Client Intake Form

Date: ____________________

The information requested in this form will be kept confidential and will be used to assist you.

General Information

Last Name___________________ First Name ______________ Middle Initial ____

Birth Date ___/____/____ Male___ Female____

Street Address ____

City _________________________________ State __________ Zip ___________

Home Telephone # _________________ Cell Phone # _________________

OK to leave message on: Home: Y N Cell: Y N

EMERGENCY CONTACT: Name __________________________ Phone #

____

Guardian/ Parent (if under 18) ____

Relationship: ____

Referred by: ____

WHAT BROUGHT you to us today? (In your own words) _____________________

____

Payment Method

Responsible Party if other than client: ___________________________________

Do you plan to file insurance for these services? Yes___ No___

Insurance Company: ____

Policy Number: ____

Policy Holders Number: _________________ Date of Birth: _________________

Do you wish to apply for Fee Assistance? Y___ N____

Problem Definition   Please Circle All That Apply

Are any of the following conditions a problem to you at this time?

Anxiety	**Grief**	**Stress**
Depression	**Alcohol/Drug Use**	**Conflicts at work**
Suicidal Feelings	**Hopelessness**	**Other (List)**
Nervousness	**Loneliness**	*** ______________________**
Anger	**Marital Problems**	
Job Loss	**Relationship with parents**	
Relationship with children		

List of current medications: ____

____

How do you express your spirituality? ____________________________________

Do you wish to incorporate spirituality into your therapy?   Yes _____   No _____

Have you or any member of your family received Drug and Alcohol Counseling?

Yes _____   No _____

When? ___________ Where? ____

Have you or any member of your family received Mental Health counseling in the past?   Yes _____   No _____

When? __________________ Where? ____________________________________

ADULTS:

<u>Female</u>: In the past three months did you have four (4) or more standard drinks per occasion? YES NO

<u>Male</u>: In the past three months did you have five (5) or more standard drinks per occasion? YES NO

In the last year have you used drugs other than those prescribed by a physician? YES NO

ADOLESCENTS:

Have you ever gotten into trouble while you were using alcohol or drugs?

YES NO

Have you been in a car driven by someone (including yourself) that was "high" or had been using alcohol or drugs?

YES NO

ACKNOWLEDGEMENT: Please sign and date this document attesting that the information you have provided on this form is accurate to the best of your knowledge.

I give my permission to share information regarding my treatment with:

____

I give my permission to share billing information with:

____

Please note there is a $ 50.00 cancellation fee for less than 24 hour notification.

Client or Guardian Signature _________________________ Date ______________

Patient HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- **Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);**
- **Obtaining payment from third party payers (e.g., my insurance company);**
- **The day to day healthcare operations of your practice.**

I have also been informed of and given the right to review and secure a copy of your ***Notice of Privacy Practices*****, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.**

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Today's Date ________________

Client Name ___________________________ Signature ____________________________

Parent/Guardian ________________________ Signature ____________________________

Parent/Guardian ________________________ Signature ____________________________

The Samaritan Center at the Jersey Shore
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