**Balance Counseling**

9409 Hull Street Road · Suite D1 · North Chesterfield, Virginia 23236

Phone: (804)745.2225 · Fax: (804) 745-2242

www.mybalancecounseling.com

[LTW@mybalancecounseling.com](mailto:LTW@mybalancecounseling.com%20)

**ADULT INTAKE**

Appointment Date/Time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_

FIRST MIDDLE INITIAL LAST

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_ Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is it okay to email you? Y N

How did you hear about us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: S M Sep D W Education level \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place of Employment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to you \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAYMENT INFORMATION: Who will be responsible for payment of this account?**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CANNOT SIGN FOR SOMEONE ELSE

**INSURANCE INFORMATION**

I authorize medical payments from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to clinician for services rendered.

NAME OF INSURANCE COMPANY

Name of Policy Holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer of Policy Holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Co-pay amount \_$\_\_\_\_\_\_\_\_\_\_\_

Is there a Secondary Insurance Policy?  YES  NO

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_ INITIAL HERE IF YOU DO NOT WISH TO USE INSURANCE**

**HEALTH INFORMATION**

Current Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Current or past illnesses, injuries, health problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous treatment (i.e. therapy, hospitalizations, drug/alcohol rehab., etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Describe why you are seeking counseling and what you hope to get out of it (i.e. therapy goals): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please place a check by any symptoms or issues you are currently experiencing:

\_\_\_\_\_ DEPRESSION \_\_\_\_\_ ANXIETY \_\_\_\_\_ SCHOOL/WORK PROBLEMS

\_\_\_\_\_ INSOMNIA \_\_\_\_\_ FEEL TENSE \_\_\_\_\_ FINANCIAL PROBLEMS

\_\_\_\_\_ NO APPETITE \_\_\_\_\_ CONSTANT WORRYING \_\_\_\_\_ LEGAL PROBLEMS

\_\_\_\_\_ INCREASED APPETITE \_\_\_\_\_ PANIC ATTACKS \_\_\_\_\_ MARITAL/FAMILY PROBLEMS

\_\_\_\_\_ FATIGUE/LOW ENERGY \_\_\_\_\_ EXCESSIVE FEARS \_\_\_\_\_ EMOTIONAL ABUSE BY PARTNER

\_\_\_\_\_ IRRITABILITY \_\_\_\_\_ WITHDRAWN \_\_\_\_\_ PHYSICAL OR SEXUAL PARTNER VIOLENCE

\_\_\_\_\_ CAN’T MAKE DECISIONS \_\_\_\_\_ EXCESSIVE GUILT \_\_\_\_\_ EMOTIONAL ABUSE IN CHILDHOOD

\_\_\_\_\_ LOW SELF-ESTEEM \_\_\_\_\_ FLASHBACKS \_\_\_\_\_ PHYSICAL ABUSE IN CHILDHOOD

\_\_\_\_\_ MOOD SWINGS \_\_\_\_\_ NIGHTMARES \_\_\_\_\_ SEXUAL ABUSE IN CHILDHOOD

\_\_\_\_\_ ANGER PROBLEMS \_\_\_\_\_ HEADACHES \_\_\_\_\_ RECENT LOSS/GRIEF

\_\_\_\_\_ SEXUAL PROBLEMS \_\_\_\_\_ STOMACH PROBLEMS \_\_\_\_\_ ABUSING ALCOHOL

\_\_\_\_\_ SUICIDAL THOUGHTS \_\_\_\_\_ HALLUCINATIONS \_\_\_\_\_ ABUSING DRUGS

\_\_\_\_\_ PAST SUICIDE ATTEMPT(S) \_\_\_\_\_ MEMORY PROBLEM \_\_\_\_\_ OVERLY SUSPICIOUS/PARANOID

**POLICIES**

**FEES**

Initial Evaluation (60 minutes)………..$150 Letters or Reports..…….….…….$25 per 15 minutes

Psychotherapy (55 minutes)……...…..$125 Returned Check Fee……………….……………...…..$25

Telephone Sessions…...……...$31.25 per 15 minutes

**\*\*\*Missed Session/Late Cancellation…...........Full Fee\*\*\***

\_\_\_\_\_ **Payment:** All fees, co-pays, etc. are due on the date services are rendered before your session

begins. If you choose to use insurance, the therapist will file a claim as a courtesy to you. Please be aware that you, not the insurance company, are ultimately responsible for payment of all charges. There are limits to what information is kept confidential when you use insurance to pay for your treatment. Typical information required by managed care organizations includes dates of treatment, type of treatment, mental health diagnosis, treatment plans, and periodic review of client records.

\_\_\_\_\_ **Cancellation Policy:** Your appointment time is reserved for you. If you arrive at your session late, the

session will end at the regular scheduled time and you will be charged for the full session. If you need to cancel or reschedule, you must providenotice **at least one full business day in advance**; otherwise you will be charged the full fee for the missed session/late cancellation.

Please note: Insurance companies do not cover Missed Session/Late Cancellation Fees.

\_\_\_\_\_ **Confidentiality:** The information you discuss in therapy is strictly confidential and will not be shared

with anyone without your written consent. There are some legal exceptions to this rule, however. Your therapist is legally bound to break confidentiality in cases where the client may be in danger of harming themselves or another person, a client is gravely disabled, there is suspicion of child or elder abuse, and by order of the court. The HIPAA Notice of Privacy Practices and Policies given to you explains in detail the ways in which your protected health information may be used and disclosed.

\_\_\_\_\_ **In Case of Emergency:** If you are experiencing a mental health emergency, you may contact your

therapist via emergency cell phone number. In the unlikely event that your therapist does not respond within a reasonable time period (usually within one hour), please call the crisis number that corresponds to the county in which you live or call 911.

\_\_\_\_\_ **Collections:** If your account is more than 30 days delinquent and arrangements have not been

made, your therapist reserves the right to use legal means to secure payment. The cost of collection

services, up to 33.33% of the amount owed, will be added to your balance. Please be aware that

these actions will require disclosure of confidential information to outside collection agencies.

If you have any questions about the above policies, please discuss them with your therapist.

**I have read and understand the above policies and agree to abide by all conditions outlined.**

**I have received a copy of the HIPAA Notice described above.**

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERMISSION TO NOTIFY PRIMARY CARE PHYSICIAN AND/OR PSYCHIATRIST OF TREATMENT**

If you would like your therapist to inform your Primary Care Physician (PCP) and/or Psychiatrist that you are receiving counseling services, please complete the information below and sign and date the form.

If you would prefer that your PCP and/or Psychiatrist NOT be notified, please sign under “DECLINE”.

If you do not have a preference, please sign under “DECLINE”.

Your decision will in no way affect your treatment by the therapist. This option is offered as a courtesy to you to enhance coordination of care.

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I hereby GIVE my consent for LICIA THOMAS-WAGONER, LCSW (BALANCE COUNSELING, LLC) to inform my Primary Care Physician and/or Psychiatrist that I am receiving treatment and the reasons for treatment. This release is valid for one year unless otherwise noted. I have the right to revoke this authorization at any time by notifying my therapist in writing. However, my revocation will not be effective to the extent that my therapist has already taken action in reliance on the authorization.

PCP Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychiatrist Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**-------------------------------------------------------------------------------------------------------------------------------------------**

**OR**

**-------------------------------------------------------------------------------------------------------------------------------------------**

I hereby DECLINE consent for my therapist to inform my Primary Care Physician and/or Psychiatrist that I am receiving treatment.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Disclaimer**

I understand and acknowledge that LICIA THOMAS-WAGONER, LCSW (BALANCE COUNSELING, LLC) operates independently and is not an employee of the Life Enrichment Center of Virginia, PLLC.  No services are being provided to me by Life Enrichment Center of Virginia, PLLC, which is not responsible or liable for services provided or actions taken by LICIA THOMAS-WAGONER, LCSW (BALANCE COUNSELING, LLC) while using the space and resources provided by Life Enrichment Center of Virginia, PLLC.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

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**Authorization for Credit Card Charges**

For your convenience, your credit card information will be securely on file with Balance Counseling. In providing your credit card information, you are giving Balance Counseling permission to automatically charge your credit card on file for your (or any other patient(s) you have listed on this form) co-pays/co-insurance, outstanding balances, services, and/or other products.

**Co-Pays/Co-Insurance:** Co-pays and co-insurances are due at the time of the office visit. You may still choose to make your payment by cash, check, or a card different from the credit card on file.

**Outstanding Balance:** If your insurance provider has paid their portion of your bill (or any other patient(s) you have listed on this form) and there is still an outstanding balance owed, Balance Counseling will notify you via email, phone, and/or mail. If the balance remaining is not paid in full within 5 days of the notice, at that time, any balance owed will be charged to your credit card. A copy of the charge will be mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company’s determination of payment. Missed appointments, late cancellations, and other non-insurance-billable fees will be charged at the time of the missed appointment, late cancellation, or fee assessment. A receipt will be mailed to you.

**Services and Products:** Self-Pay services and other fees are due at the time of the office visit.

This card will only be authorized for the use of the credit card holder or any person(s) listed below by the credit card holder. **This agreement will expire upon termination of services and settlement of final balance.** The card holder may also revoke this consent at any time in writing while understanding that continued services may not be available if an unpaid balance accrues.

**All Information Must Be Completely Filled In Below:**

Account Type: Visa MasterCard

Credit Card Holder’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

(Please print)

Credit Card Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Zip Code \_\_\_\_\_\_\_\_\_\_\_\_ CVV# (on back of card): \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please fill out the information below for any other person(s) you authorize this credit card for: If NO OTHERS ALLOWED, strike through and initial.

Patient Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_\_\_

Patient Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_\_\_

Patient Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_\_\_

Signature of Authorized Credit Card User: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_