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