INTAKE FORM

Client information:
Client Name_____
Address_____
City_____
State_____Zip_____
Home/Cell Phone_____
Work Phone_____
Birth Date_____
Religion_____
Yearly Gross Income_____
e-mail: _____

Family Information:
Spouse/Parents Name_____
Address_____
City_____
State_____Zip_____
Home/Cell Phone_____
Work Phone_____
Birth Date_____
Names of Children and Ages_____
_____
_____

Referral Information:
Recommended by_____
Address_____
City_____
State_____ Zip_____
Phone_____

Emergency Contact Information:
Address_____
City_____
State_____Zip_____
Home/Cell Phone_____
Work Phone_____

Employment Information:
Company_____
Address_____
City_____
State_____

Insurance Information:
Address_____
City_____
State_____Zip_____
ID#_____Group#_____
Phone_____

Primary Care Physician:
Name_____
Contact info:_____
First seen:_____
Last seen:_____

Presenting Problem:
_____
_____
_____
_____

Previous Treatment:
Counselor Name_____
Address_____
City_____
State_____Zip_____
Phone_____

Appointment Information:
Appointment with_____
Date_____
Time_____
Appointment Confirmation_____
Counselor Notified_____

To the best of my knowledge, the information on this form is correct:
Signed:_____Date:_____

PLEASE READ THE INFORMATION ON THE BACK AND SIGN & INITIAL

Dr. Erroll E. Stephens Ph.D 4/15/2003

CONSENT to Release Confidential Information for Insurance Purposes
Name:_____

Birth date:__/___/_____

I consent to the release of information from m confidential treatment record for treatment, payment, and healthcare operations. (See definitions below.) I understand that, by law, I need not consent to the release of this information. This Consent for disclosure of information is not required for my treatment. However, I choose to do so willingly for the purposes specified above. I understand that I may revoke this Consent, in writing, at any time, except to the extent that action has been taken in reliance on my consent. Further, I understand that copies of all billings, reports or similar documents released to my insurance company or its agent shall also be available to me.

Please review the definitions below, and this practice's ***Notice Of Privacy Practices*** for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent.

Signature_____Date:_____
Client, or parent or legal guardian of client

Definitions:

***Treatment** includes activities performed by this practice in providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care professionals. This consent includes treatment provided by any professional who covers this practice as an on-call professional.

****Payment** includes uses and disclosures required for determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and health plan management activities which may include review of your services for clinical necessity, justification of charges, pre certification and preauthorization.

Changes in Privacy Practices:

Because we reserve the right to change our privacy practices in accordance with HIPAA Privacy Rules, the terms contained in the ***Notice of Privacy Practices*** may change also. A summary of the ***Notice of Privacy Practices*** will be posted in each professional office of this practice indicating the effective date of our current ***Notice of Privacy Practices*** in the upper right hand corner. We will offer you a copy of the ***Notice of Privacy Practices*** on your first visit to us after the effective date of the current ***Notice of Privacy Practices***. You will be given a copy of the ***Notice of Privacy Practice*** at your request. As more full explained in the ***Notice of Privacy Practices***, you may have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations. *We are not required to agree to your request.* If we agree, we are required to comply with your request unless the information is needed to provide emergency treatment to you. Other practitioners who may provide coverage for this practice are required to use and disclose your protected health information consistent with the ***Notice of Privacy Practices.***

I understand that I have the right to revoke this CONSENT provided that I do so in writing except to the extent that my therapist has already used or disclosed the information in reliance on this CONSENT.