Date:_______________

For Office Use Only:
DX: ____________
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STARKVILLE COUNSELING
ASSOCIATES

PERSONAL INFORMATION: ***Please print neatly.***

Client's Name: ____________________________________ Name of Parent/Guardian(*minor clients*):________________________________

Client's Address: ____ Client's Cell Phone:____________________________

City/State/Zip ____ Client's Home Phone:_____________________________

Client's email: ____ Client's Work Phone:_______________________________

Date of Birth:__________ Age:_____ Sex: ____ Single ___ Married ___ Divorced ___ Widowed ___ Partnered ___

Would you like a voicemail reminder for your appointments? _____YES _____NO *(Occasionally it will be necessary for our office to contact you regarding matters about counseling. By entering information above, you are agreeing for us to leave a voice mail, text or email. We will always be discrete in any message or correspondence, but cannot guarantee confidentiality once the message is sent.)*

Emergency Contact:____________________________________Relation:___________Phone Number:_________________________

If married/partnered, please indicate their name ___________________________________ Length of relationship ________________
Is your spouse/partner supportive of you seeking counseling? Yes ___ No ____

Children(Age/Sex/Name) or, if no children, name/age of siblings: (***Example: 1daughter, age 6, Jan; 1 son, age 4, Jack***.)

Education: _____ grade in school/ H.S or equivalent / College: FR___ SO___JR___ SR___ Bachelors___ Masters___ Doctorate___

Occupation: ___________________Employer:______________________ My degree (if applicable) is in: _______________________

MEDICAL/COUNSELING HISTORY

Personal Physician: _____________________________Phone: _______________Are you currently under medical care? Yes ___ No___

If yes, please indicate reasons

Medications (Please indicate name of medicine/dosage/ & medical condition it treats)

Other significant medical history:

Have you previously seen a counselor, therapist, or psychiatrist? Yes___ No___ If yes, please indicate the name of the professional, the year of treatment, the length of treatment and the diagnosis or nature of your problem at that time.

Indicate your reasons for seeking therapy at this time and your expectations from therapy.

BILLING INFORMATION:

Billing Party Name *(if other than client)*: ______________________________ Date of Birth: ______________

Billing Party Address ______________________________ Relation: ______________

City: ______________________________ State: ______________ Zip: ______________

Cell Phone: ______________________________ Home Phone: ______________________________

Employer: ______________________________ Work Phone: ______________________________

Email: ______________________________ Social Security #: ______________________________

INSURANCE INFORMATION: Please present your card to be copied.

Insurance carrier: ______________________________ Phone # for providers: ______________________________

Policy Owner: ______________________________ Policy Owner DOB: ______________________________

Address: ______________________________ City/State/Zip: ______________________________

Member ID: ______________________________ Relation to Policy Owner: ______________________________

BILLING POLICY/RELEASE OF INFORMATION:

1. Payment for services rendered is expected at each session. Acceptable forms of payment include cash, personal check or money order. We offer access to credit card payments on our website through PayPal. Accounts 60 days past due are subject to referral to an outside collection agency. In the event that your account is forwarded to an external collection agency, all collections fees will be added to your account. Information such as name, social security number, employer, address, and date of birth of the client and/or billing party are released for collection purposes only. My initials indicate permission to release this information if necessary. ______ (Initial)

2. I understand that my insurance company may require release of information regarding my treatment, and I authorize the release of such information, if applicable. I understand that I am responsible for any charges not reimbursed by my insurance company. I also authorize SCA to obtain/release/exchange information with my Primary Care Physician, other healthcare practitioner(s) or as requested by my insurance company for the purpose of service coordination and continuity of care. ______(Initial)

3. **I understand that my counselor will not willingly testify in any court proceedings as this role, more often than not, jeopardizes the therapeutic relationship.** SCA will generally file a motion to quash an attempt to have an SCA counselor participate in a legal matter. **All legal fees** for SCA representation will be passed on to the client(s) and/or guardian(s) who waive the right to confidentiality and/or legally subpoena an SCA counselor to be deposed or to testify. SCA counselors will charge $1500.00 per day for any scheduled deposition, hearing or courtroom appearance, regardless of the time spent in said activities. This fee applies whether the SCA counselor is able to testify that day or not. Payment for any appearance will be required prior to my counselor's participating. SCA counselors charge $150.00 an hour for time spent on any additional activities related to any legal matter. ______ (Initial)

CANCELLATION POLICY;

There is a cancellation policy, which requires that you **cancel** your appointment **24 hours** in advance to avoid being charged. You may call the office (323-5588), text your counselor's cell phone or email our office manager or your counselor any time to cancel an appointment. When canceling, please indicate when you would like to reschedule your next session. In the event that your counselor has to cancel a session, he or she will notify you promptly.

Signature: ______________________________ Date: ______________________________