Therapist _____ Date _____

SUMMIT COUNSELING
AT FIRST BAPTIST JACKSON

Client Intake Information

Name _____

Gender _____ Marital Status _____ Spouse's name _____

Name of parent/legal guardian (if client is under 18) _____

Client's Address_____

City _____ State _____ Zip _____

Date of Birth _____ Age _____ Place of Birth _____

Cell Phone _____ Cell Phone Provider _____ Home Phone _____
(AT&T, C-Spire, Verizon, etc.)

Email _____

WE WILL SEND A REMINDER ABOUT YOUR APPOINTMENT TIME. PLEASE INDICATE YOUR PREFERENCE: EMAIL ____ TEXT ____

Place of Work and Telephone _____

Emergency Contact _____ Phone _____
(Name and Relationship)

Are you active in a local church? Yes No If yes, name of church & city _____

Do you know for certain that you will have Eternal Life in Heaven when you die? Yes No I do not know

HOW DID YOU LEARN ABOUT SUMMIT COUNSELING? _____

Method of Payment (Choose one - Fee to be paid at time of session)

*Sliding Scale **Insurance First Baptist Jackson Active Member Other _____

*Sliding Scale fees are based on total family income. Indicate income here: _____

**Our office will file claims only for clients who have Blue Cross Blue Shield insurance or AHS (MS state employees) as their primary coverage. Information needed for client to file with other insurance companies will be provided when requested.

Summit Counseling cannot make any promise concerning payment of claims by your insurance company.

Clients are ultimately responsible for the whole fee, including any portion not paid by the insurance company.

Please turn the page over

ACKNOWLEDGEMENT/ CONSENT/ AUTHORIZATION

I have received, read and understand the HIPAA Consent Form and Notice of Privacy Practices.

If applicable, I authorize release of any medical or other information necessary to process an insurance claim. I also authorize payment of medical benefits to the Provider of Services. I am the Client or Authorized Representative.

MISSED/CANCELLED APPOINTMENT POLICY

Therapists are obligated to wait 15 minutes for a late client. After that time, the session is considered **MISSED** and client will be responsible for paying a $25 missed appointment fee.

If a client needs to **CANCEL** an appointment, at least 24 hours advance notice is requested. This allows the office to assist another client with an appointment, often someone who is on a waiting list.

_____

Signature of Client (age 18 and over) or
Signature of Authorized Representative (Parent/Legal Guardian of child under age 18)
To be signed in our office at time of first session

With this signature, client or parent/legal guardian indicates understanding and agreement with policies of Summit Counseling, which include:
Fees/Method of Payment
HIPAA Consent & Notice of Privacy Practices
Missed/Cancelled Appointments

Please complete the next page

SUMMIT COUNSELING
AT FIRST BAPTIST JACKSON

COUNSELING INFORMATION

SUMMIT COUNSELING
AT FIRST BAPTIST JACKSON

Have you (or your spouse) ever been involved in therapy or any other type of counseling program?

____Yes _____No If yes, when? _____ Where?_____

Counselor _____ Did that counseling help? _____

Reasons for considering counseling at this time _____

What problem(s) you are presently experiencing _____

_____

_____

What do you expect from therapy? _____

_____

_____

If need be, would other relatives be willing to come into therapy sessions? ___Yes ____No If no, please indicate reason

_____

_____

MEDICAL INFORMATION

Are you presently taking any medications (prescribed or over the counter)? _____Yes _____No

If yes, please list each medication and the reasons taking: _____

_____

_____

Have you ever been hospitalized for any mental health reasons? _____Yes _____No

If yes, when? _____ Where? _____

By whom? _____ Length of treatment _____

Have you ever been or are you now being treated for any type of chemical dependency? _____Yes _____No

If yes, when? _____ Where? _____

By whom? _____ Length of treatment _____

Are you at the present time using any type of chemical substance? _____Yes _____No

If yes, please indicate what you are using (drugs and/or alcohol) _____

How frequently do you use the substances? _____

Are you presently under a physician's care? _____Yes _____No

Name of family physician _____ Telephone _____

Address _____

Please turn the page over

FAMILY INFORMATION

Please list Name of Child/Children

1. _____ Date of Birth _____ Age _____ Sex _____

Living arrangement (with father, mother, etc.)_____

School Attending _____ Grade _____ Teacher _____

2. _____ Date of Birth _____ Age _____ Sex _____

Living arrangement (with father, mother, etc.)_____

School Attending _____ Grade _____ Teacher _____

3. _____ Date of Birth _____ Age _____ Sex _____

Living arrangement (with father, mother, etc.)_____

School Attending _____ Grade _____ Teacher _____

4. _____ Date of Birth _____ Age _____ Sex _____

Living arrangement (with father, mother, etc.)_____

School Attending _____ Grade _____ Teacher _____

5. _____ Date of Birth _____ Age _____ Sex _____

Living arrangement (with father, mother, etc.)_____

School Attending _____ Grade _____ Teacher _____

EMPLOYMENT HISTORY

Place of Employment _____ Work Phone _____

Length of Employment _____

Previous Place of Employment _____

Length of Employment _____

Spouse's Employment

Place of Employment _____ Work Phone _____

Length of Employment _____

EDUCATIONAL HISTORY

Education Completed (highest grade) _____ Schools Attended _____

_____

Spouse's Education Completed (highest grade) _____ Schools Attended _____

_____