



CLIENT INTAKE GROUP FROM

Name: _____ Date: _____

Address:

City _____ State _____ APT# _____
ZIP _____

May we leave a message? Yes No

Home: _____ Cell: _____ Work: _____

E-Mail: _____

How did you learn of our services (circle all that apply)?

Friend/Family Member

Workshop/Presentation

Web Site

Other (specify)

Date of Birth: _____ Gender: F M

Ethnicity: _____

What brings you here?

Please check the number that tells us how urgent your concern(s) are:

1 2 3 4 5 6 7

Not at all urgent-Extremely urgent

Treatment and Medical History

Are you currently receiving, or have you previously received services from a Counselor/Mental Health Professional for this reason?

If yes, please list provider name and date last seen

Did you find this helpful? Yes No

Do you have health Insurance? Yes No

Name of Insurance Company: _____

Name of Insured _____

Policy# _____

Group# _____

Phone# _____



Wholistic Mental Health Offices

Disclosure

This office operates as an independent private practice within a group setting. It is understood that any agreements are made between you and the treating provider only. The other therapists in the suite operate independent practices and are not responsible for your care. We also cannot be responsible for the care provided by professionals or groups that we refer you to.

Referrals-

Referrals to other health care providers are given with the intent to expand/support your mental health well being. It is your responsibility to ensure the health care providers are a good fit for you or your family. This office is not responsible for suggestions, recommendations or care given by other health care providers.

Supplements/Nutrition-

Any recommendations of supplements or vitamins are only a suggestion and you should always consult with your primary physician for recommendations based on your medical history. Wholistic Mental Health Offices therefore is not responsible for your consumption of vitamins and supplements without a physician's approval.

Exercise/Lifestyle Changes-

Any recommendations of physical exercise or lifestyle changes are only a suggestion and you should always consult with your primary physician for recommendations based on your medical history before starting any exercise routine. Wholistic Mental Health Offices therefore is not responsible for your physical or health condition resulting from any exercise or lifestyle changes without a physician's approval.

By signing this disclosure I am agreeing and understand my responsibility for my health.

Client Signature _____

Date _____

Counselor Signature _____

Date _____



Treatment Agreement Credit Card and Payment Authorization Form

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.

I, _____, authorize Wholistic Mental Health Offices to render services to me as Licensed Professional Counselors and I agree to pay for those services as follows:

Please initial:

_____ Pre Pay charges for reservation for groups in the amount of \$_____ per visit.

_____ Payments will be rendered (ahead of time) by: Check Credit Card Cash

_____ By initialing this line I understand and agree that I will be responsible for groups missed or cancelled **without 24-hour** notice and my credit card will be charged in the amount of \$25. (Unless emergency situation)

_____ I give Wholistic Mental Health Offices permission to bill my insurance company for groups attended in their office.

_____ I agree to pay the co-pay and/or coinsurance and the difference between what the insurance will pay and the amount charged for services if out-of-network.

_____ I understand and agree that I am financially responsible for all groups attended.

_____ I understand that if the unpaid balance after the out-of-network insurance company has processed the claim becomes 30 days past due that the credit card on file will be charged without further notice.

_____ I understand this form is valid until client or provider amend it and the amended one is signed.

_____ **I understand and agree that my card will be charged for balances of charges not paid by me or my insurance (such as deductibles and co-pays).**

_____ I understand this form is valid until I cancel the authorization in writing.

_____ I will not dispute charges ("charge back") for groups I have attended or reserved and missed according to the above policy.

Charges will appear on your credit card statement as "Wholistic Mental Health Offices"

Please Circle One Visa MasterCard Debit Card

Card # _____

Expiration Date: _____ Verification/security code: _____

Name as printed on card: _____

Billing Address (Street, City, State, & Zip): _____

Print Name: _____

Signature: _____