center for
VALUED LIVING

CLIENT INTAKE FORM

Today's Date: _____ Date of 1st Appt: _____ Time of 1st appt: _____

Name: _____
First Middle Last

Address: _____
Street & Apt # City State Zip

Date of birth: _____ Age: _____ Sex: _____ Gender: _____
Month / Day / Year

☐ Please send any outstanding bills to this alternate address: _____
_____

Home Phone: (_____) _____ Cell Phone: (_____) _____
Work Phone: (_____) _____ Email Address: _____

Employer: _____ Occupation: _____

Name, address, and phone # of person responsible for bill (if not client): _____
_____

If this or another person is responsible financially, I give C4VL permission to contact this person about anything related to billing. I acknowledge that this person would have to sign a form stating they are taking financial responsibility for this treatment. If this is not done, I acknowledge I am then responsible financially. For minor clients, the parent(s) who have signed this document and the Minor form are responsible financially, regardless of custodial and decision-making arrangements. **Please initial: _____**

Referred by: _____

In case of emergency, contact: Name_____ Phone(s)_____

Relationship to you_____ **Please initial** for permission to contact in emergency_____

I have read the ***HIPAA Privacy Notice*** AND the ***Practice Guidelines and Policies,*** *both available for download at any time on www.c4vl.com*. The contents of both of these documents were also verbally explained by my therapist.

Please sign above to acknowledge: _____
Client Signature

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INSURANCE INFORMATION: Please completely fill out if you are using insurance benefits. Please also call your insurance company to find out all the following information prior to your first session. It is your responsibility to make sure you will be covered adequately at the time of service. If you do not have this information, you may be billed at the time of service.

PRIMARY INSURANCE:

Your Name: _____ Your Bday:_____

Your Address: _____

Your phone #: _____

Insurance Company: _____ Plan name: _____

Claims Address: _____

Provider Tel: _____ Ins Co Payer ID for electronic claims _____

Your Policy ID # _____ Group # _____

Are you the policy holder? _____ Relationship to policy holder _____

Primary policy holder: Name: _____ Tel: _____ Bday: _____

Primary policy holder address if different: _____

Mental health deductible? _____ Deductible amount? _____ $ deductible met for yr? _____

When does deductible begin annually? _____ Max # sessions/year _____

Prior authorization necessary?: _____ Authorization # _____

Copay amount: _____ Coinsurance amount: _____ PCP name _____

PLEASE BRING A PHOTOCOPY (BOTH SIDES) OF YOUR INSURANCE CARD TO YOUR FIRST VISIT.

I give permission for C4VL to bill my insurance company for psychological services rendered.

Please sign: _____ **Date:** _____

PLEASE INITIAL EACH BOX BELOW, which indicates that you acknowledge the following information as described in the documents, Practice Guidelines and Policies and HIPAA (available on c4vl.com):

	My provider included licensure and regulatory board information which is on the website.
	My therapist was available to answer questions on what I can expect about therapy and my rights.
	My provider's fee for therapy ranges from $120-150/session, depending on time spent or code used.
	My provider's late cancel / no-show fee for time reserved is as follows:
	*** The cancelation / no show fee is $120. I am responsible for paying this fee, unless I have made other arrangements with a guarantor, in writing, signed by that person or if I am legally exempt (Medicaid or EAP only). If I miss multiple sessions, my therapist reserves the right to terminate therapy and refer out.**
	*** Requires 48 hours / 2 days notice for cancelation.**
	* No reimbursement from insurance for missed sessions or late cancels = client responsibility
	* When schools / businesses close for inclement weather, imminent life-threatening illnesses, inpatient hospitalizations, death to loved ones, client may cancel w/ less than 48 hours.
	No appointment reminders given; client responsibility to keep track of time, date, and location.
	Copays are due at the time of service or full payment if no insurance being used. Payments can be made via cash, credit card (can be kept on file and is PCI compliant), or check.
	Client responsibility to confirm mental health benefits and know what the ongoing patient responsibility is (copays, coinsurance, deductible, etc).
	Contact – phone/ email /text policy reviewed – email and text used for non-emergency only
	Limits to Confidentiality = harm to self or others, child abuse; general confidentiality reviewed
	Minor policy, if applicable, was reviewed. Minor paperwork will be filled out / provided if applicable.
	C4VL may provide me a referral to another therapist in the group if I do not find my initial therapist to be a good fit for my therapeutic needs.

***** IF YOU HAVE SECONDARY INSURANCE, PLEASE FILL OUT BELOW *****

Insurance Company: _____ Plan name: _____

Claims Address: _____

Provider Tel: _____ I

Your Policy ID # _____ Group # _____

Are you the policy holder? _____ Relationship to policy holder _____

Primary policy holder: Name: _____ Tel: _____ Bday: _____

Primary policy holder address if different: _____

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What are the reasons you are seeking therapy at this time?

☐ depression	☐ PTSD / trauma history	☐ grief / loss
☐ general anxiety	☐ panic attacks	☐ school or work problems
☐ mood swings / bipolar	☐ stress management	☐ sexuality / gender identity
☐ relationship problems	☐ ADHD	☐ disordered eating
☐ low self esteem	☐ obsessive/compulsive (OCD)	☐ trust issues
☐ family problems	☐ addiction / substance abuse	☐ auditory or visual hallucinations
☐ social anxiety	☐ anger management	☐ traumatic brain injury
☐ Other: please explain below	☐ Other: please explain below	☐ Other: please explain below

_____

_____

_____

_____

_____

What are you hoping to gain from therapy?_____

_____

_____

Treatment plan / goals / additional info: (Please check all that apply or write in)

☐ reduce depression	☐ grief / loss	☐ work on trauma
☐ reduce anxiety / stress management	☐ anger management	☐ increase self esteem
☐ improve relationships with others	☐ address addiction issues	☐ sexuality / gender identity
☐ clarify values / work on living life more meaningfully	☐ reduce disordered eating behaviors	☐ acceptance of life circumstances
☐ improve coping skills	☐	☐
☐	☐	☐
☐	☐	☐

Race: African-American/Black Hispanic/Latino(a) Native American Asian
Caucasian/White Pacific Islander Other: _____

* Please indicate how you self-identify, as these categories may not best apply.

First language: _____ Other languages: _____

Others living in your household:
First name_____ Relationship to you_____
_____ _____
_____ _____

Who would you consider your emotional support network? _____

Have you had previous mental health treatment? □ Yes □ No
Provider name(s)_____ Dates_____
_____ _____

Relationship Status and History: (*Circle ALL that apply that are important to your history*).

Single Married Separated Divorced (Single) Divorced (Remarried) Widowed
Committed Relationship Other _____

Please briefly indicate anything about your current or past relationship history that would be relevant to your treatment. _____
_____
_____
_____
_____

Please briefly describe your family of origin (parents/guardians, siblings, grandparents, etc.) How would you describe your relationships with these people during childhood? Now? _____
_____
_____
_____
_____

Substance Use

Drug	How often	How much	Age began	Treated?	Problem bx?
Alcohol					
Marijuana					

Other – specify					

Suicide and self-harm

Current thoughts of hurting yourself? _____ Current plan/ method? _____

Previous thoughts or attempt(s)? _____

Homicide and Harm to Others

Current thoughts of hurting someone else? _____

Current plan / method? _____History of violence? _____

Criminal History: Misdemeanors? Felonies? When? For what?

_____

_____

Trauma history? Physical Abuse? Sexual Abuse?

_____

_____

Abuse reported? By whom? To whom? When?

_____

_____

Describe education and/or work history.

_____

_____

Have you ever taken any medications on a regular basis? If yes, please list medications and doses.

_____

_____

Any other relevant info:

_____

_____

_____

_____

_____

_____

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CREDIT CARD AGREEMENT

PLEASE READ: Please fill this out if you would like Center for Valued Living, PLLC ("C4VL") to use a credit card to remit any necessary payments in lieu of using a check or cash. By signing this agreement, you acknowledge and accept the credit card terms and conditions listed on the C4VL.com website. We will use this credit card to pay any balance in full for the client. This includes any balance for copay, coinsurance, deductible, or charges for late cancels or missed sessions. **If we know the copay, cards will be charged soon after the appointment. If not, cards will be charged once claims have been processed; it can take a minimum of 30-45 days from the date of service but can sometimes take longer depending on the insurance.** Please use black ink and write legibly. This form can be faxed directly to Julie Burke @ Flatirons Practice Mgmt, our billing company at 866-715-5418.

Client: _____

_____ _____
Signature of Cardholder only please Date

Billing Address for Cards:

_____ Special Instructions:

_____ _____

Phone Number: _____ _____

Type of Card:
☐ Visa ☐ Master Card
Card Number: _____/_____/_____/_____
Expiration Date: _____/_____ (mm/yyyy)
Security Number on back of Card: _____
Exact Name on Card: _____

Please use the following card as a "backup" for the first, in case it does not allow charges.
Type of Card:
☐ Visa ☐ Master Card
Card Number: _____/_____/_____/_____
Expiration Date: _____/_____ (mm/yyyy)
Security Number on back of Card: _____
Exact Name on Card: _____