CentrePointe Counseling
P.O. Box 339
Ashton, MD 20861
800.491.5369 • Fax: 301-774-3678

Office Use Only – Counselors please complete before submitting new Intakes.
Paypal ID_____ **Initial Interview Date**_____
Location _____ **Association**_____
Counselor_____ **Fee/Insurance**_____

INTAKE FORM

Please print and give complete information

Client Name_____ Male/Female_____ Race_____
Date of Birth_____ Current Age_____Social Security Number_____
Parent(s)/Guardian (if under 18 years of age)_____
Street Address_____
City_____State_____ Zip Code_____
County of Residence_____
Home Telephone_____Work Telephone_____Other (specify)_____
May a telephone message be left for you at these numbers? □ Yes □ No _____

Please indicate any restrictions for leaving messages_____

Current Marital Status:

□ Single □ Engaged □ Married □ Remarried □ Separated □ Divorced □ Widowed □ Living w/Significant Other

Spouse's Name:_____

Would you like to receive our newsletter via email? __Yes __No Email Address:_____

People Living in the Home - Male	Age	People Living in the Home - Female	Age

Spiritual: Religious Denomination/Affiliation_____Church Attending_____

Referral: How did you learn about CentrePointe? _Clergy _Family _Friend _CP Website/Online Search
__Physician __Other (BCMD/Church/CP Counselor/Insurance/Phonebook) _____
Name of referring person/agency/church _____

Education: (circle highest grade completed) 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 20+
Degree/Major_____School (if currently a student)_____

Insurance: I will use insurance Yes No Policy Number: _____
Company _____Claims Telephone Number _____
Type of plan PPO HMO POS Policy Holder _____

(note: if client is a minor, please complete the following employment information for parents'/guardians' employment)
Employer/Company _____Job Title_____Gross Salary _____
Street Address _____City _____State _____Zip Code _____
Spouse's Employer _____Job Title_____Gross Salary _____
Street Address _____City _____State _____Zip Code _____

Medical and Mental Health Information

Primary Physician_____Telephone_____
Street Address _____City _____State_____Zip Code_____

Please list any current medical conditions and treatments (including prescription, over-the counter, herbal, etc.)

Medical Condition/Concern	Medication/Treatment	Dosage/Frequency

Are you currently seeing a psychiatrist, psychologist, or other counselor/therapist? Yes No

Name _____Telephone_____
Street Address _____City _____State_____Zip Code_____
Have you ever received psychological services before? Yes No

When? From/To	Clinician/Therapist/Agency	Reason for Treatment	Results

Have you ever taken medications for emotional or psychological problems? Yes No

When?	Prescribing Physician	What Medication?	For What?	Results

Please indicate the frequency and amount that you currently consume:

	How much?	How often?			
Caffeine			Recent Increase	Recent Decrease	Past Use
Alcohol			Recent Increase	Recent Decrease	Past Use
Tobacco			Recent Increase	Recent Decrease	Past Use
Marijuana			Recent Increase	Recent Decrease	Past Use
Pornography			Recent Increase	Recent Decrease	Past Use

What is happening in your life that resulted in this appointment? Briefly summarize issues you wish to discuss.

_____

_____

_____

_____

CentrePointe Counseling

Professional Disclosure Statement & Consent for Treatment

Counselor Professional Education & Certifications

Details are listed on the agency website www.centrepointecounseling.org and on business cards. Licenses for staff are displayed in counseling offices when possible and are on file in the central office.

Fees

The professional counseling fee for individuals, families, and couples is $125 per 45-minute session, **except for the first session which is $155.** The professional counseling fee for group therapy is $60 per 90- minute session. Fee_____

Payment

Clients are expected to make payment at the beginning of each session—including the initial session. Please make **checks payable to CentrePointe.** There is a **$10** service charge for returned checks. When insurance is used, copayments are expected at the time of service and clients are responsible for any unreimbursed portion of the fee as contractually allowed. Credit card payments can be made at www.centrepointecounseling.org by clicking on "make a payment." Payment should be made online before the therapy session occurs.

Cancellation Policy

Your counselor has reserved time specifically for you for each session. Therefore, it is necessary to charge your established fee for sessions that are not canceled **at least 24 hours in advance of your appointment. To cancel appointments,** please call your counselor at 800.491.5369 and leave a message on the 24-hour answering machine. Per federal law, Medicaid clients are not charged. For all clients, frequent absences may result in discharge because therapy cannot be effectively provided with inconsistent attendance.

This information is required by the Board of Social Work Examiners & the Board of Examiners of Professional Counselors which regulate all licensed clinical social workers & professional counselors. The Board addresses and phone numbers are:

Maryland Social Work Board of Examiners, 4201 Patterson Avenue, Baltimore, MD 21215-2299, 410-764-4788.
Maryland State Board of Examiners of Professional Counselors and Marriage and Family Therapists, 4201 Patterson Avenue, Baltimore, MD 21215-2299, 410-764-4732.
Virginia Board of Counseling, 9960 Maryland Drive, Suite 300, Henrico, VA 23233-1463, 804-367-4610.
Virginia Board of Social Work, 9960 Maryland Drive, Suite 300, Henrico, VA 23233-1463, 804-367-4441.

Counseling

Counseling is a confidential relationship between you and your counselor. Your counselor promises to have been trained as a professional, to reserve a specific time for you each week or as arranged, to plan for each session, to actively listen, and to give constructive feedback.

You are asked to attend each session, to spend the time between sessions reflecting upon or trying out that which emerged in each session, and to talk in each session about the issues and experiences which are bothering you.

Office Policies and Procedures

Confidentiality

You are entitled to confidentiality in the counseling relationship. However, this is limited by law. All mental health professionals are required by law to suspend confidentiality if there is a clear indication that a client may injure self or others. Mental health professionals must also report any physical/sexual abuse and/or neglect of any person under 18 years of age, the elderly, or impaired. If other confidential information is requested for release, you will be asked to sign a release of information form.

Prescription Drugs

You agree to inform your counselor if you are taking any medication(s), prescription or other, and the dosage. If you are taking medication prescribed by a physician, you agree to take the recommended dosage as prescribed. If there is a problem with any prescribed medication or dosage, you are to return to your physician immediately for assessment.

Alcohol and Substance Use and Abuse

If one of your issues is substance abuse, you are to remain alcohol and drug free. You must not come to a session while intoxicated. Doing so will cause the session to be terminated with full fee payable.

Emergencies or Crises

If you are experiencing an emergency or crisis, you are directed to call 911 or go to your nearest emergency room. You may then request the hospital staff to contact your counselor.

Court Appearance Requests

Counselors do not appear in court unless ordered to testify by a judge.

Emails & Phone Calls to Your Counselor

Only use email to contact your counselor for routine, non-emergent questions, records requests, or non- clinical matters. All email communication is included in your medical chart and can become part of the legal document. Allow 72 hours for the counselor to respond to your request. You may notify the office if no response is received in 72 hours. For telephone for other than a brief check-in, an over-the-phone session may be arranged— usually during normal office hours and will be charged at the regular rate. Please do not contact the church or association office where you come for therapy. Staff members at the churches do not work for CentrePointe, and it is a confidentiality violation for them to become involved.

Informed Consent for Therapy & HIPAA Notice of Privacy Practices

Having understood the nature and risks of therapy, the alternatives to treatment, the qualifications and values of the counselor, the nature of the fees and policies regarding cancellations, the limits to confidentiality, the right to terminate therapy, and the right to voice a grievance, I consent to treatment with this counselor and CentrePointe Counseling, Inc. I have read and understand the information contained in this document. **I have received a copy of the HIPAA notice of privacy practices.**

Client Signature (or parent/guardian of minor) _____

Date _____

Insurance Reimbursement

I give my counselor and CentrePointe Counseling, Inc. permission to submit claims to my insurance company for reimbursement. I understand my responsibility for payment if insurance does not cover.

Client Signature _____

Consent to Use or Disclose Information for Treatment, Payment, and Health-Care Operations (TPO)

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities (known as *health-care operations*). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more details. You have the right to review the Notice of privacy practices before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, the revised Notice will be posted in the office. You may ask for a printed copy of our notice at any time. You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health-care operations. However, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding. You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation. This consent is voluntary. You may refuse to sign it. However, we are permitted to refuse to provide health-care services if this consent is not granted or if the consent is later revoked.

I hereby consent to the use/ disclosure of my Protected Health Information as specified above.

Client/Patient Name _____

Client (or parent) Signature _____

Date: _____

Email Communication

I agree to allow my counselor and the office staff to contact me via email. I understand that a notice of confidentiality will be attached to all email communications from this office. I understand that this authorization may be revoked by me at any time in writing.

Client (or parent) Signature_____
Date: _____
Yes, you can contact me by email. If so, provide your email address: _____

Guardianship-Please complete if the counseling client is a minor (under age 16)

As parent, guardian, or legal custodian, I (we) give permission for counseling by _____(counselor) and CentrePointe Counseling, Inc. for_____(client). I (we) understand that the above named counselor is providing professional services to and on behalf of the above named client. I (we) agree to assume full responsibility for payment of all reasonable charges by the above-named counselor and CentrePointe.

Date_____

Signature(s)_____

Please print name(s)_____

Address_____

Home Telephone_____

Relationship to Client_____

Voluntary Waiver of HMO/Insurance Benefits

(THIS FORM IS ONLY USED IF YOU ARE NOT USING INSURANCE FOR PAYMENT)

Signing this document will alter your legal rights under Maryland law. Please read carefully and do not sign unless you understand the document. I (*client)* _____am seeking medical treatment from _____(*therapist*).

Check One:

_____ 1. I am not a member of Health Maintenance Organization (HMO) and do not have private health insurance coverage (PPO, POS, etc.) and will be responsible for the payment of any amounts owed to *my therapist* for services provided.

_____2. I am a member of an HMO, but I have been informed that my therapist is not a participating provider with that HMO and that if my therapist provides services to me, I will be billed at my therapist's usual rate and I, instead of my HMO, will be responsible for full payment of that bill. I understand that if, instead of receiving treatment from my therapist, I had elected to obtain treatment from a health care provider participating in my HMO and the HMO determined that the service was covered under my benefit pan, I would be entitled to have this service reimbursed as set forth in that plan. Therefore, this means that I will be solely responsible for my therapist's charges. My therapist will not seek payment from my HMO.

_____3. I have private health insurance, but I have been informed that my therapist is not a participating provider with that insurance plan and that if my therapist provides services to me, I will be billed at my therapist's usual rate and I will be responsible for full payment of that bill. I understand that if, instead of receiving treatment from my therapist, I had elected to obtain treatment from a health care provider participating in my plan and the plan determined that the service was covered under my benefit pan, I would be entitled to have this service reimbursed as set forth in that plan. Therefore, this means that I will be fully responsible for my therapist's charges. My therapist will not seek payment from my insurance company. I can seek out-of-network reimbursement and the therapist will provide a receipt for me to attempt this. I understand that there is no guarantee that out-of-network reimbursement can be obtained for these therapy services.

_____4. I am using my EAP or Minister's Counseling Service (MCS) to pay for counseling sessions and therefore insurance will not be billed.

The undersigned agree that they are, at their request, choosing not to use their health insurance for coverage of fees with a CentrePointe counselor and will be fully and solely responsible for the charges incurred.

Client Signature_____**Date** _____

Counselor Signature_____**Date**_____