New Client Intake Form

All information on this form is strictly confidential.

Please complete all information on this form 48 hours prior to your first appointment time with Owens & Associates Counseling & Therapy Center, LLC.

Client Information

Client Name:_____ Date:_____

Preferred name to be called by:_____ Pronouns:_____

Date of Birth:_____ Social Security Number:_____

Full Address:_____

Cell Phone:_____ Email:_____

Emergency Contact Person:_____ Phone:_____

Responsible Party

Client Name:_____ Relationship:_____

Date of Birth:_____ Social Security Number:_____

Phone:_____ Email:_____

Full Address:_____

How did you discover our practice?_____

Primary Care Physician:_____

Psychiatrist:_____

Appointment Reminders

Phone Call ☐ Email ☐ Text Message ☐ All ☐ None ☐

We use the client's contact information for notifications. If it should be different, please specify. We offer automated appointment reminders as a courtesy. However, technology is not foolproof. Clients are responsible for attending scheduled appointments, whether a reminder has been received or not.

HIPAA

_____ (initial) I acknowledge that I have viewed/have been offered a copy of the Notice of Privacy Practices explaining HIPAA. This is also available on our website.

(optional) Other than to myself, I authorize Owens & Associates Counseling & Therapy Center, LLC. to disclose my health information to:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Consent for Treatment

_____ (initial) I hereby authorize Owens & Associates Counseling & Therapy Center, LLC. to render mental health services to me. I have read and understand these policies and have received a copy for myself.

Financial Responsibility

_____ (initial) I authorize this provider to release information to insurance carriers listed and be paid directly by insurance carriers for services billed. I acknowledge that I am responsible for all charges not paid by my insurance carriers, including copays, coinsurance, deductibles, no show / late cancellation fees, and insurance plan refusal to pay for failure to obtain authorization.

_____ (initial) Any missed appointments and late cancellations will be charged to the card obtained on file of $110.00.

Case Management Fees

_____ (initial) Case management (which includes Guardian ad Litem (GAL) meetings, letters, phone conversations with other professionals, or anything outside of the regular session with a client) costs are billed in minutes:

- 5-10 minutes = $30.00
- 11-20 minutes = $60.00
- 21-30 minutes = $90.00
- 31-50 minutes = $110.00
- 51-60 minutes = $150.00

_____ (initial) Any court appearances are $350.00 per hour, including travel time. These fees and case management fees are patient responsibility and will not be covered by your insurance carrier.

If it becomes necessary to effect collections of any amount owed, the undersigned agrees to pay all costs and expenses, including reasonable attorney fees.

Signature:

_____

Signature of Responsible Party (for minors under the age of 12):

_____

Date:_____ Are you signing this form electronically? Yes ☐ No ☐

Goals • Skills • Hope • Change

NO SHOW / LATE CANCELLATION FEE ($110.00 CHARGE)

Please understand that appointment times are limited, and out of respect for your therapist and other clients, we respectfully require 24-hour notice. Missed appointments or appointments canceled without 24-hour notice will incur a fee of $110.00. This fee is patient responsibility and will not be covered by your insurance carrier. If you are unable to attend your session, please call our administrative office at (847) 854-4333 or email the administrative office at admin@owenscounseling.com so that we have time to fill your time slot with another client, a client on a waitlist, or a client with a clinical emergency.

We offer automated appointment reminders as a courtesy. However, technology is not foolproof. Clients are responsible for attending scheduled appointments, whether a reminder has been received or not. The credit card information you provide will be used to process this payment. By providing your credit card information or booking an appointment, you consent to this policy. We appreciate your understanding and cooperation with this policy, as it helps us maintain efficient scheduling and quality service for all our clients.

Please provide the following credit card information. It is understood that despite your means of payment you authorize Owens & Associates Counseling & Therapy Center, LLC. to use the credit card provided as explained below.

Card Number:_____

Expiration Date:_____ Security Code (3 digits):_____

Name as it appears on card:_____

Please select the following: Visa ☐ Mastercard ☐ Discover ☐

Owens & Associates Counseling & Therapy Center, LLC. does NOT accept American Express.

Signature:

_____

Signature of Responsible Party (for minors under the age of 12):

_____

Date:_____ Are you signing this form electronically? Yes ☐ No ☐

What are the reasons for treatment?

_____

_____

_____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? Yes ☐ No ☐

If yes, please answer the following. If no, please skip to Homicide Risk Assessment.

Do you currently feel that you don't want to live? Yes ☐ No ☐

On a scale of 1 to 10 (10 being the strongest), how strong is your desire to kill yourself currently?

_____

Homicide Risk Assessment

Have you ever had feelings or thoughts of harming another? Yes ☐ No ☐

If yes, please answer the following. If no, please skip to Legal.

Do you currently feel that you want to hurt someone? Yes ☐ No ☐

On a scale of 1 to 10 (10 being the strongest), how strong is your desire to hurt someone else currently?

_____

Legal

Have you ever been arrested? Yes ☐ No ☐

Do you have any pending legal problems? Yes ☐ No ☐

Substance Use

Have you ever been treated for alcohol or drug use or abuse? Yes ☐ No ☐

If yes, for which substances? _____

Do you think you may have a problem with alcohol or drug use? Yes ☐ No ☐

Medical History

List all current prescription medications and how often you take them:

Medication Name Total Daily Dosage

_____

_____

_____

Current over-the-counter medications/supplements: _____

_____

Past Psychiatric History

Outpatient treatment? Yes ☐ No ☐ If yes, please describe for what reason, when, and where:

Reason Date Treated By Whom

_____

_____

Psychiatric Hospitalization? Yes ☐ No ☐ If yes, please describe for what reason, when, and where:

Reason Date Hospitalized By Whom

_____

_____

Trauma History

Do you have a history of being abused emotionally, sexually, physically, or by neglect? Yes ☐ No ☐

Educational History

What is your highest educational level or degree attained?_____

Current school:_____

Attendance: Daily ☐ Regularly ☐ Intermittent ☐ Refuse/Reason _____

Occupational History

Are you currently:

Working ☐ Not working by choice ☐ Unemployed ☐ Disabled ☐ Retired ☐

How long in present position? _____ What is/was your occupation?_____

Have you ever served in the military? Yes ☐ No ☐ If so, what branch?_____

Honorable discharge? Yes ☐ No ☐ Other type of discharge?_____

Relationship History and Current Family

Are you currently: Married ☐ Divorced ☐ Single ☐ Widowed ☐ How long?_____

If not married, are you currently in a relationship? Yes ☐ No ☐

Describe your relationship with your significant other:_____

What is your significant other's occupation?_____

Do you have children? Yes ☐ No ☐ If yes, list their ages and genders:_____

Describe your relationship with your children:_____

List everyone who currently lives with you:_____

Family Psychiatric History

Has anyone in your family been diagnosed with or treated for:

Bipolar Disorder ☐ Yes ☐ No

Depression ☐ Yes ☐ No

Anxiety ☐ Yes ☐ No

Schizophrenia ☐ Yes ☐ No

Post-traumatic Stress ☐ Yes ☐ No

Suicide ☐ Yes ☐ No

Violence ☐ Yes ☐ No

Substance Abuse ☐ Yes ☐ No

If yes, who had what problems?_____

Family Background and Childhood History

Where did you grow up? _____

List your sibling(s) and their age(s):_____

_____

What was your father's occupation?:_____

What was your mother's occupation?:_____

Are your parents divorced? Yes ☐ No ☐ If yes, how old were you at the time?_____

If your parents are divorced, who did/do you live with?_____

Describe your father and your relationship with him:_____

_____

Describe your mother and your relationship with her:_____

_____

How old were you when you left home?_____

Has anyone in your immediate family died?_____