Successful Family Solutions, LLC

CLIENT INFORMATION

Client Name: _____ Nickname: _____

DOB: _____ SEX: M or F SSN: _____

Street Address: _____ City: _____ State: _____ ZIP _____

Marital Status: M S D W Spouse Name: _____

Children (names and ages): _____

Parent or Guardian (if under 18): Father: _____ Mother: _____

	OK to call?	OK to leave message
Home Phone: _____	YES NO	YES NO
Work Phone: _____	YES NO	YES NO
Cell Phone: _____	YES NO	YES NO

Email Address*: _____ Okay to contact? YES NO

*Email is used for scheduling and administrative functions only. Email is not used to address clinical concerns.

Who should we contact in an Emergency (Name and Phone #)? _____

Any special requests for leaving messages or for billing arrangements? Yes No If Yes, please describe:

_____

Comments or additional information: _____

_____

_____

Who can we thank for referring you to us? _____

INSURANCE INFORMATION

All statements will be sent to the Policy Holder unless otherwise indicated

Policy Holder: _____ DOB: _____ Relationship to client: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Policy Holders SSN: _____ Employer: _____

Insurance Company Name: _____ Phone: _____

Group #: _____ ID#: _____ Plan Name: _____

Co-Pay: _____ Deductible: _____

Responsible Party: _____ Phone: _____

BACKGROUND INFORMATION

Have you previously received any type of mental health services (psychotherapy, psychiatry, etc)? _____

_____

Name(s) of previous provider or practitioner: _____

Are you currently taking any prescription medication (please list)? _____

_____

Have you ever been prescribed psychiatric medication (please list)? _____

_____

GENERAL HEALTH INFORMATION

How would you rate your current physical health (circle one)?

Poor Unsatisfactory Satisfactory Good Very Good

Please list any current physical problems you are experiencing: _____

_____

How would you rate your current sleep habits (circle one)?

Poor Unsatisfactory Satisfactory Good Very Good

Please list any current sleep problems you are experiencing: _____

_____

How many times per week do you exercise? _____ What types of exercise? _____

List any difficulties you experience with your appetite or eating patterns: _____

_____

Are you currently experiencing overwhelming grief or sadness (describe)? _____

_____

Are you currently experiencing Anxiety, panic attacks or have any phobias (describe)?_____

_____

Are you currently experiencing chronic pain (describe)? _____

Do you drink alcohol more than once per week? _____ Use recreational drugs?_____

What significant life changes or stressful events have you experience lately? _____

_____

_____

FAMILY MENTAL HEALTH INFORMATION

Identify if there is any family history of the following. Circle all that are applicable then use the additional space provided to identify the family members' relationship to you:

Alcohol/Substance Abuse Anxiety Depression Domestic Violence Eating Disorders

Obesity Obsessive Compulsive Behavior Schizophrenia Suicide Attempts

_____

_____

ADDITIONAL INFORMATION

Are you currently employed (describe): _____

Do you enjoy your work? Is there anything particularly stressful about your work? _____

_____

Are you spiritual or religious (describe)? _____

What do you consider to be some of your strengths? _____

_____

What do you consider to be some of your weaknesses? _____

_____

What would you like to accomplish out of your time in therapy? _____

_____

_____

PLEASE READ AND SIGN THE FOLLOWING:

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS:

Person or Organization granted this consent: Successful Family Solutions, LLC
Mileah L. Koudele, LCSW

Federal regulations allow us to disclose protected health information 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" (for example, quality improvement activities). With this chosen consent form, we are asking you to make this permission explicit. By signing this consent, you are giving us permission to use or disclose your protected information for these activities. These uses and disclosures are described in out Notice of Privacy Practices. You have the right to review that notice 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 mailed to you. 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 not be allowed 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 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.

Signature of Client or Personal Representative:_____Date_____

Relationship of Personal Representative to the client:_____

AUTHORIZATION OF ASSIGNMENT OF BENEFITS & SFS FINANCIAL AND BILLING POLICIES
PLEASE READ AND INITIAL:

_____I/we authorize direct payment of insurance payments from my insurance company to Successful Family Solutions, LLC for services rendered.

_____It is understood that the responsible party should obtain an authorization number prior to the initial therapy session depending on the insurance company policy; otherwise the responsible party will accept responsibility for payment of full cost of services rendered.

_____Payment is required at the time services are rendered unless prior arrangements are made. I/we agree to be responsible for all charges for professional services rendered on behalf of the identified client, including any charges not reimbursed (copay, deductible and coinsurance, collateral services, no show fee) by my insurance carrier unless a special arrangement has been agreed upon in writing.

_____It is understood that I/we will be financially responsible for missed appointments unless a 24-hour notice is given prior to scheduled appointment. The fee for a missed appointment is $65. Insurance will not pay charges for missed appointments.

_____It is understood that Successful Family Solutions, LLC does not bill to secondary insurance companies and that I/we will be responsible for charges after the primary insurance has made payment.

_____It is understood that my/our credit card will be charged for the balance of fees not paid by myself, my guarantor or my insurance company within 45 days.

_____It is understood that any checks written that are returned from the bank for any reason will incur a charge.

_____It is understood that it is my/our responsibility to notify Successful Family Solutions, LLC of any pertinent information changes to include address, phone number and insurance companies. It is understood that any charges incurred due to failure to provide the pertinent updated information will be my/our responsibility.

My/Our signature(s) below indicate that I/we understand SFS financial policies and certify that I/we are financially responsible for services provided. I/we will be responsible for any collection or attorney fees or court costs associated with the use of outside agencies required for collection of my/our account.

Client Signature:_____ Date:_____

Responsible Party Signature:_____ Date:_____