CHOICES MENTAL HEALTH COUNSELING PLLC

Contact Information – Face Sheet

Legal/Preferred Name(s): _____ Home Phone: _____
Mailing Address: _____ Work Phone: _____
_____ Cell Phone: _____
E-Mail Address: _____ Weight: _____Height: _____
DOB: _____ Gender: _____ Smoke: [ ] No [ ] Yes [ ] Former _____ per day
SSN: _____ Insurance: _____
Employer: _____ Occupation: _____
Primary Care MD: _____ Other MDs: _____
Medications (or provide printed list): _____
Relationship Status: _____ Spouse's/Partner's Name:: _____
Children (names and ages): _____
Ethnicity or Race: _____ Religion: _____
Alcohol/Unprescribed Drugs – Last drank (date): _____ Last other drug use (date): _____
Prior mental health counseling: _____

CONSENT TO BE TREATED

I voluntarily consent to be treated by Choices Mental Health Counseling Services PLLC.
Describe the issue that brought you here, very briefly: _____
_____ Referred by: _____
Current legal issues, if any (pending charges, probation, parole [and name of attorney and/or PO, etc.): _____
_____

AUTHORIZATION FOR MESSAGES

EMERGENCIES

Emergency Contact: *(name, phone, address, relationship)*: _____
Next of Kin *(name, phone, address, relationship)*: _____

TELEPHONE

I [ ] DO <u>or</u> [ ] DO NOT give permission to leave messages (appointment reminders, etc.) on voice-mail or answering machine(s) and/or with any person(s) who answer(s) the phone at number(s) listed above

INTERNET

I [ ] DO <u>or</u> [ ] DO NOT give permission to contact me by e-mail, SMS text message, chat, or social networking.

**RELEASE OF INFORMATION, LIFETIME SIGNATURE ON FILE,
CANCELLATION POLICY, PAYMENT AUTHORIZATION,
ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES,
PERMISSION TO SEE CHILD(REN) AND OTHERS PRESENT IN COUNSELING**

I understand that being on time for appointments is my responsibility. I agree to pay 50% of my usual fee for any block of time reserved for me unless I have provided 24 hours advance notification. I will be responsible for this and for any co-payments, deductibles, and for services provided that are not covered by my insurance plan. I authorize payment of all insurance benefits for services rendered by this office to be made payable to Choices Mental Health Counseling PLLC or the provider and authorize the aforesaid to release to the Centers for Medicare and Medicaid, its agents, or any other insurer or third-party payer all information necessary to determine benefits payable for related services. If I do not provide Choices with my complete and accurate insurance information, I will be a "cash pay" client (out of pocket or out-of-network) and I will be opting to not use any insurance with which I might be in-network. Further, if I provide insurance information at a later date, it will not be retroactively applied but will alter the agreement going forward only. If using Medicaid Transportation, I authorize my provider to confirm my attendance at healthcare appointments with Medical Answering Service LLC and any transportation vendors: and to be seen in the presence of family members or unrelated persons I allow to attend appointments with me. I permit a copy of this authorization to be used in place of the original. This form will serve as a lifetime signature form. I acknowledge receipt of and reading the Notice of Privacy Practices, and that any future revisions will be posted on the web at <u>choicesmhc.com</u>. The undersigned agrees that all unpaid fees owing after the date of service may be assessed a service charge at the rate of one and one-half percent (1-1/2%) per month or eighteen percent (18%) per annum from that date. In the event of default where it becomes necessary to turn this account over to a third party for collection, the undersigned agrees to pay all costs of collection, including reasonable attorney's fees and court costs. To the best of my knowledge, the above information is true. I understand that falsification of any information above could result in termination of services. *If seeking services for a child under age 18:* I consent to all the above on behalf of my minor child <u>and</u> myself.

Signature *(for all of the above)* _____ Date: _____