

Hope Counseling, Inc.
Intake Form

Client Information

Name(s) _____, _____ DOB _____

Address _____ City, State _____ Zip Code _____

Home # _____ Work # _____ Employer _____

Who recommended me? _____ Address _____ Phone _____

My Email Address: _____
(We often utilize your email address for communication and to send you our latest self-help newsletters)

Payment

Fee schedule is as follows: Fees are based on 50 minute sessions at our usual and customary fee of \$140.00 per session, or at a sliding fee scale of \$10 per \$10,000 Annual Gross Family Income, with a \$40.00 minimum per session. Extra fees exist for longer evaluations, testing, expert witness fees, consultation, and test interpretation. All reports are billed at a minimum \$100.00 based on \$200.00 per hour. Telephone calls are billed at \$2.00 a minute in blocks of 5 minutes. Full payment is expected before or at time of service. If you wish to pay by credit card, you will need to visit our website and make a payment prior to your session.

Gross Family Income _____ Agreed Counseling Fee _____ PLEASE INITIAL _____

Cancellations

I require that you cancel at least 24 hours in advance in order that your appointment time can be filled. You will be charged for appointments not cancelled within this time frame. Please note that this is an out-of-pocket expense, as insurance companies will not cover missed sessions. I do not charge for missed appointments due to emergencies, illness or weather. PLEASE INITIAL _____

Emergencies

I offer outpatient-counseling services only. If you or your loved one requires more intensive treatment, please call your insurance company as they typically have specific facilities that are covered. Otherwise, call your local hospital crisis line for other emergencies. I do attempt to return all calls within 24-48 hours, but you may need more prompt service than this in an emergency.

Consent to Receive Services, Insurance Correspondence, Referral Source Contact and Receipt of Privacy Practices

By signing below I consent to participate in counseling services offered by Hope Counseling, Inc. I understand I am consenting and agreeing only to those services that Hope Counseling, Inc. staff are qualified to provide within the scope of license, certification, and training. PLEASE INITIAL _____

By signing below I acknowledge I am giving consent for communication to occur between Hope Counseling, Inc. and my insurance company, as well as between Hope Counseling, Inc. and the person/agency that referred me to Hope Counseling, Inc. PLEASE INITIAL _____

By signing below I acknowledge that I have received a copy of Hope Counseling, Inc.'s Notice of Privacy Practices. PLEASE INITIAL _____

COMMUNICATION: The client must be aware that communications by cell phone or email are not as secure as communication by land telephone line. Clients who agree to communicate in ways other than land telephone line understands the risk of someone overhearing or reading communication more easily. Please initial to give Hope Counseling, Inc. permission to leave a message when attempting to contact client. PLEASE INITIAL _____

CONSENT TO TREAT: The client(s) has been made aware and consents to the nature, structure and limitations of the treatment, and understands the limitations or exceptions to confidentiality within the family or marriage when in family or marital counseling. Unless noted otherwise, the client(s) understand that Hope Counseling, Inc. offers Clinical Christian counseling from a Biblical foundation. PLEASE INITIAL _____

I understand that this consent is subject to revocation by me at any time, unless action has already been taken.

Client Signature _____ Date _____

Client Signature _____ Date _____

Client Signature _____ Date _____

Witness _____ Date _____