Date:_____

For Office Use Only:
DX: _____
_____
_____
_____

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 text or call reminder for your appointments? ____Text ____Call ____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.)*

If married/partnered, please indicate their name _____ Length of relationship _____
Is your spouse/partner supportive of you seeking counseling? Yes ☐ No ☐

Emergency Contact:_____Relation:_____Phone Number:_____

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 #:_____

CANCELLATION POLICY;

Our cancellation policy requires that you **cancel** your appointment **24 hours** in advance to **avoid being charged the full session rate**. 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. The credit card information you provide below will be used for missed appointment charges only.

Credit Card Information: Name on card: _____

Card Number:_____ Expiration Date: _____ CVC code: _____

Billing Address for this card: _____

City: _____ State: _____ Zip code: _____

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)**

Signature: _____ Date: _____