

# Myers Counseling Group Intake Form

**Today's Date:**

C L I E N T  I N F O R M A T I O N	NAME:		
	Street Address		Home Telephone Number
			Cell Phone Number
	City	State	Zip
	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	
F I N A N C I A L  &  I N S U R A N C E	Person Financially Responsible for Account:		Relationship to Client
	Birthdate of Financially Responsible person: / /		
	Address (if different from client)		Telephone Number
	City	State	Zip
	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](http://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

# 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

Urinalysis - \$65.00

Records request/copying fees - \$5.00 per record + \$.31 per page + postage

Written reports - \$37.00 - \$150.00

Court appearances, phone calls, consultations/meetings - \$125.00 per hour (Prices subject to change)

Diagnostic Reports - \$10 and up, depending on reports. (Please consult with your therapist.)

## **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.

Signature of responsibility party or client: \_\_\_\_\_

Date: \_\_\_\_\_

# Myers Counseling Group

## Release Form Permission of Services For Minor (Only)

**Fill Out For Minor**

**(to be filled out by parent for child under 18 years of age)**

Child's name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

As the parent or legal guardian with the authority to consent on behalf of the minor child named above, I hereby give my consent for the minor to seek counseling, psychotherapy, psychological assessment from the professional staff associated with or employed by Myers Counseling Group. The mental health provider responsible for the care, Myers Counseling Group, has explained to me the proposed treatment plan, the general nature and extent of the risks involved in the treatment, and alternative treatment options, if any. However, treatment will not be delayed if any emergency exists. This consent will be valid until the minor reaches the age of 18 but can be revoked at any time by written notification. Any questions related to this form or the proposed treatment can be directed to Myers Counseling Group at (815) 308-3368, ext 100.

\_\_\_\_\_  
(Print Name of Parent/Guardian)                      (Signature of Parent/Guardian)

\_\_\_\_\_  
(Print Name of Parent/Guardian)                      (Signature of Parent/Guardian)

I/We, \_\_\_\_\_, \_\_\_\_\_, (sign by both parents if applicable) certify that I/We are the parent of the minor listed and agree for Myers Counseling Group to provide mental health counseling to my child.    Date:

\_\_\_\_\_