CLIENT INFORMATION FORM

Full Name____ Today's Date_______________

Birth date_____________ Soc Sec #_________________ Address____

City______________________________ State___________ Zip_________________ Sex: M F Marital Status: M S D Sep

Home phone________________________ Work phone_______________________ Cell phone___________________________

Fax_________________________ Email Address____

Employer_________________________________ Employer Address____

Occupation____

Responsible Party Information

Full Name_____________________________________ Relationship to Client__________________ Birth date_____________

Soc Sec #_______________________ Address____ City____________________

State_________ Zip_____________ Home phone__________________________ Work phone___________________________

Cell phone_______________________ Fax__________________ Email address_______________________________________

Sex: M F Marital Status: M S D Sep Employer____

Employer Address____ Employer Phone_________________________

Insurance Information

Primary Insurance Company________________________________ Name of Policy Holder_____________________________

(Policy Holder) Address____ City______________ State________________

Zip___________________ Phone Number_____________________________ Fax Number______________________________

Policy Number_________________________________ Group Number____

Insurance Plan Name_______________________________ Policy Holder's Date of Birth_______________________________

Secondary Insurance Company_______________________________ Name of Policy Holder____________________________

Address____ City___________________________ State________________

Zip___________________ Phone Number_____________________________ Fax Number______________________________

Policy Number_________________________________ Group Number____

Insurance Plan Name_______________________________ Policy Holder's Date of Birth_______________________________

Referral Source

How did you hear about us?____

Presenting Problem
Reason for seeking therapy?____

What do you hope to gain from therapy?____

Medical History
Primary Care Physician_________________________________ PCP Phone____________________ Fax________________

Physician's Address____

List any health concerns_______________________________ List Medications___________________________

Therapy History
Have you received therapy before? Name_______________________________________
Phone__________________________

Address____ Fax_____________________ Was it helpful?____________

Have you ever seen a psychiatrist? Name_______________________________________ Phone__________________________

Address____ Fax___________________________

Are you currently seeing a psychiatrist? Name___________________________________ Phone__________________________

Address____ Fax___________________________

Are you currently taking psychotropic medications? Please list____

Emergency Contact
Name____ Relationship to Client_______________________________

Home Phone________________________ Work Phone_________________________ Cell Phone________________________

Do you want appointment reminders? Y/N
_____ phone
_____text
_____email

Informed Consent (initial all)
____I have received a copy and read the HIPPA Privacy Policy for Aspen Valley Counseling.
____I have received a copy of, understand, & I agree to Aspen Valley Counseling's Service Agreement.
____I consent to have my insurance company billed for the services provided by Aspen Valley Counseling.
____I consent to psychotherapy treatment by Aspen Valley Counseling.
____If my account is not paid, and therefore turned into collections, I will be responsible for all collection costs, court costs and attorney fees.

____ ______________________
Signature Date

Professional Service Agreement

Thank you for coming to Aspen Valley Counseling for mental health therapy services. We look forward to working with you to improve your life and your relationships. This agreement is to clarify the business aspects of our relationship, and to help our therapeutic relationship go smoothly.

Fees & Billing

Intake	$150
Individual Therapy (45-50 min)	$110
Couples Therapy (45-50 min)	$110
Family Therapy (45-50 min)	$110
Group Therapy (90 min)	$40
Clinical Mental Assessment	$200
Neurofeedback	$110
Neurofeedback pre-paid 20 sessions	$1000

- Payment is due in full at the beginning of each session by cash, check, or card. Included in the above fees are brief phone calls (under 15 min) and routine paperwork.

- There will be a $25 fee for any canceled check.

Health Insurance Coverage

We will work with your insurance company to pay for your visit. However, all co-pays are due at the beginning of each session. If your insurance company does not pay for the visit, you will be responsible for the balance of all charges as outlined above.

Confidentiality

- The information you share will be kept confidential. I will ask you to sign a release-of-information form before discussing your treatment, or sending records about you to anyone else.
- Your confidentiality/privacy is protected by state law and by the rules of our profession, except in the following circumstances. The limits of confidentiality are:

1. **If you were sent to me by a court or an employer** for evaluation or treatment, the court or employer expects a report from me. You have a right to disclose only what you are comfortable with me telling.
2. If you are **involved in a law suit**, and you tell the court that you are in therapy, I may then be ordered to show the court my records. Please consult your attorney about these issues.
3. If you **threaten to harm** yourself or another person, the law requires me to try to protect you and/or that other individual.
4. If I believe a **child, an elderly individual, or a vulnerable adult has been or will be abused or neglected**, I am legally required to report this to the authorities.
5. If I **bill your insurance** it will have a mental health diagnosis listed and it will become part of your permanent medical record.
6. In order to provide you with the best treatment I may **consult with other mental health professionals** about your case.

Late Cancellation/No Show Policy

If you are unable to make your scheduled appointment, please cancel at least 24 hours in advance so another client can be scheduled during that time. If 24 hours notice is not given, you will be charged the full session amount.

If Case of Emergency

If you are experiencing an emotional, behavioral, or medical crisis, call 911 or go to the nearest emergency room. We do not provide 24 hour crisis services.

I understand, and agree to, the policies as stated above, and I give consent for treatment by Aspen Valley Counseling.

____ ______________________________

Client's Name Date

____ ______________________________

Client's (or Responsible Party's) Signature Relationship to Client Date