Myers Counseling Group Intake Form

Today's Date:

CLIENT INFORMATION

NAME:		
Street Address		Home Telephone Number
		Cell Phone Number
City State	Zip	Email Address
Birthdate / /		Age
(Please Circle One) Single Married Divorced Widowed		(Please circle one) Female Male
Client Employment/School		Occupation
Business Address		Business Telephone
In case of an emergency, who should we notify? (Name + telephone number)		Relationship to Client

FINANCIAL & INSURANCE

Person Financially Responsible for Account:		Relationship to Client
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 #:
Insurance Telephone Number		Number of Sessions Authorized

(For Office Use Only - Circle one)

Insurance EAP Self Pay $_____ EAP Billing Manager

Myers Counseling Group
Permission(s)

(Please initial boxes next to each permission)

Initial _____ **Services for Permission:**

I/we grant permission for Myers Counseling Group to provide services for Mental Health Counseling. I/we understand that all information shall be treated as confidential in accordance with state laws.

Initial _____ **Email Permissions:**

I/we 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.

Any correspondence we have via email will be limited in nature. We will not discuss clinical information in these correspondences. Relative information will be discussed in session and email exchanges will be limited to billing and appointment questions. Also, be aware that email correspondence can become part of your clinical record.

Initial _____ **Social Media Policy Permissions:**

Myers Counseling Group is on several social media sites. We offer information on mental health and related issues. This information is not meant to replace therapy but present more information on topics you could find helpful. The various social media sites are not interactive for Myers Counseling Group subscribers. We will not reply to questions submitted through these sites. If you have questions or comments we can discuss them in session.

To maintain client confidentiality and maintain boundaries in our therapeutic relationship, we will not accept requests to friend or be-friended, offer fanning or following. You are more than welcome to access information and postings via RSS without creating a visible profile or link to the company page. Social media forms are visible for anyone and do not require sign ups. We post information on Facebook that does not require a following.

As our clients, we do not expect or require you to follow. Our feeds from twitter are posted on our website in the blog section. If you follow I/us on Twitter that is by your own choice. It will also have no bearing on our therapeutic relationship.

Myers Counseling group is registered on sites such as Healthgrades, Yahoo, and Yelp. These sites are used to evaluate providers. Any information you decide to post on these sites is by your violation. I do not solicit nor discourage your feedback on these sites.

Name of Client:_____ Date:_____

Signature:_____

Myers Counseling Group
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 do 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:_____DOB:_____
Date:_____
Client signature:_____
(if client is under 12 years of age, only parents need to sign)
Parent\Guardian signature:_____

Witness:_____ Date:_____

Myers Counseling Group

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

For More Detailed Information Please Visit Our Website At

www.myerscounseling.com

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.

Name of Client:_____ Date:_____

Signature:_____

Myers Counseling Group

Medication Checklist

☐ I am not taking any medication

Name of Medication	Dosage	Frequency	Reason for taking