Eberhart Counseling

Ellen Eberhart, LCMHC, MLADC

CLIENT INFORMATION FORM

Today's date: _____

First name _____ Home phone _____

Last name _____ Cell phone _____

Address _____ Email _____

City, State, Zip _____ Date of Birth _____

I would prefer you contact me at: _____ or email: _____

Male_____ Female_____ Marital Status: Single _____ Married _____ Other _____

In case of emergency please notify: _____

Occupation _____Highest level of education_____

Who referred you ? _____

Is client responsible for bill? Y N If no, list responsible party (not insurance, list parent or guardian)

Responsible Party #1	Responsible Party #2
Name: _____	Name: _____
Address:_____	Address:_____
City, State, Zip_____	City, State, Zip_____
Responsible for _____% of bill	Responsible for _____ % of bill

Client's relation to insured self ____ spouse ____ child ____ other____

Family members in your home

Name	Age	Relationship

Primary care physician_____ Phone #_____

List any health problems for which you are currently receiving treatment:

_____

Other significant medical history:

_____

List any current medications, vitamins and supplements:

_____

Have you had previous counseling? If so, with whom and when:

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I understand that I am responsible for FULL payment for the services rendered. Eberhart Counseling, will submit claims to my insurance company as a service to me. I also understand that I am responsible for obtaining pre-certification from my insurer, billing fees, which I might incur, and any late charges on outstanding balances. I am also responsible for collection fees and/or legal fees incurred in settling any outstanding accounts I might have. If I am unable to keep a scheduled appointment and do not give 24 hours notice, I understand that I will be charged directly for that visit; Eberhart Counseling, cannot bill insurance for missed appointments. My signature below authorizes the release of any medical information necessary to the insurer of record so as to pay insurance claims for services rendered.

I authorize payment of benefits by my insurer to Eberhart Counseling, for services described on the health insurance claim form.

_____ _____

Signature Date

If I choose to pay for services on my own and without insurance, I agree to pay $ _____ per session as discussed with my provider. If I choose not to use my insurance and pay privately for services, I agree to waive any right to reimbursement from my insurance company.

_____ _____

Signature Date

_____

Do you have a family history of emotional/psychological difficulties? _____ If yes, please specify:

_____

Current symptoms/functional challenges. Please check all that apply:

____Anxiety	____Inattention	____Substance Misuse/Abuse
____Depressed Mood	____ Impulsivity	____ Addiction History
____Delusions/Hallucinations	____Obsessive Thinking	____Past Trauma
____Decreased Energy	____Compulsions	____Recent Trauma
____Hyperactivity	____Changed Eating Habits	____Work/School Difficulties
____Hopelessness	____ Panic Attacks	____ Self injury
____Relationship Difficulties	____ Sleep Pattern Change/Difficulties	____ Suicidal thoughts
____Irritability	____ Physical Difficulties/Illness	***Other*** _____

TO BE COMPLETED BY CLINCIAN:

INTAKE DATE_____ DIAGNOSIS CODE _____USUAL CPT CODE _____

FEE_____ COPAY_____

AUTH #_____ #VISITS_____ DATE RANGE_____to _____