SUSQUEHANNA COUNSELING GROUP

DATE _____ INTAKE INFORMATION

Name: _____

Address: _____City: _____State: _____Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail: _____ Date of Birth: _____Age: _____ M ____F_____

Referred by: _____ Physician _____Friend/Family _____ Phone Book _____Web Site _____ Insurance

Living Status: _____ Single _____ Married _____ Separated _____ Divorced _____ Widow _____Co-Hab

Place of Employment: _____ Occupation: _____

Name of Spouse / Partner / Guardian: _____

Place of Employment: _____ Occupation: _____

Patient's Social Security #: _____

Religious Preference (if any): _____ Education (highest level): _____

EMERGENCY CONTACT INFORMATION

Who May We Call In Case Of An Emergency:

Name: _____ Relationship: _____Phone: _____

Primary Care Physician (PCP): _____Phone: _____

Do you want information released to your PCP by us? Yes _____ No _____

INSURANCE INFORMATION

PRIMARY INSURANCE:_____ ID # _____

Subscribers Name: _____ DOB _____ SS # _____

Your Relationship to Policy Holder: _____

SECONDARY INSURANCE: _____ ID # _____

Subscribers Name: _____ DOB _____ SS #_____

Your Relationship to Policy Holder: _____

Briefly state the reason you are seeking counseling/psychotherapy services at this time:

_____

_____

If any section below does not apply write: N/A

HEALTH INFORMATION:

Previous Counseling / Psychiatric Treatment: _____ Yes _____ No

Date	Treatment Provider	Problem

Previous Drug / Alcohol Treatment: _____Yes _____ No

Date	Treatment Provider	Problem

Current Medical Issues:

_____

_____

_____

Current Medications:	Dosage:	Prescribed by:

_____

_____

_____

_____

_____

PLEASE READ AND SIGN:

I authorize the release of medical information to process claims for services rendered, and I also authorize the payment of medical benefits directly to Susquehanna Counseling Group.

I understand and agree that I am ultimately responsible for any balance on my account for professional services rendered and broken appointments. I as the client or guardian of the client have read and completed the above information; I certify the information is true to the best of my knowledge. I will notify Susquehanna Counseling Group of any changes in the above stated information.

_____ _____

Signature **Date**

_____

Please PRINT Name

SUSQUEHANNA COUNSELING GROUP

Please complete this page if the client is **UNDER THE AGE OF18.**

1) Please list all the parent's names, addresses and phone numbers:

_____
_____
_____
_____

2) Are the clients parents married? _____ YES _____ NO

If no, is there a legal custody agreement? _____ YES _____ NO

3) Please list all other children and stepchildren within this family and their ages.

_____
_____
_____
_____

4) Are the parents involved in a custody or visitation litigation regarding any minor children? _____ YES _____ NO

If yes, please describe: _____

_____

5) Are the parents or the client currently court mandated to counseling?

_____ Yes _____ NO

SUSQUEHANNA COUNSELING GROUP
400 Third Ave, Suite 212
Kingston, PA 18704

AUTHORIZATION FOR DISCUSSION OF PROTECTED HEALTH INFORMATION (HIPPA AUTHORIZATION)

I, (please print name) _____, hereby give permission for Susquehanna Counseling Group or their designee to contact and discuss information concerning my history, assessment, diagnosis, current care and prognosis. This is to include, but not limited to progress notes, psychological and social history and evaluation, drug and alcohol history, case history and mental status examination.

The purpose of the information is to provide overall continuity of care between myself, family, friends, and my physician who are involved in my total care and treatment.

I hereby authorize the release of any medical information necessary to process insurance claims for payment of medical benefits to Susquehanna Counseling Group for services rendered.

Insurance Company: _____ Initials: _____

I hereby give permission for the following people (family member, physicians, etc.) to speak with my counselor at Susquehanna Counseling Group and receive the above mentioned protected health information.

Name _____ Relationship to patient _____ Phone _____
Name _____ Relationship to patient _____ Phone_____
Name _____ Relationship to Patient _____ Phone _____

I understand that I am not obligated to disclose information if I do not wish to and I may revoke the above authorization at any time by written request.

I certify that I understand this form and have had the opportunity to ask questions concerning this form.

Client Signature * _____ Date _____

Legal Guardian Name ** _____ Date _____

Legal Guardian Signature ** _____ Date _____

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If CLIENT is **14 or older**, client must sign all paperwork and add legal guardians to their HIPPA.

If CLIENT is **13 or under**, a legal guardian must sign all paperwork.

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OFFICE POLICIES

The following important information is regarding your treatment here, as well as some policies and procedures we follow.

- All information about you is treated as confidential
- Consultation with other treating professionals outside of SCG requires your approval
- Confidentiality will be waived in case of:
  - ~ Threat to harm self or others
  - ~ Concerns regarding the neglect or abuse of children
- A copy of the HIPPA Privacy Policies will be provided upon request
- SCG is a provider for multiple insurance companies, PPO's, and HMO's
- You will be responsible for determining your outpatient mental health benefits
- Co-payments and Non-reimbursable fees are due on the day services are rendered
- Monthly statements will be provided and due upon receipt
- Finance charges will be applied to unpaid balances
- Delinquent account balances over 60 days will be referred to a collection agency and you will be responsible for all fees, interest fees, and/or attorney fees related to a delinquent account
- 24 hour notice or one business day notice is required to cancel an appointment
- There is a charge for broken appointments
- After normal office hours, there is an answering service available for emergencies. Your call will be directed to the professional you request or another staff member if that person is unavailable
- In the event of an extreme emergency requiring immediate response, crisis intervention services can be accessed at the emergency department of the nearest hospital

This acknowledges that I have read, understand and agree to the above.

_____ _____

DATE SIGNATURE

_____

PRINT NAME