Therapeutic Treatment Center

Serenity. Courage. Wisdom.

For Office Use Only:

Group _____
Individual _____
Time _____
Day/s _____
Insurance _____
Self-Pay _____
Co-Pay _____
Client ID #: _____

CLIENT INTAKE INFORMATION

About the Client:

Name:_____ **Today's Date:**_____

Birth Date:_____ **Age:**_____ **Social Security Number:**_____

Male_____ **Female**_____ **Race**_____ **Single**_____ **Married**_____ **Divorced**____ **Separated**____ **Widowed**____

Address:_____ **City, State, Zip:**_____

Home Phone:_____ **Work Phone:**_____ **Cell Phone:**_____

Email:_____

If there is an emergency at the office and we must cancel the appointment, who should we called:

_____

Your emergency contact person: Name: _____
Relationship: _____
Work:_____ **Home:**_____ **Cell:**_____

Responsible Party

Name:_____ **Relationship to Patient:**_____

Birth Date:_____ **Social Security Number:**_____

Address:_____
Street **City** **State** **Zip**

Employment

Employer:_____ **Phone:**_____

Address _____
Street **City** **State** **Zip**
Occupation:_____

Family Physician

Physician Name:_____ **Phone:** _____

Address _____
Street **City** **State** **Zip**
Last Visit:_____ **Concerns?**_____

Do you have any chronic medical concerns?_____ **If so, please list:**_____

List all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had:_____
_____

List *all* medications or drugs (legal or illegal) you take or have taken in the last year:_____
_____

Prior Hospitalizations: Hospital_____ **Date**_____ **Cause**_____

INSURANCE

Company Name _____

Insurance Company Address_____
Street **City** **State** **Zip**

If insurance is not in your name, whose name is it in? _____

Insured's Social Security #_____ **Insured's Date of Birth:** _____

Insured's ID #_____ **Insured's Group #**_____

Insured's Employer _____ **Occupation** _____

Business Address _____ **Phone** _____
Street **City** **State** **Zip**

Authorization and Release:

I authorize and request my insurance company to make payments directly to Therapeutic Treatment Center, LLC. all insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill services. I agree to be responsible for payments of all services rendered on my behalf or for my dependents. I give Therapeutic Treatment Center, LLC. the right to seek the services of a bill collecting agency in efforts to collect fees that my insurance company has not paid and that I have not paid for services rendered and/or for cancelled or missed appointments. I understand that there is a fee for all sessions not cancelled within twenty four hours notice.

X_____ _____ _____
Client Signature **Client Printed Name** **Date**

REFERRED BY_____ **Phone** _____

Do we have permission to contact referral source? Yes_____ No _____

Please indicate by placing a check beside the appropriate box which has caused you to seek treatment:

- ☐ Alcohol
- ☐ Anger
- ☐ Anxiety
- ☐ Attention Problems
- ☐ Career concerns
- ☐ Childhood issues (your own)
- ☐ Children
- ☐ Choices I have made
- ☐ Codependence
- ☐ Confusion
- ☐ Crying
- ☐ Deaths
- ☐ Debt
- ☐ Decision making
- ☐ Delusions (false ideas)
- ☐ Dependence
- ☐ Depression
- ☐ Divorce
- ☐ Drug Abuse
- ☐ Eating Issues
- ☐ Emptiness
- ☐ Failure
- ☐ Fatigue
- ☐ Fears
- ☐ Financial troubles
- ☐ Friendship problems
- ☐ Gambling
- ☐ Grieving
- ☐ Guilt
- ☐ Pessimism
- ☐ Hostility
- ☐ Impulsiveness
- ☐ Indecision
- ☐ Inferiority feelings
- ☐ Inhibitions
- ☐ Interpersonal conflicts
- ☐ Irritability
- ☐ Judgment problems
- ☐ Legal matters
- ☐ Loneliness
- ☐ Loss of control
- ☐ Losses
- ☐ Low energy
- ☐ Low frustration tolerance
- ☐ Low mood
- ☐ Marital coldness
- ☐ Marital conflict
- ☐ Marital distance
- ☐ Marital infidelity/affairs
- ☐ Medical concerns
- ☐ Memory problems
- ☐ Mood swings
- ☐ Motivation
- ☐ Obsessions
- ☐ Outbursts
- ☐ Oversensitivity
- ☐ Panic/anxiety attacks
- ☐ Parenting
- ☐ Perfectionism
- ☐ Employment Issues
- ☐ Physical Problems
- ☐ Relationship
- ☐ Sadness
- ☐ School problems
- ☐ Self Abuse
- ☐ Self-control
- ☐ Self-esteem
- ☐ Self-neglect
- ☐ Separation
- ☐ Sexual conflicts
- ☐ Sexual desire differences
- ☐ Sexual dysfunctions
- ☐ Sexual(other issues)
- ☐ Sleep Problems
- ☐ Stress
- ☐ Suicidal thoughts
- ☐ Suspiciousness
- ☐ Temper problems
- ☐ Tension/Stress
- ☐ Threats of violence
- ☐ Tiredness
- ☐ Violence
- ☐ Work Problems
- ☐ Weight issues
- ☐ Withdrawals/ Isolation
- ☐ Internet Pornography

Any Other Concerns:_____

_____

_____

_____

❑ I understand that as my therapist, or the therapist working with my child, I am in control of the counseling

relationship and may choose at any time to end our therapeutic relationship.

- ❑ I understand that if any assignment is given that I disagree with morally, ethically, or emotionally, I have the right not to proceed in that assignment.
- ❑ I understand that if I am concerned about slow progress or lack of progress I have the right to speak to my therapist about this.
- ❑ I understand that my therapist does not perform formal testing but refers individuals to those who do.
- ❑ I understand that our paths may cross in social situations, but that our therapeutic relationship comes first, along with protection of my confidentiality.
- ❑ I understand that there are some occasions when confidentiality can/must be breached. Those are: a) I direct Therapeutic Treatment Center, LLC, or one of it's associates to tell someone else in writing or verbally, b) My therapist determines that I may pose a threat to myself or others, c) If TTC or one of it's associates is ordered by a court to disclose information, or d) that child abuse is alleged, at which time authorities will be notified.
- ❑ I understand that counseling can improve as well as upset the equilibrium in any person or family.
- ❑ I understand that if I have a complaint I cannot resolve with TTC or one of its associates and I wish to file a formal complaint I may contact the Virginia State Board of Examiners of Licensed Professional Counselors at 1-800-533-1560.
- ❑ I understand that there is returned check fee of $50.00 and that if a returned check is not cleared up in 30 days TTC will file a suite with the Richmond City Attorney's Office.
- ❑ I understand that all co-pays are due at the time of service.
- ❑ I understand that I am responsible for all fees that my insurance denies, rejects, or fails to pay to TTC.
- ❑ I understand that if I do not give at least 24 hours notice in canceling an appointment I will be charged a fee of $50.00 that must be paid at my next scheduled appointment.
- ❑ I understand that no associate at TTC can recommend or prescribe medications but can encourage clients to see an M.D. for medication evaluation or make an appropriate referral.

By signing below I confirm that I have read, agreed to and received a copy of the above information:

***Client/Parent of Client*_____**

***Date Received and Read*_____**

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future:

1. Facilitate payment by third parties for services rendered by us.
2. Or, to assist with, aid in, or facilitate the collection of data for purpose of utilization review, quality assurance, or medical outcomes purposes.

Such information may be released to insurance companies, HMO's and PPO's managed care organizations, IPA's Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions.

This office will not use or disclose any of you medical and financial information for any purpose not stated above without your specific authorization. You, the patient, may revoke the authorization at any time.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

You may register a complaint with this office if you suspect that you privacy rights have been violated. We will investigate the compliant and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also file a compliant with the Department of Health and Human Services.

You may speak with the office manager to obtain additional information regarding any questions you may have concerning this Notice, or to receive a printed copy of the Notice.

The Notice of Privacy Practices is effective as of January 1, 2011

THIS IS YOUR COPY TO KEEP

I acknowledge that I have received and understand the Notice of Privacy Practices for this office:

Patient:_____ Date:_____
(If patient is a minor, Parent or guardian must sign)

Consent for use and Disclosure of Health Information

I hereby permit Therapeutic Treatment Center, LLC to release and furnish all medical and financial data related to my care that may be necessary now or in the future for the purposes of treatment, payment of healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evalution purposes. Such information may be released to HMO's and PPO's managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or and organizations contracting with any of the above entities to perform such functions.

Client Signature:_____ Date Signed:_____
(Client or Guardian if Patient is a Minor)

You have the right to request that this office restrict uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, expect to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional on your signing this consent.

Authorization for Release of Information

Client's Name	Birth Date	Client's ID# SSN Chart #
Parent's/Legal Guardian (if applicable)	Birth Date	SSN
Street Address	City	State Zip Code

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.

I understand that my records may contain information regarding my medical health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS - related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below.

I also understand that my health plan may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form, except for certain eligibility or enrollment determinations prior to my enrollment in its health plan, and for health care that is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that I may revoke this authorization at any time by notifying TTC in writing, but if I do, it will not have any effect on any actions TTC took before it received the revocation.

I hereby authorize Therapeutic Treatment Center, LLC to (check all that apply):
Exchange with Release to Obtain from **the parties I have indicated below**

I hereby authorize Therapeutic Treatment Center, LLC to exchange/ release/ obtain information:
Verbally only Written form only Both Verbally and in Writing

Person/organization receiving/communicating the information:

Name: _____

Address: _____

City	State	Zip

Phone Number: _____ Fax Number: _____