Aspire
Counseling

Healing | trauma | grief | fear | stress

Intake Form

PLEASE PRINT CLEARLY Today's Date _____

PERSONAL INFORMATION

CLIENT (S) _____ **RESPONSIBLE PARTY** _____

Date of Birth _____ Gender _____ Responsible Party's SSN _____

Address _____ Address (if different) _____

_____ _____

City, State _____ Zip _____ City, State _____ Zip _____

Home Phone _____ Home Phone (if different) _____

Work Phone _____ Work Phone (if different) _____

Cell Phone _____ Cell Phone (if different) _____

E-mail_____ E-mail (if different)_____

Please indicate with an * which phone numbers we may NOT leave a message.

Clients' relationship to Responsible Party (check one): Self_____ Spouse_____ Child_____ Other _____

Relative or friend in case of emergency _____

Name Phone # Relationship

Client Employer or School: _____

How did you hear about Aspire Counseling LLC? _____

FINANCIAL

I understand that Aspire Counseling LLC does not accept insurance. I will be given a receipt that I may submit to my insurance for possible reimbursement. As well, I understand that if I cancel within 24 hours or do not show up for an appointment I will be billed the entire amount of the session. I have been given the opportunity to ask questions regarding this statement.

_____ _____ _____

Signature of Responsible Party Printed Name Date

OVER

Therapist Use Only	**Location**	**Billing**
Therapist Name _____	☐ Columbia, MO	☐ Client Self Pay

Aspire
Counseling

Healing | trauma | grief | fear | stress

FAMILY INFORMATION

NAME	M/F	AGE	DATE OF BIRTH	RELATIONSHIP TO PATIENT &/or MARITAL STATUS	EDUCATION	OCCUPATION
Patient (s)						
1.						
2.						
Parent (s)						
1.						
2.						
Children/Step Children/Siblings						
1.						
2.						
3.						
4.						
5.						
6.						
Others Living in Household						
1.						
2.						

How could your life be better? Please include as many details as possible. Sometimes it helps client to think about an answer to this question: If you woke up tomorrow and the issues bringing you to counseling were "better" or you no longer needed counseling, how would you know? What in your life would be different?

Aspire
Counseling

Healing | trauma | grief | fear | stress

MEDICAL INFORMATION

1. **Client Name _____**

Have you ever been treated for emotional difficulties before (When and Where?) _____

_____

Have you ever been hospitalized for psychiatric reasons (When and Where?)_____

_____

Physician: Name/Practice _____ Address_____ Phone _____

Date of and reason for last physical exam _____

How is your general health now? _____

List all current medications: _____

Are you presently being treated by a physician for any physical condition? _____

Name of psychiatrist:_____

Have you had any serious illness? (List) _____

Have you ever had any surgery? (List) _____

***If more than one client, please indicate above medical information on separate sheet for other clients.**

PLEASE MARK ALL THAT APPLY: (If more than one patient, please separately initial)

___Anger	___Grief	___Paranoia
___Anxiety	___Guilt	___Physical Aggression
___Behavior Problems	___Hallucinations	___School/Work Problems
___Changes in Appetite/Eating Habits	___Hopelessness	___Self Abusive Behavior
___Criminal Activity	___Hyperactivity	___Sleep Disturbance
___Decreased Energy	___Impulsiveness	___Somatic Complaints
___Delusions	___Interpersonal Conflicts	___Suicidal Thoughts/Attempt
___Depressed Mood	___Irritability	___Weight Gain
___Disruption of Thought Process/Content	___Manic	___Weight Loss
___Emotional/Physical/Sexual Trauma	___Mood Swings	___Worthlessness
___Excessive Crying	___Oppositional	___Other (Specify)
___Family Conflicts	___Panic Attacks	

Aspire
Counseling

Healing | trauma | grief | fear | stress

You, or a member of your family, are about to become involved in counseling or psychotherapy with a trained and licensed/certified therapist. We wish to take this opportunity to welcome you and also to state some basic principles we believe essential in establishing a good counseling relationship between us. Please read through this information, asking questions as needed.

1. INITIAL INTERVIEW: Your first 2-3 visits are considered a diagnostic or evaluation interview. At this time, the following decisions will be made with you:
   a) Type of therapy needed (individual, group, medication referral, etc.)
   b) Frequency of therapy sessions (weekly, biweekly, etc.)
   c) Goals of therapy (what you hope to gain from this process.)

2. ASSESSMENT: In addition to speaking to the client directly, your therapist may gather information for assessment purposes including through speaking to other involved parties when releases are provided, a basic internet search, or reading documents you supply from outside agencies. When a youth is receiving services from Aspire Counseling and has a 504 plan or IEP through their school, we ask that parents/guardians provide their therapists with a copy of the 504 or IEP.

3. APPOINTMENTS: Each appointment is approximately 45-50 minutes unless a longer appointment is scheduled ahead of time.

4. CANCELLATIONS: If you find that you need to cancel an appointment, please give as much notice as possible so that we can schedule people that are on our waiting list. You will be charged for your appointment if not canceled at least 24 hours in advance.

5. PAYMENTS: We would greatly appreciate payment in full for each office visit when you come for your appointment. Charges for services in addition to therapy may be levied (i.e., involvement in client litigation, attending IEP meetings, document preparation, etc.). We accept cash, check, health savings account cards and credit cards. Please make checks out to "Aspire Counseling LLC".

6. INSURANCE: Insurance is an agreement between you and your insurance company as to how counseling will be paid for. We will assist you in any way possible by providing receipts and documentation. We currently do not directly participate with insurance plans. However, we will assist you by providing receipts to submit. Many insurance companies will pay for a portion of outpatient mental health services. You should check with your insurance company representative to find out specific requirements and limitations of this coverage. We will be happy to assist you in the preparation of insurance forms if you feel there is a chance your insurance company will pay for these services. The hourly rate will apply. Payments for services received through Aspire Counseling LLC are ultimately your responsibility. If your insurance company requires that outpatient mental health services be preauthorized, it is your responsibility to initiate the reauthorization process, i.e. contacting your primary care physician, insurance company, or a third party "gate keeper". Failure to obtain required preauthorization for outpatient mental health services will result in you being held 100% responsible for all charges. Late charges of 5% per month will be added to balances existing for more than 30 days and services may be terminated when clients are behind payment for more than three sessions.

7. CONFIDENTIALITY: All information regarding the specific nature of your counseling or psychotherapy is maintained at Aspire Counseling LLC and is considered confidential within the office unless specified by you in writing. However, each therapist at this office reserves the right to use specialty consultation with other therapists as deemed necessary. We follow HIPAA and maintain confidentiality. We are bound to report suspected child abuse/neglect, harm to self/others, or follow a court-issued subpoena.

If more than one adult patient, each person should check and initial boxes.

☐ Yes ☐ No I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions.

☐ Yes ☐ No I have received a copy of the Privacy Practices Form.

☐ Yes ☐ No I consent to the exchange of treatment information between Aspire Counseling and my primary care physician.

Patient(s):

Signed: _____ Date: _____

Aspire
Counseling

Healing | trauma | grief | fear | stress

Signed: _____ Date: _____

Privacy Practices & Policies – Client Copy

You, or a member of your family, are about to become involved in counseling or psychotherapy with a trained and licensed/certified therapist. We wish to take this opportunity to welcome you and also to state some basic principles we believe essential in establishing a good counseling relationship between us. Please read through this information, asking questions as needed.

8. INITIAL INTERVIEW: Your first 2-3 visits are considered a diagnostic or evaluation interview. At this time, the following decisions will be made with you:
    a) Type of therapy needed (individual, group, medication referral, etc.)
    b) Frequency of therapy sessions (weekly, biweekly, etc.)
    c) Goals of therapy (what you hope to gain from this process.)

9. ASSESSMENT: In addition to speaking to the client directly, your therapist may gather information for assessment purposes including through speaking to other involved parties when releases are provided, a basic internet search, or reading documents you supply from outside agencies. When a youth is receiving services from Aspire Counseling and has a 504 plan or IEP through their school, we ask that parents/guardians provide their therapists with a copy of the 504 or IEP.

10. APPOINTMENTS: Each appointment is approximately 45-50 minutes unless a longer appointment is scheduled ahead of time.

11. CANCELLATIONS: If you find that you need to cancel an appointment, please give as much notice as possible so that we can schedule people that are on our waiting list. You will be charged for your appointment if not canceled at least 24 hours in advance.

12. PAYMENTS: We would greatly appreciate payment in full for each office visit when you come for your appointment. Charges for services in addition to therapy may be levied (i.e., involvement in client litigation, attending IEP meetings, document preparation, etc.). We accept cash, check, health savings account cards and credit cards. Please make checks out to "Aspire Counseling LLC".

13. INSURANCE: Insurance is an agreement between you and your insurance company as to how counseling will be paid for.
We will assist you in any way possible by providing receipts and documentation. We currently do not directly participate with insurance plans. However, we will assist you by providing receipts to submit. Many insurance companies will pay for a portion of outpatient mental health services. You should check with your insurance company representative to find out specific requirements and limitations of this coverage. We will be happy to assist you in the preparation of insurance forms if you feel there is a chance your insurance company will pay for these services. The hourly rate will apply. Payments for services received through Aspire Counseling LLC are ultimately your responsibility. If your insurance company requires that outpatient mental health services be preauthorized, it is your responsibility to initiate the reauthorization process, i.e. contacting your primary care physician, insurance company, or a third party "gate keeper". Failure to obtain required preauthorization for outpatient mental health services will result in you being held 100% responsible for all charges. Late charges of 5% per month will be added to balances existing for more than 30 days and services may be terminated when clients are behind payment for more than three sessions.

14. CONFIDENTIALITY: All information regarding the specific nature of your counseling or psychotherapy is maintained at Aspire Counseling LLC and is considered confidential within the office unless specified by you in writing. However, each therapist at this office reserves the right to use specialty consultation with other therapists as deemed necessary. We follow HIPAA and maintain confidentiality. We are bound to report suspected child abuse/neglect, harm to self/others, or follow a court-issued subpoena.

If more than one adult patient, each person should check and initial boxes.

☐ Yes ☐ No I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions.

☐ Yes ☐ No I have received a copy of the Privacy Practices Form.

☐ Yes ☐ No I consent to the exchange of treatment information between Aspire Counseling and my primary care physician.

CLIENT COPY – KEEP THIS FORM FOR YOUR RECORDS