ELEVATION
CHRISTIAN COUNSELING

Adult Intake

Client Information		Spouse Information	
Name	_____	Name	_____
DOB/Age	_____	DOB/Age	_____
Address	_____	Address	_____
City, Zip	_____	City, Zip	_____
Mobile Phone	_____	Mobile Phone	_____
Home Phone	_____	Home Phone	_____
Email	_____	Email	_____
Employer	_____	Employer	_____
Occupation	_____	Occupation	_____
Insurance	_____	Policy Holder	_____

Emergency Contact and Number _____

Circle all that apply:

Therapist may leave a detailed message: Mobile Phone Home Phone Email

Therapist may leave appointment reminders: Mobile Phone Home Phone Email

Summary of Circumstances that bring you in to Elevation Christian Counseling

_____

_____

_____

_____

Mental Health History

Have you received counseling before? YES NO

If yes, please list Previous therapist, Dates, Reasons, and any Mental Health Hospitalizations

_____

_____

_____

_____

Current Diagnosis' and psychotropic medications and dosage

_____

_____

Family History of Mental Health? YES NO

If yes, please list Name, Relation, and Mental Health Diagnosis (including substance abuse struggles)

_____

_____

_____

_____

Medical History

Serious Illnesses

_____

_____

_____

Serious Injuries or Accidents and Dates

_____

_____

_____

Name and Date of any Operations and/or Hospitalizations

_____

_____

_____

Current Physical Diagnosis' and Medication/Supplements and Dosage

_____

_____

_____

Marital Status

Married? YES NO Date Married _____
Divorced? YES NO Date Divorced _____
Widowed? YES NO Date Widowed _____

Previous Marriage From _____ to _____
Divorced? YES NO Date Divorced _____
Widowed? YES NO Date Widowed _____

Children

Name	Sex	DOB	Health	Grade

Family Members

Members	Sex	DOB	Health	Date of Death	Cause
Father -					
Mother -					
Spouse -					
Siblings -					

Personal History

What is your last grade/degree completed? _____

Do you smoke? YES NO
If so, how much/often? Cigarettes _____ Pipe _____ Cigars _____ Vape _____ Juul _____

Do you drink Caffeinated Beverages? YES NO
If so, how much/often? Coffee _____ Tea _____ Soda _____

Do you drink alcohol? YES NO
If so, number/amount per Day _____ Week _____ Month _____

Please list other chemicals or illegal drugs along with amount per day/week
_____
_____

Do you have difficulty falling asleep? YES NO
Do you wake in the middle or the night? YES NO

Have you experienced a change in appetite? YES NO
Have you gained or lost weight in the last year? YES NO
Lost _____ Gained _____

Are you currently having thoughts of suicide? YES NO
Please explain
_____
_____
_____

Have you had previous thoughts of suicide and/or attempts in the past? YES NO
_____
_____
_____

Please write down anything else you'd like for me to know
_____
_____
_____
_____
_____

_____ _____
Client Signature Date Therapist Signature Date

Fee Schedule and Late Cancellation/No-Show Policy

Elevation Christian Counseling has no control over your individual rate when using insurance. Co-pay rates are subject to your insurance policy. If you are having an issue or believe your payment to be incorrect, please contact your insurance company to verify your rate. Please also know that we at Elevation Christian Counseling are willing to help you figure it out with our billing company, MED Management, if there are any further questions.

We understand there are times you must miss and appointment due to emergencies or obligations to work or family. However, if you do not notify your therapist you are unable to make your appointment, it hinders their ability to schedule another client. Therefore, if an appointment is not cancelled at least 24 hours in advance, you will be charged a $75 fee. If you do not cancel and you fail to show for your appointment, you will be charged a $100 fee. **Insurance companies do not cover late cancellation and no-show fees therefore making it each individual client's responsibility to make a payment.**

All clients will need to fill out a credit card on file/private pay form to help minimize missed payments, which affect you as the client and your therapist. MED Management will charge your card by the end of the week of your scheduled session.

Rates according to CPT codes:

90791 – Intake	$225
90847 – 38-52 min (Couples)	$220
90837 – 53-60 min	$200
90834 – 38-52 min	$150
90832 – 16-37 min	$100
90853 – Group 60 min	$100
Private Pay Rate	$100
Late Cancel Charge	$75
No-Show Charge	$100
Written Reports/Letters/ Exchange of Client info (60 Min)	$150
Required/Requested Provider Appearance (per hour)	$200

I have read the Fee Schedule and Late Cancellation/No-Show Policy. I understand and agree to this policy.

Client Signature Date

Therapist Signature Date

Parent/Guardian Signature Date

Supervisor/Collaborator Signature Date

Credit Card on File/Private Pay Form

All therapy sessions (Individual, Group, Family, and/or Marriage) vary from 45 minutes to 60 minutes. Insurance or private pay can be used for these services. Please read through the following information and defer to your therapist for any questions.

_____ Insurance: Credit card on file for copay/deductible/coinsurance payments for each appointment.

_____ Private Pay: Credit Card on file for the private pay agreement with my therapist for each appointment.

Client Name: _____

Therapist Name: _____

Private Pay Rate: _____

Credit Card information and authorization:

Name as it appears on the credit card: _____

Type of credit card: _____ MasterCard _____ Visa _____ Discover _____ Amex

Card Number: _____

Expiration Date: _____ CVV: _____

I, _____, authorize Elevation Christian Counseling to utilize their desired billing service of MED Management to process my credit card for my date of service. I have been made aware that MED Management will process my payment at the end of the week of my date of service. I agree to be charged the late cancellation fee of $75, and the no-show fee of $100, as stated in the financial agreement in the intake packet. I will update this form if credit card information changes at any time. If I have any questions, I understand that I may address said questions with my therapist, and we will work to resolve any issues.

_____ _____

Client Signature Date Therapist Signature Date

_____ _____

Parent/Guardian Signature Date Supervisor/Collaborator Signature Date

Insurance Information

Primary Insurance

Insurance Name: _____ Phone: _____

Member ID#: _____ Group #: _____

Policyholder's Name: _____ DOB: _____

Claims Address: _____

Ins. Rep. Name: _____ Effective Date: _____

Ded.: _____ Ded. Met: _____ OOP: _____ OOP Met: _____

Co-Pay: _____ Co Ins.: _____ Coverage Limits: _____

Secondary Insurance

Insurance Name: _____ Phone: _____

Member ID#: _____ Group #: _____

Policyholder's Name: _____ DOB: _____

Claims Address: _____

Ins. Rep. Name: _____ Effective Date: _____

Ded.: _____ Ded. Met: _____ OOP: _____ OOP Met: _____

Co-Pay: _____ Co Ins.: _____ Coverage Limits: _____

I verify the above insurance information is correct. I understand that at the time of my first appointment I am to provide a copy of my insurance card and drivers license.

Client Signature Date

Therapist Signature Date

Parent/Guardian Signature Date

Supervisor/Collaborator Signature Date

Client Acknowledgement and Authorization

- I have reviewed the *Client Rights* document available on the website.
- I have reviewed the *Consent to Treatment* document available on the website.
- I have reviewed and signed the *Fee Schedule and Late Cancellation/No-Show Policy*.
- I understand I will be charged the late cancellation/no-show fee as applicable, which is not covered by my insurance company.
- I have reviewed and signed the *Credit Card on File/Private Pay Form*.
- I understand if I have any questions regarding my rights and privacy, I may contact my therapist.
- I understand Elevation Christian Counseling and MED Management will be contacting my insurance regarding benefits, eligibility, and claim information.
- I understand any treatment charges not covered by my insurance plan will be my responsibility.
- I understand if I have 3 cancellations and/or no shows, I may be subject to discharge and referral for other therapeutic facilities.
- I understand Psychotherapy is done in person. If I am to reach out to my therapist via phone or email with a non-critical problem, I understand my therapist may suggest I meet with them.
- I understand email is not to be used for immediate attention or emergency care.
- I understand Elevation Christian Counseling is not a crisis prevention facility and **if there is an emergency**, I am to contact my primary care physician, 911, or an emergency crisis line:
    - National Alliance on Mental Illness (NAMI) – 24/7 crisis and suicide prevention counseling (800) 273-8255
- I understand recording of sessions is strictly forbidden.

Taking care of and being responsive to clients is your therapist's priority. However, they will not always be available. Please allow your therapist up to 24 hours to contact you if you reach out to them via phone or email. Your therapist will check his/her voicemail and email at least once a day and respond to you as soon as you call. Please discuss and respect appropriate boundaries with your therapist regarding contact.

I have read the Client Acknowledgement and Authorization Policy. I understand and agree to this policy.

Client Signature	Date	Therapist Signature	Date
Parent/Guardian Signature	Date	Supervisor/Collaborator Signature	Date