Balance Counseling
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www.mybalancecounseling.com
LTW@mybalancecounseling.com

ADULT INTAKE

Appointment Date/Time _____

Name _____ Gender: M F T
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 _____
_____

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	_____ 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_____ IRRITABILITY	_____ WITHDRAWN	_____ PHYSICAL OR SEXUAL PARTNER VIOLENCE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)…….$125	Telephone Sessions……..$30 per 15 minutes
Psychotherapy (90 minutes)……$150	Letters or Reports……$25 per 15 minutes
Psychotherapy (55 minutes)……$100	Returned Check Fee……$25
*****Missed Session/Late Cancellation……Full Fee*****	
Court Appearance/Other legal proceedings…$650 for the first 3 hours; $185 per hour thereafter	

_____ **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 _____

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.

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