERGIES: _____

LIST ALL MEDICATIONS YOU ARE TAKING: _____

LIST YOUR PHYSICIAN(S) NAME(S): _____

LIST ANY PAST PSYCHOLOGICAL/PSYCHIATRIC/ COUNSELING/TREATMENT YOU HAVE HAD:

HOW OFTEN DO YOU DRINK ALCOHOL? _____ IS THERE ALCOHOLISM IN YOUR FAMILY?

WHAT ILLICIT DRUGS HAVE YOU USED? _____

DO YOU BELIEVE YOU HAVE, OR HAD AT ANY TIME IN THE PAST, A PROBLEM WITH ALCOHOL OR DRUGS? _____
EXPLAIN: _____

IS THERE ANYTHING ELSE WE SHOULD KNOW? _____

PLEASE READ AND SIGN THE REVERSE SIDE OF THIS FORM

Integrity Counseling & Coaching

FINANCIAL POLICY

Full payment is due at time of service (unless prior arrangements have been made).

Please feel free to ask if you have any questions about our financial policy. Understanding our financial policy is important to our relationship. Insurance is a contract between you and your insurance company. We will file your claim to your insurance company or provide you with the proper information needed for you to file a claim. You are responsible for the timely payment of your Account. We will send information, including clinical information i.e. diagnosis, to your insurance company unless you specifically instruct us not to do so. We will send information electronically, so please read the HIPPA notice.

Uncollected balances may be turned over for collection or reported to the state attorney's office.

CANCELLATION POLICY

Please help us to serve you and others better by keeping your scheduled appointments. If you need to cancel or reschedule, please give us as much notice as possible so we can offer that time to someone else.

Unless cancelled **at least 24 hours in advance**, our policy is to charge for missed appointments at the rate of a normal counseling session. This will be billed to you. We may require prepayment in order to schedule a subsequent appointment

CONFIDENTIALITY

Federal and State laws protect your confidentiality (See 42 U.S.C. 290dd-3 and 290ee-3 for Federal laws and 42 CFR Part 2, 491.0147 FL). Your counselor will not share information with any person outside of Integrity Counseling, Inc. without your written permission, except as required by law or as needed to file your insurance claim. Information obtained from minors is not generally shared with parents without permission.

Exceptions to Confidentiality: Federal regulations do not protect from disclosure of information related to a client's involvement in a crime against property or personnel. We are required under State law to report suspected abuse of a child, elderly person, or individual with a disability. We may share limited information in the event of a medical emergency or in the event of a specialized court order signed by a judge. Your counselor has the option of breaching confidentiality if you report a specific plan or intent to cause serious bodily harm to an identifiable person.

HIPAA (Health Insurance Portability and Accountability Act) laws allow you access to your file and protect the electronic transfer of information.

CONSENT TO TREATMENT

I am voluntarily seeking outpatient counseling at Integrity Counseling & Coaching. I understand that I have rights and responsibilities regarding my participation in treatment, including the right to discontinue therapy. I am strongly encouraged to discuss my treatment plan and status in treatment with my counselor. Counselors will also discuss alternatives, procedures, qualifications, and drawbacks to therapy. **With my signature below, I acknowledge that I have read, understand, and agree to all of the above. I also acknowledge that I have been given a copy of HIPAA/Privacy Practices implemented here at Integrity.**

Counseling sessions are intended to be 45-50 minutes in length.

Please note: We do not provide emergency services. In true crisis call 911.

Date: _____

Signature of Client and/or Legal Guardian