

AIM Counseling Center
NEW CLIENT INTAKE FORM

Client Information:

First: _____ M.I. _____ Last: _____

Address _____

City _____ State _____ Zip _____

Phone #'s: Home () _____ Work () _____

Cell () _____ Other () _____

E-mail: _____ @ _____

May we contact you via e-mail? ___Yes ___No At work? ___Yes ___No

Date of Birth: ____ / ____ / ____ Age _____ SS# _____

Occupation: _____ Marital Status: ___M ___D ___W ___Single ___Sep

Parent / Guardian Name (if applicable): _____ Relationship? _____

Emergency Contact: _____ Phone # () _____

Current Medications: _____

How did you hear about us? _____

Your reason for coming in today? _____

Family Members Living At Home:

Name: _____ Birth Date: _____ Age: _____ Relationship to client: _____

Consent to Treatment

I do hereby seek and consent to take part in treatment by the therapist named below. I understand that the success of my treatment is significantly based on my attending sessions regularly, working on the behavioral changes and / or 'homework' assigned by my therapist between sessions, and communicating honestly. I understand the treatment style will be brief, solution-focused, and may involve other therapeutic methods such as insight-oriented and cognitive behavioral methods or groups. I understand the best way to see results is to implement the changes my therapist suggest between sessions. I have had all of my questions answered fully.

I attest that no promises have been made to me regarding the results or length of treatment, or of any procedures provided by this therapist. I agree that in order to achieve improvement or results I must be an active participant in the therapeutic process.

I am aware that I may stop my treatment with my therapist at any time. If I do, I understand that I will still be responsible for payment of services rendered to that date, and that termination may not be in my best interest, and may not achieve the results I am seeking.

I agree that I have received and read the following

- * Client Intake Information
- * Consent to Treatment
- * Policy & Procedures
- * Client Privacy Information
- * Client Rights & Responsibilities

I am aware that an agent of my insurance company or other third party payer may be given information about the type(s), cost(s), date(s) and provider(s) of services or treatment I receive from **AIM** Counseling Center. I understand that if my insurance company does not reimburse my therapist, I am responsible for the charges for my treatment.

My signature below shows that I understand and agree with, and will abide by all of these statements.

X

Signature of Client (or person acting for client)

Date

Printed Name

I, the therapist, have discussed the issues above and contained in these pages with the client (and / or his / her parent, Guardian or other representative). My observations of this person's behavior and response give me no reason to believe that this person is not fully competent to give information and willing consent. My signature below indicates that this information was accepted and understood by the client, and that I will keep a copy of this document in the clients permanent file.

Signature of Therapist

Date

Insured's Information:

Insurance Co. Name: _____ Phone # () _____

Policy # / Member ID # _____ Group # _____

Subscriber: _____ SS# _____ - _____

Date of Birth: ____ / ____ / ____ Relationship To Client: _____

Address _____

City _____ State _____ Zip _____

Phone #'s: Home () _____ Work () _____

Cell () _____ Other () _____

Insured's Employer: _____

Address _____

City _____ State _____ Zip _____

May we contact you or leave a message for you at work? _____

The undersigned hereby authorizes:

(1) The release of all client information by the therapist for the purposes of pre-certification of treatment, clinical review, and to insurance companies and / or third party payers providing mental health benefits. Such disclosures are limited to information reasonably necessary for your treatment, or that are required by your insurance company for reimbursement.

(2) **AIM Counseling Center** to charge a fee of \$130.00 on the credit card below if the appointment scheduled is not kept or cancelled without 24 hours notice per our policy.

Credit Card on file:

AMEX _____ MC _____ VISA _____ # _____ Exp. ____ / ____

CVV number (3 digit code on the back of the card) _____

billing address: ___ same as above or: _____

Signature: **X** _____

Date: _____

Printed Name: _____

Relationship to Client: _____