PeaceLovHarmony Counseling, LLC
Love without the "e" lacks Peace and Harmony
1401 Montgomery Hwy, Suite 151
Vestavia Hills, AL 35216
205-259-8775

Intake Form

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____ Your age _____ Date of Birth _____

Occupation/Employer _____

Have you had prior experience in counseling? Yes ___ No ____

If yes, please describe with whom, when, how long, and for what: _____

_____

_____

What are three significant problems you face currently?

1. _____

2. _____

3. _____

Is there anything in particular that you want the therapist to know about your situation?

_____

_____

_____

Present Marriage (or significant relationship)

Have you been married before? ____ Divorced? _____ When? _____

Children of this marriage (names/ages) Stepchildren (names/ages)

_____ _____

_____ _____

Parents:

Mother still living _____ Deceased_____ Present relationship with mother_____

Father still living _____ Deceased _____ Present relationship with father _____

Parents still together _____ Divorced _____ Remarried _____

Siblings ____yes _____ no How many brothers _____ Sisters _____

If siblings, which are you ____oldest ___ middle _____ youngest

Extended and Immediate Family History (please check those which apply)

Divorce ___ Alcohol/substance abuse ___ Physical abuse ___ Sexual abuse ___

Depression ___ Anxiety ___ Suicide ___ Mental illness ___ Other
_____

Current/Recent Mood (general state lately)

Anxiety ___ Fear ___ Sadness ___ Grief ___ Anger ___ Irritability ___ Happy ___ Impatient ___

Any changes or concerns involving the following? (Please check those which apply)

Finances ___ Legal Matters ___ Work/Job ___ Education/School ___ Moving ___ Marriage ___
Parenting ___ Concentration ___ Memory ___ Energy ___ Health/Illness ___ Surgery/Injury ___
Grief/Loss ___ Addition of a Family Member ___ Family Member Leaving Home ___ Sexual Activity
___ Sleep Habits ___Eating Habits ___ Tobacco Use ___ Alcohol Use ___ Drug Use ___

Your Personal Health

Identify any significant health problems you currently have:
_____

Do you take any medications? Yes ( ) No ( )

If yes, what are you taking: _____

Please describe reason taking: _____

Have you ever been hospitalized for a mental illness? Yes ( ) No ( ) If yes, please describe
_____
___

Other

Years & Level of Education: _____

Is Spirituality/Religion important to you? _____

Do you attend a religious organization? Yes ( ) No ( ) If yes, what organization
_____

Do you attend (or have you attended) any Self-Help Groups? Yes ( ) No ( ) _____

Who do you consider as your greatest support? _____

What do you consider your greatest strengths? _____

How did you hear about Counselor?

____www.psychologytoday.com

____General internet search

____Referred by friend

____Referred by physician

____ Other, Please specify_____

Tell anything else in the space below that you think would be helpful for me, as your therapist, to know.

_____

_____

_____

_____

_____

_____

I, _____, understand and agree to pay costs incurred as agreed upon with the therapist during the initial session. I understand I am responsible for sessions not cancelled 24 hours in advance.

I understand that my sessions are confidential unless I sign a release. I also understand that there are exceptions by law to the privilege of confidentiality. If I say I am going to harm myself or another person, my clinician may report this to the appropriate persons. If I have knowledge of abuse or neglect of a child, elderly person or disabled person, and I tell the clinician, she is obligated to report this to a state agency for follow-up. If a judge subpoenas my records, my clinician must comply.

My signature below confirms that I have read and agree to the above and that I give my consent for treatment to the clinician listed herein.

Client's Signature: _____ Date: _____

Representative if Minor _____ Date: _____

Therapist's Signature _____ Date: _____

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HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization

I authorize _____ (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Effective Period
This authorization for release of information covers the period of healthcare from:
a. □ _____ to _____.

OR
b. □ all past, present, and future periods.

3. Extent of Authorization
a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. □ I authorize the release of my complete health record with the exception of the following information:

□ Mental health records
□ Communicable diseases (including HIV and AIDS)
□ Alcohol/drug abuse treatment
□ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____

Signature of patient or personal representative

_____

Printed name of patient or personal representative and his or her relationship to patient

_____

Date

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Information and Consent for Treatment

Counseling sessions are 50 minutes, unless otherwise agreed upon by you and counselor. Any time beyond 50 minutes, you will be charged in 30minute increments.

I, _____, understand and agree to pay costs incurred as agreed upon with the therapist during the initial session. I understand I am responsible for sessions not cancelled 24 hours in advance.

I understand that my sessions are confidential unless I sign a release. I also understand that there are exceptions by law to the privilege of confidentiality. If I say I am going to harm myself or another person, my clinician may report this to the appropriate persons. If I have knowledge of abuse or neglect of a child, elderly person or disabled person, and I tell the clinician, she is obligated to report this to a state agency for follow-up. If a judge subpoenas my records, my clinician must comply.

In the event that you experience a crisis after hours, you should call the Crisis Center at 205-323-7777. The Crisis Center will receive calls 24 hours a day.

My signature below confirms that I have read and agree to the above and that I give my consent for treatment to the clinician listed herein.

Client's Signature: _____ Date: _____

Representative if Minor _____ Date: _____

Therapist's Signature _____ Date: _____

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Financial Agreement

Total number of people living in my household: _____

Please check the box that most accurately represents your total household income:

___ Less than $15,000 ____ $65,001 - $75,000
___ $15,001 - $25,000 ____$75,001 - $85,000
___ $25,001 - $35,000 ____$85,001 - $95,000
___ $35,001 - $45,000 ____$95,001 - $100,000
___$45,001 - $55,000 ____$100,001 +
___$55,001 - $65,000

*Fees are determined on a sliding scale based on stated household income. Payment can be made in the form of cash, credit card or debit card. Proof of income required (recent tax form or pay stub).

* I understand that payment is due upon arrival for my appointment, if not able to pay appointment will be rescheduled.

* I am allowed a 15 minute grace period to arrive to my appointment. Arriving more than 15 mins late will not be allowed, appointment will have to be rescheduled. Some exceptions allowed, but full 50mins fee is required.

* If I must cancel my appointment, 24hr notice is required or 50% of my fee will be due upon arrival for my next scheduled appointment.

* Should I no show, I will be charged 100% of my fee and payment is due upon arrival for my next scheduled appointment.

* I will not arrive to my appointment under the influence of alcohol or any other mind-altering substance. If I do, counselor will not agree to see me, however payment will be required and appointment will be rescheduled.

I, _____, understand and agree to the financial terms established by PeaceLovHarmony Counseling, LLC and accept my fee to be $_____ per session (50 minutes).

Signing this form indicates that I understand and agree to abide by these policies.

Client's Signature: _____ Date: _____

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PATIENT INSURANCE VERIFICATION OF BENEFITS FORM
(Please complete in full)

Name and address DOB_____/_____/_____

_____
_____
_____

Home Phone_____ Cell Phone _____

Policyholder name_____

Policyholder DOB____/____/_____

Policyholder address (if different than above) _____

Employer_____

Insurance Co._____

Mental Health Phone #_____

Policy/Contract ID#_____Group ID#_____

Eff. Date_____

Please contact your insurance company to answer the following questions:

Do you have outpatient mental health benefits? Yes or No

Copay Amount $_____

How many visits per year am I allowed? #_____

Patient Signature:_____Date:_____

Please understand that we do not accept financial responsibility for patients who see a provider who is not in network and/or benefits that are not covered under your insurance plan. Please also note that missed appointments are not covered by your insurance plan.