Balance Counseling
1517 Huguenot Road · Suite 202 · Midlothian, Virginia 23113
Phone: (804) 794.3200 · Fax: (804) 794.3220
LTW@mybalancecounseling.com
www.mybalancecounseling.com

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 _____________________________________ Email ____________________________________

Address____ Phone #_________________

Signature ____ Date ____________________
CANNOT SIGN FOR SOMEONE ELSE

HEALTH INFORMATION

Current Medications ____
____
____
____

Current or past illnesses, injuries, health problems ______________________________
____
____
____

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

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

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

_____ DEPRESSION
_____ INSOMNIA
_____ NO APPETITE
_____ INCREASED APPETITE
_____ FATIGUE/LOW ENERGY
_____ IRRITABILITY
_____ CAN'T MAKE DECISIONS
_____ LOW SELF-ESTEEM
_____ MOOD SWINGS
_____ ANGER PROBLEMS
_____ SEXUAL PROBLEMS
_____ SUICIDAL THOUGHTS
_____ PAST SUICIDE ATTEMPT(S)

_____ ANXIETY
_____ FEEL TENSE
_____ CONSTANT WORRYING
_____ PANIC ATTACKS
_____ EXCESSIVE FEARS
_____ WITHDRAWN
_____ EXCESSIVE GUILT
_____ FLASHBACKS
_____ NIGHTMARES
_____ HEADACHES
_____ STOMACH PROBLEMS
_____ HALLUCINATIONS
_____ MEMORY PROBLEM

_____ SCHOOL/WORK PROBLEMS
_____ FINANCIAL PROBLEMS
_____ LEGAL PROBLEMS
_____ MARITAL/FAMILY PROBLEMS
_____ EMOTIONAL ABUSE BY PARTNER
_____ PHYSICAL OR SEXUAL PARTNER VIOLENCE
_____ EMOTIONAL ABUSE IN CHILDHOOD
_____ PHYSICAL ABUSE IN CHILDHOOD
_____ SEXUAL ABUSE IN CHILDHOOD
_____ RECENT LOSS/GRIEF
_____ ABUSING ALCOHOL
_____ ABUSING DRUGS
_____ OVERLY SUSPICIOUS/PARANOID

_____ OTHER:
____
____
____
____

POLICIES

FEES	
Initial Evaluation (60 minutes)……….$175	Letters or Reports……………$37.50 per 15 minutes
Psychotherapy (55 minutes)……..…..$150	Returned Check Fee…………………..……………..…..$25
Telephone Sessions……….…..$37.50 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 provide notice **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 ____________________

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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.

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

Co-Pays/Co-Insurance: Co-pays and co-insurances are due at the time of the appointment.

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.

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: ___/___/_____

Signature of Authorized Credit Card User: _____________________________________ Date:________