Patient Demographics

General Information:

Today's Date:		Date of Birth:
Name:		Gender: ❑Male ❑ Female
Address:		SSN:
City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:
Email:		Preferred Contact Method: ❑Home ❑Work ❑Cell
Race:		Language: ❑ English ❑Spanish ❑Other
Employer:		

Financially Responsible Party Information:

Responsible Party: ❑Self ❑Spouse ❑Dependent	Date of Birth:
Responsible Party Name:	
Responsible Party Address:	
Phone:	❑Home ❑Work ❑Cell

Insurance Information:

Policy holder: ❑Self ❑Spouse ❑Dependent	Subscriber Date of Birth:
Subscriber Name:	Subscriber Employer:
Insurance Company Name:	
ID#:	Group#:

Emergency Contact:

Name:	
Relationship:	Phone: ❑Home ❑Work ❑Cell

Pharmacy Information

Preferred Pharmacy:		
Address:	Phone:	
City:	State:	Zip:

By signing I verify the information on this page is correct to the best of my knowledge. I understand quoted benefits are not a guarantee of payment and I am responsible for any portion not covered by insurance. I authorize the release of any medical or other information needed to process insurance claims. I also authorize payment of medical benefits to this practice for services rendered.

Print Name _____ Signature _____

If not signed by patient, please indicate relationship to patient (i.e., parent, Power of Attorney, etc.)

Relationship _____ Date _____

Witnessed by _____ Date _____

FINANCIAL STATEMENT OF UNDERSTANDING

- Initial _____ Payment is expected on the day of your appointment. Your insurance contract requires that we collect your copay for services. A $15.00 fee will be charged if payment is not made on the date of service
- Initial_____ All balances should be paid within 20 days of the date of service
- Initial_____ Missed Appointment Fee: We require at least 24 hours' notice to cancel an appointment. We provide a 24 hour live answering service, courtesy confirmation calls, and can take your call during business hours. If we are not notified of your missed appointment:
    - You will be responsible for the missed appointment fee
        - $45.00 for a therapy appointment
        - $50.00 for a medical appointment
    - You will not be rescheduled until the fee for the missed appointment is paid.
    - We cannot bill your insurance for the missed appointment fee.
- Initial_____ You are required to keep three consecutive visits with your provider before we are able to complete any FMLA, or Disability forms. Please review our Disability Form Fee Notice if you have a request. Fees for these forms can range from $25.00 - $75.00 and must be paid prior to the forms being reviewed and completed.
- Initial_____ There is a $45.00 fee for returned checks. If not paid in full within 10 days your account will be turned over to the Worthless Check Unit in Rock Hill, which will result in additional fees.
- Initial_____ Requests for medical records are charged a base fee of $15.00. If records are provided to include greater than 30 pages, an additional $ .65 per page is charged. If records are provided to exceed 50 pages, an additional $.50 per page is charged.
- Initial_____ Upon request prescriptions can be mailed, a $15.00 fee will be required prior to mailing.
- Initial_____ It is your responsibility to meet all requirements for EAP Authorizations as set forth in your EAP contract.
- Initial_____ It's your responsibility to provide correct insurance information at the time of service. If incorrect information results in insurance denial, balances will be your responsibility.

I understand the above statement of fees and policies.

_____ _____

Patient/Authorized Person Signature Date

_____

Authorized Person Relationship to Patient *(if applicable)*

_____ _____

Witness Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Concerning the use of my personal medical information, I ALLOW the following family members and/or friends as written below on my behalf:

1) _____

Print Full Name of Person

- ☐ to schedule/reschedule/cancel appointments
- ☐ to pick up written prescriptions or samples
- ☐ to discuss billing information
- ☐ to discuss insurance information

2) _____

Print Full Name of Person

- ☐ to schedule/reschedule/cancel appointments
- ☐ to pick up written prescriptions or samples
- ☐ to discuss billing information
- ☐ to discuss insurance information

3) _____

Print Full Name of Person

- ☐ to schedule/reschedule/cancel appointments
- ☐ to pick up written prescriptions or samples
- ☐ to discuss billing information
- ☐ to discuss insurance information

- Initial_____ I have been presented with a copy of The Saluda Counseling Center's Notice of Privacy Practices, I understand this notice and that my information may be used only as permitted under federal and state law.

_____ _____

Patient/Authorized Person Signature Date

_____ _____

Printed Name Authorized Person Relationship to Patient (*if applicable)*

_____ _____

Witness Signature Date

Family Intake Form

Parents/Legal Guardian Please Complete this form

Today's Date: _____

Child's Name: _____
First Middle Last

Date of Birth: _____ Age: _____

Address: _____
Street City State Zip

Mother's/Legal Guardian Name: _____

Birth date: _____ Age: _____ Social Security# _____

Address: _____

Phone Number: _____
Home Work Cell

Occupation and Place of Employment: _____

Father's/Legal Guardian Name: _____

Birth date: _____ Age: _____ Social Security# _____

Address: _____

Phone Number: _____
Home Work Cell

Occupation and Place of Employment: _____

All people currently residing with child: _____

Other Children in family (including half/step brothers/sisters) and their ages: _____

_____

Name of child's school and/or Childcare Facility: _____

Grade in School and Teacher's Name: _____

Please describe your reasons for bringing your child into counseling at this time:

_____

_____

_____

_____

What is the marital status of child's parent: _____

Names of step-parents: _____

Family's religious affiliation and involvement: _____

_____

Has your child been involved in counseling previously: _____

Name(s) of counselors/dates of involvement: _____

Reason for counseling at that time: _____

List any medication your child is currently taking: _____

_____

Prescribing Physician: _____

Other Physician: _____

Did your child meet developmental milestones (i.e. crawling, walking, talking, etc) when you expected him/her to: _____

_____

Serious medical conditions for which you have sought treatment for your child/surgeries and dates of such conditions: _____

_____

Please circle all of the following that apply to your child:

Anxiety	Depression	Mood Swings
Attention Deficit Disorder (ADD)	Suicide Attempts	Self- inflicted injury
Alcohol or Drug Abuse	Unusual thoughts or beliefs	Unusual sleep pattern
Bladder/Bowel control problems	Eating Disorder	Problems with peers
Problems with adults	Chronic Physical complaints	Criminal behavior
Aggression/violence	Sexual problems	

Date of suicide attempts: _____

Does your child have any disabilities/type: _____

Have other family member previously received counseling or been diagnosed with a psychiatric illness? Name/relationship/diagnosis: _____

_____

Has your child had a physical examination in the last year: _____

Has your child seen a physician within the last 6 months for any reason other than a physical exam: □YES □ No

If yes please specify reasons:_____

Please circle all of the following your child is currently experiencing or has experienced in the past and note age of child at the time of problem:

Headaches	Dizziness	Severe nausea
Fainting spells/blackouts	Seizure/convulsions	Memory loss
Recurrent ear infection	Asthma	Ulcers
Head injury	Heart disease	Allergies
Recurrent respiratory infection		

Any additional information you think would be helpful: _____

_____

_____

_____

Signature of person completing this form: _____ Date _____

Relationship to child: _____