Myers Counseling Group Intake Form

Date:

CLIENT INFORMATION

Name	Social Security Number
Street Address	Home Telephone Number Cell Phone Number
City State Zip	Email Address
Birthdate / / Age	Can we email if needed? Y N
(Please Circle One) Single Married Divorced Widowed	(Please Circle) Male Female
Client Employment/School	Occupation
Business Address	Business Telephone
In case of emergency who should we notify? (Name + telephone number)	Relationship to Client

FINANCIAL & INSURANCE

Person Financially Responsible for Account:	Relationship to Client
Social Security Number	Birthdate of Financially Responsible person:
Address (if different from client)	Telephone Number
City State Zip	Person Financially Responsible Employed by:
Occupation	Business Address and Telephone
Primary Insurance Holder:	Birthdate of Insurance Policy Holder:
Insurance Company:	Policy Number:
Group number:	Certification or Authorization number
Insurance Telephone Number	Number of Sessions Authorized

(For Office Use Only)

Referral Source:	Diagnosis _____	Therapist Initial	EAP Therapist EAP Billing Mgr. Insurance Self-Pay

Eff 9/16

Myers
Counseling
Group, Ltd.

300 Memorial Drive, Suite 200
Crystal Lake, IL 60014
Telephone: (815) 308-3368
Fax: (815) 356-7044

Permission for Services

I/we_____grant permission for

Myers Counseling Group to provide services to _____

for Mental Health Counseling. I/we understand that all information shall be treated

as confidential in accordance with state laws.

_____ _____
Client Date

_____ _____
Parent (if client is under the age of 18 years) Date

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Client Consent/Waiver for Primary Care Physician Notification of Service Provision

Pursuant to Illinois Law (PL 86-1434) you are hereby notified that it is desirable that you confer with your primary care physician, if you have one, about seeking and receiving mental health services. Unless you waive such notification, I am required to notify your primary care physician that you are seeking or receiving mental health services.

Please indicate your desire by checking the appropriate box.

( ) I do not have a primary care physician and don not wish to see or confer with one. I therefore **WAIVE NOTIFICATION** of a primary care physician that I am seeking or receiving mental health services.

( ) I **WAIVE NOTIFICATION** of my primary care physician that I am seeking or receiving mental health services, and I direct you **NOT** to notify him or her.

( ) I **AGREE TO YOUR NOTIFYING** my primary care physician, that I am seeking or receiving mental health services.

My primary care physician is:

Name: _____

Address: _____

_____

Telephone number: _____

Please act in accordance with these, my instructions:

Client name: _____ Date: _____

Client signature: _____
(if client is under 12 years of age, only parents need to sign)

Parent\Guardian signature: _____

Witness:_____Date: _____

Myers Counseling Group E- mail Permission Notice

I, _____ grant permission to Myers Counseling Group to include my name on their e-mail distribution list. I understand my e-mail address will only be used for follow up surveys, newsletters, and notices regarding Myers Counseling Group services. It will not be distributed to any third parties. I also am aware that I could unsubscribe at any time.

Name of Client: _____

Signature: _____

Date: _____

E- Mail address: _____

Additional e-mail address: _____

Myers Counseling Group

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS (TPO)

Patient Name _____

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities (known as "health care operations."). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, the revised Notice will be posted in the office. You may ask for a printed copy of our Notice at any time.

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my Protected Health Information as specified above.

Client Name:_____ Date:_____ Signature:_____

Parent Name:_____ Date:_____ Signature:_____
(If client is under the age of 12 years, only parent needs to sign)

Medication Check List

☐ I am not taking any medication

Name of Medication	Dosage	Frequency	Reason for taking

Myers Counseling Group
Financial Agreement

Insurance:

It is up to you to check your insurance plan and limits of your coverage. We have verified your insurance as a courtesy and cannot guarantee the accuracy of the information. For initial sessions, you will be required to obtain approval/authorization /certification. If you do not obtain this prior to the first session, you will be responsible for full payment. Myers Counseling Group will get approval for subsequent sessions. Myers Counseling Group is willing to assist you by filing insurance claims. We do not bill secondary insurance however, we will be glad to assist you so that you may be reimbursed.

Your insurance policy is between you and your insurance company. We may not be party to that relationship. Our primary relationship is with you, not your insurance company. All charges are your responsibility whether your insurance company pays or not. You will also need to notify us of any changes in your insurance plan. If you do not notify us, and your new policy does not cover services, you will be billed for the full payment.

Payment Policy:

You are expected to pay for all fees/co-payments at the end of each appointment, unless special arrangements have been made. Payment for services is due at the time services are rendered. Myers Counseling Group accepts cash, checks, Visa, Master Card, and Discover. There is a $35.00 fee for returned checks. We understand that things do happen and financial problems may affect timely payment of your bill. We will do everything we can to help you. All we ask is that you contact us as soon as possible to make arrangements. Credit card information will be kept on file. Any account balance 31+ days past due will be charged to the account on file.

The following services are not covered by insurance and are due at the time of service:

Oral Drug Screen - $60.00
Records request/copying fees - $5.00 per record + $.31 per page + postage
Court appearances, phone calls, consultations/meetings - $125.00 per hour
Urinalysis - $65.00
Written reports - $37.00 - $150.00
(Prices subject to change)

Divorce Situations:

Myers Counseling Group looks to the adult who has brought the child in for the appointment to be responsible for payment of services which are rendered to the child. We also expect the parents to be able to work out payment arrangements with each other and not involve our office in any disputes which may arise.

Cancellation Policy:

Unless appointments are cancelled at least 24 hours in advance of their scheduled time, there will be a $40.00 fee charged for the first missed appointment and a subsequent increase of $5.00 for each appointment missed after. Insurance will not reimburse for missed sessions. Balance needs to be paid in full prior to future sessions being scheduled.

Collection Costs and Procedures:

If your account becomes delinquent, you agree to pay additional charges to collect your unpaid bills, including, but not limited to, reasonable attorney fees, court costs, and collection agency fees. By signing this policy, you acknowledge that Myers Counseling Group reserves the right to release any patient information and any medical records to our collection agency deemed necessary to assist their staff and attorneys in the collection of this debt.

Assignment and Release:

I hereby authorize payment to be made directly to Myers Counseling Group and fully understand that I am the responsible party for all charges incurred by me or my dependents at Myers Counseling Group. I also authorize the release of any and all information required to collect or process my claims. If legal action becomes necessary, I agree to pay all reasonable fees.

By signing below, you do affirm that you have read and understood our Financial Agreement and that you agree to its contents.

Name of Patient:_____ Date:_____

Signature of Patient or Responsible Party:_____