Office use only:
Diagnosis code:
Therapist:

Joe Martino Counseling Network
CLIENT INTAKE FORM

Today's Date: [Date]			PCP:		
PATIENT INFORMATION					
Patient's last name: First:		Middle: [Choose an item]		Marital status: [Choose an item]	
Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Former name:	Birth date: [Birthday]	Age:	Sex: ○ M ○ F
Address:		City:		Zip:	
Social Security no.:	Home phone no.:		Cell phone no.:		
Occupation:	Employer:		Employer phone no.:		
Chose clinic because/referred to clinic by (Please choose one option): ○ [Doctor's name] ○ [Choose an item]					
Email address:					
INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	Birth date: [Birthday]	Address:	Home phone no.:		
Is this person a patient here? ○ Yes ○ No		Is this patient covered by insurance?	○ Yes ○ No		
Occupation:	Employer:	Employer address:	Employer phone no.:		
Please indicate primary insurance: [Choose an item] | Other: [Other insurance]					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: [Birthday]	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber: [Choose an item]					
Name of secondary insurance (if applicable):		Subscriber's name:	Group no.:	Policy no.:	
Patient's relationship to subscriber: [Choose an item]					
IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address): [Friend or relative name]		Relationship to patient:	Home phone no.:	Work phone no.:	
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Joe Martino Counseling Network or insurance company to release any information required to process my claims.					
_____ Patient/Guardian signature			_____ Date		

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ON A SCALE FROM 1 TO 5 PLEASE RATE THE FOLLOWING

(1 being the worst and 5 being the best)

Mentally
Physically
Socially
Spiritually
Emotionally
Vocationally

CHECK ALL THAT APPLY:

- ☐ Eating habits changed
- ☐ Procrastinating
- ☐ Attempted suicide
- ☐ Poor Concentration
- ☐ Crying
- ☐ Withdrawing socially
- ☐ Skipping class/work
- ☐ Binge drinking
- ☐ Compulsive behaviors
- ☐ Acting aggressively
- ☐ Disorganization
- ☐ Friend problems
- ☐ Impulsivity
- ☐ Recklessness
- ☐ Irritability
- ☐ Passivity
- ☐ Alcohol use
- ☐ Drug use
- ☐ Sexual dysfunction
- ☐ Unsafe Sex
- ☐ Marital problems
- ☐ Family problems
- ☐ Lack of ambition
- ☐ Nightmares

CHECK ALL THAT APPLY (CONTINUED):

- ☐ Worry about body image
- ☐ Dating concerns
- ☐ Financial problems
- ☐ Compulsive masturbation
- ☐ Issues with Pornography
- ☐ Addictions
- ☐ Weight gain or loss
- ☐ Frequent headaches
- ☐ Tightness in chest
- ☐ Dizziness
- ☐ Lightheadedness
- ☐ Numbness/Tingling
- ☐ Vomiting
- ☐ Self-starving

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- [ ] Tired all the time
- [ ] Rapid heart beat
- [ ] Eating problems
- [ ] Pregnancy issues
- [ ] Divorce
- [ ] Recently diagnosed with terminal illness
- [ ] Excessive sleep
- [ ] Loss of memory
- [ ] Pregnant
- [ ] Miscarriages
- [ ] Death of loved ones
- [ ] Job loss

I FEEL:

- [ ] Ugly
- [ ] Unmotivated
- [ ] Worthless
- [ ] Numb
- [ ] Helpless
- [ ] Guilty
- [ ] Sad
- [ ] Sensitive
- [ ] Stressed
- [ ] Excited
- [ ] Lovable
- [ ] Unlovable
- [ ] Distracted
- [ ] Angry
- [ ] Afraid
- [ ] Depressed
- [ ] Shameful
- [ ] Lonely
- [ ] Hopeless
- [ ] Organized
- [ ] Honest
- [ ] Hopeful

CHECK ALL THAT APPLY

- [ ] Attempted suicide in the last 12 months.
- [ ] Been convicted of a crime.
- [ ] Harmed yourself in any way.
- [ ] Currently sexually active.
- [ ] Find fulfillment in sex life.
- [ ] Been sexually abused or assaulted in your life.
- [ ] Have you been hospitalized? If so, how long ago?

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Please describe in your own words what brings you in today:

Are you currently taking any medications? If so, please list the drug name and dosage amount below.

1.

2.

How many children do you have and what are their ages?

Names	Ages	Grade	Lives in home? Y/N

How many times have you been married?

Have you ever been to counseling before? Y/N

If yes, how long ago and who did you see?

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COUNSELING AGREEMENT

COUNSELING SERVICES

The decision to begin counseling may have important consequences for the rest of your life. Research has shown that when individuals enter this type of treatment with a good understanding of what they are about to undertake, they are likely to achieve good results. This document contains important information about the professional services you will receive. **PLEASE READ IT CAREFULLY AND JOT DOWN ANY QUESTIONS YOU MIGHT HAVE SO THAT WE CAN DISCUSS THEM AT OUR NEXT MEETING. WHEN YOU SIGN THIS DOCUMENT, IT WILL REPRESENT AN AGREEMENT BETWEEN JOE MARTINO COUNSELING-LOWELL, CREATIVE SOLUTIONS COUNSELING, AND JOE MARTINO COUNSELING-GRANDVILLE.**

APPOINTMENTS

Individual appointments are generally 45 minutes in length. If for any reason you are unable to keep your appointment, it is essential for you to notify us 24-hours in advance of your scheduled appointment. If you do not give 24-hour notice, you may be charged for the time reserved for you. If you do need to reschedule an appointment, we will do our best to accommodate your preferences. Sometimes our office may close due to weather. If we close, please check the company Facebook page, website for weather or emergency related closers.

RATES & PAYMENTS

It is our mission to make professional counseling services affordable for everyone. Our billable rate for CPT code 90791 (client intake) is $200.00 per session for CPT code 90834 and 90871 (Psychotherapy session 45 and 60 minutes) is $125 per session. If we are unable to bill your insurance discounts are available.

OTHER FEES

In addition to weekly appointments other services maybe needed such as report writing, attendance at meetings with other professionals, court appearance, group therapy, business development services and conferences. Below is a breakdown of cost for those services:

Notes and Report Summaries: $125.00 per hour.

Attendance at meetings with other professionals: $125 per hour.

Court Appearance: $1,500 per day to be paid 3 days prior to appearance.

Group Therapy Sessions: $45.00 per meeting (Unless otherwise indicated).

Business Development Services: $50.00 per hour.

Conferences: Varies

Late Cancelation Fee: $125

CONFIDENTIALITY POLICY

Confidentiality and privileged communication remains the right of all clients of professional counselors according to law. However, there are limits to such communication some of which are mandated by state law. It is very important that you and those seeking counseling with you read carefully and understand the following limits of confidentiality.

Duty to Warn

If an individual intends to take harmful, dangerous, or criminal action against another human being, or against himself or herself, it is the counselors duty to warn appropriate individuals of such intentions. Those warned may include a variety of persons such as:

1. The person or the family of the person who is likely to suffer the results of harmful behavior.
2. The family of the client who intends to harm him/herself or someone else.
3. Associates, friends of those threatened, or making threats.
4. Law enforcement and medical emergency officials.

Child Abuse

Michigan state law mandates the reporting of incident on suspected incidence of child abuse including physical abuses, sexual abuse, unlawful sexual intercourse, neglect, emotional and psychological abuse. All actual or suspected acts of child abuse will need to be reported to the appropriate agencies.

Dependent Adult and Elderly Abuse

Michigan law requires that incidence of “dependent adult” or elderly physical abuse reported to your counselor must also be reported to Michigan authorities.

Professional Misconduct

Professional misconduct by a healthcare professional must be reported by other healthcare professionals. In cases where a professional or legal disciplinary meeting is being held regarding the health care professional’s actions, related records may be released to substantiate disciplinary concerns.

Court Orders Verses Attorney Subpoena’s

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Healthcare professionals are protected by HIPAA, therefore the only person who can require an employee from our entity to attend and testify in court is a judge. Attorneys may send a subpoena but without proper documentation, release of information and payment, attorney issued subpoena will be ignored.

Shared or joint custody

In accordance to Michigan law, children under the age of 14 cannot be seen at our office unless we have the consent of all legal guardians. If a parent is unable to sign, proof of incompetence is required.

Minors/Guardianships

Parents or legal guardians of non-emancipated minors or clients have the right to access client records.

Case Evaluation

In order to ensure the best care possible for each client, staff member regularly consult with other health professionals regarding treatment. This is traditional in both out-patient and in-patient counseling facilities and is referred to as “case conference” or “peer review.” If you have any concerns regarding this practice, please discuss this concern with your therapist at your initial session.

Please be sure that you have read the above very carefully. If you are not sure that you fully understand any of the above areas of confidentiality limitations, please ask your counselor before you sign below. I/We the undersigned, have read and fully understand the limitation of my/our confidentiality. I/we further agree to abide by the policy set above. I/We have had a chance to ask my/our counselor for clarification regarding the limits of confidentiality.

Signature: _____

Date: _____

AGREEMENT TO PAYMENT

By signing this agreement, you concur to the fact you are responsible to pay for all services. All copays, deductibles and payments are due at the time of service. Creative Solutions Counseling, Joe Martino Counseling-Grandville and Joe Martino Counseling- Lowell is happy to bill third party payers, however, you agree, if payment from third party vendors is not collected in a timely manner that you will render payment in the full amount agreed upon as soon as possible. Payments not received in a timely manner may incur fees and eventually be turned over to a debt collector to ensure the collection of all payments.

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AGREEMENT TO COUNSLEING

Please check each box

☐I, the undersigned, acknowledge that I have received and read this counseling agreement, and understand the above information, and agree to voluntarily receive and participate in the counseling process. I fully understand the responsibility of this agreement.

☐I, the undersigned, authorize the audio and or video recording of sessions.

☐I, the undersigned, hereby agree to pay for all services at the time services are rendered.

☐I, the undersigned, give permission to bill my insurance company for services rendered at Creative Solutions Counseling, Joe Martino Counseling-Grandville and Joe Martino Counseling Lowell.

☐I, the undersigned, agree that if payment arraignments have been made but not met, that additional charges may apply.

☐I, the undersigned agree to pay a $35 return check fee for any payments returned by the bank.

☐I, the undersigned understand and agree to cancel my appointments with a 24- hour notice and if notice is not given, I understand that I will be charged $125.00. Weather or sickness related cancelations will not be charged.

Signature_____ Date _____