



Client Information

First: _____ M.I.: ____ Last: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #s: Home (_____) _____ Cell (_____) _____

Work (_____) _____ Other (_____) _____

E-mail: _____

May we contact you by email? ____ Yes ____ No by phone? ____ Yes ____ No

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

Occupation: _____

Marital Status: ____M ____D ____W ____Single ____Separated – how long? _____

Parent/Guardian Name (if applicable): _____

Relationship to client? _____

Emergency Contact: _____ Phone # (_____) _____

Current Medications: _____

How did you hear about us? _____

Your reason for coming in today _____

Family Members Living at Home: _____

Name	Date of Birth	Age	Relationship to Client
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

New Client Intake Form

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 are to implement the changes my therapist suggests 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, agree with, and will abide by all of these statements.

X _____
(Signature of client or responsible party)

Date: _____

(Printed Name)

New Client Intake Form

Policy Holder's Information

First: _____ M.I.: ____ Last: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #s: Home (_____) _____ Cell (_____) _____

Work (_____) _____ Other (_____) _____

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

Relationship to client? _____

Employer: _____ Occupation: _____

May we contact you or leave a message for you at work? ____ Yes ____ No

Insurance Company Name: _____ Phone # (_____) _____

Policy Number/ID# _____ Group # _____

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 up to \$150.00 on the credit card below if the appointment scheduled is not kept or cancelled without 24 hours notice/one business day per our policy.

Credit Card on file:

AMEX ____ MC ____ VISA ____ DISC ____ # _____

Expiration Date: ____/____ CVV (the number on the back of the card) _____

Billing Address of card : _____ Same as above or _____

X _____ Date: _____
(Signature of client or responsible party)

(Printed Name)

New Client Intake Form

NOTICE TO ALL NEW CLIENTS USING INSURANCE

It is now necessary for you to contact your insurance company in advance of your appointment time to obtain any AUTHORIZATION your insurance company may require to pay for your session.

In order to determine if your particular insurance plan has this requirement, you will need to call the 800 number listed on your insurance card. If an authorization number is required, simply request one FOR THE PERSON ACTUALLY BEING SEEN in the appointment, and bring it with you to your first appointment.

If your insurance company requires an authorization number and you do not get one, we cannot bill them, and THEY WILL NOT PAY FOR YOUR SESSION.

Please be advised that insurance companies are very difficult to work with, and often have very strict rules about authorizations. Frequently they will not "back date" an authorization if you wait until after your session to get the number.

In the event an authorization number is needed and you do not get an authorization, you will be financially responsible for the normal session fee of up to \$175.00 per visit.

My signature below shows that I understand, agree with and will abide by this policy:

X _____
(Signature of client or responsible party)

Date: _____

(Printed Name)