The Mental Difference

Chicago – Oak Brook – Skokie – Crystal Lake

COUNSELING INTAKE FORM

CLIENT INFORMATION:

First Name: _____ **MI**: _____ **Last Name:** _____

Address: _____ **City/ State/ Zip:** _____

Age: _____ **D.O.B:** _____ **Gender:** Male / Female **Patient SS#:** _____

Cell Phone: _____ **Home Phone**: _____

Email Address: _____

INSURANCE INFORMATION:

Patient's Relationship to Insured: Self: _____ Spouse: _____ Child: _____ Other: _____

Policy Holder Name: _____ **Gender:** Male / Female **D.O.B:** _____

Insurance Carrier: _____ **Member #:** _____

Group #: _____ **Policy Holder SS#:** _____

Policy Holder Employer: _____

(NAME / BILLING ADDRESS / PHONE # OF RESPONSIBLE PARTY) ***(IF DIFFERENT FROM ABOVE)***

First Name: _____ MI: _____ Last Name: _____

Address: _____ City/ State/ Zip: _____

Cell Phone: _____ Home Phone: _____

***PRIMARY CARE PHYSICIAN*:** May We Contact Your Physician to coordinate care? (Circle One) **YES / NO**

Name: _____ Phone: _____

CURRENT MEDICATIONS: (continue on reverse side if more room is needed)

Name: _____ Dosage: _____ Reason: _____

Name: _____ Dosage: _____ Reason: _____

MENTAL HEALTH HISTORY: Does the patient or any family members have mental health history? (Please Check Below)

Depression: □ YES □NO	Relationship: _____
Bipolar Disorder: □ YES □NO	Relationship: _____
Anxiety: □ YES □NO	Relationship: _____
ADHD: □ YES □NO	Relationship: _____
Autism: □ YES □NO	Relationship: _____
Developmental Delays: □ YES □NO	Relationship: _____
Self-Harm: □ YES □NO	Relationship: _____
Suicide Attempts / Completion: □ YES □NO	Relationship: _____
Alcoholism / Substance Abuse: □ YES □NO	Relationship: _____
Learning Disabilities: □ YES □NO	Relationship: _____
Psychiatric Hospitalizations: □ YES □NO	Relationship: _____
Head Injuries: □ YES □NO	Relationship: _____
Concussions: □ YES □NO	Relationship: _____

Any Other Significant Mental Health History: _____

_____

_____

HOW WERE YOU REFERRED TO THE MENTAL DIFFERENCE? (Please Check Appropriate Line)

_____ PHYSICIAN/ THERAPIST – Name: _____

_____ ANOTHER CLIENT

_____ INSURANCE PROVIDER

_____ SCHOOL – NAME: _____

_____ HOSPITAL – NAME: _____

_____ INTERNET/ WEBSITE – WHICH ONE: _____

_____ OTHER – PLEASE SPECIFY: _____

INFORMED CONSENT FOR TREATMENT

I consent to have ***THE MENTAL DIFFERENCE*** and their professional staff perform counseling services and/ or related mental health treatments when deemed necessary or advisable by appropriate members of the professional staff and/ or consultants in consultation with ***THE MENTAL DIFFERENCE*.** This statement has been fully explained to me and I understand it.

Client Signature (Ages 12+): _____ Date: _____

Legal Guardian/ Responsible Party: _____ Date: _____

AUTHORIZATION OF RELEASE OF INFORMATION AND ASSIGNMENT OF INSURANCE

I authorize the release of any medical information acquired in the course of my/ patient examination or treatment to expedite insurance benefit payment to ***THE MENTAL DIFFERENCE***. **I ACCEPT RESPONSIBILITY FOR PAYMENT THE INSURANCE COMPANY MAY NOT COVER.** Payment is expected at the time of service, or according to a mutually agreed upon and documented payment schedule.

Patient/ Responsible Party: _____ Date: _____

HIPPA, PRIVACY, AND POLICIES

I acknowledge that I have been offered ***THE MENTAL DIFFERENCE'S*,** " HIPPA Privacy Practices ", "Client Right's Statement" and "Practice Policies". I have read these policies, clarified any uncertainties, and fully understand these documents.

Client (Ages 12+): _____ Date: _____

Legal Guardian/ Responsible Party: _____ Date: _____

MISSED APPOINTMENTS/ CANCELATION POLICY

In addition to **THE MENTAL DIFFERENCES'S** Policies, please acknowledge that you have read and understand ***THE MENTAL DIFFERENCE'S*** 24-hour policy for all cancelations and missed appointments. This is found within **THE MENTAL DIFFERENCE'S** policies.

Client Signature (Ages 12+): _____ **Date:** _____

Legal Guardian/ Responsible Party: _____ **Date:** _____

CREDT CARD AUTHORIZATION

THE MENTAL DIFFERENCE wants to work with you to make sure that claims and statements are paid accurately and efficiently. We require that you provide credit card information to secure your account. In the event that your account becomes past due, all open balances will be billed on a monthly basis. Your account will become past due if payment is not received within 30 days of the statement billing date. You may also set up regular monthly payments on your own if you prefer not to receive statements. Missed appointments will automatically be charged to your credit card if 24 hour notice is not given or other arrangements have been made with ***THE MENTAL DIFFERENCE.*** Unpaid past due accounts may be turned over to a collection agency if no payment arrangements are made.

Client Name (PRINT): _____

Cardholder Name (PRINT): _____ Billing Zip: _____

Credit Card #: _____ Exp Date: _____

Security Code (3 numbers on back of the card): _____

I authorize ***THE MENTAL DIFFERENCE*** to charge my credit card listed above for past due balances and missed appointment fees. I authorize ***THE MENTAL DIFFERENCE*** to keep my signature on file for future charges as authorized by me.

Cardholder Signature: _____ Date: _____

(CREDIT CARD IS REQUIRED FOR SERVICES)