Individual Client Intake Registration Form

Today's Date

Month Day Year

Identification Data

Name

First Name Last Name

Address

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Phone Number

Area Code Phone Number

Email

example@example.com

Birth Date

Month Day Year

Sex:

- ○ Male
- ○ Female

May a message be left by:

- ☐ Phone?
- ☐ Email?

Religious Preference

Church Attending

How Often?

Marital Status

- ○ Single
- ○ Engaged
- ○ Married
- ○ Separated
- ○ Divorced

How long have you been in above marital status?

Employer Information

Employer

Employer Phone

Area Code Phone Number

Occupation

Education Level

Family Information

Spouse

	Name	Age	Education Level
Spouse			

Children?

	Name	Age	Male / Female
Kid 1			
Kid 2			
Kid 3			
Kid 4			
Kid 5			

Are your parents still living?

- ○ Yes
- ○ No

Do you have brothers and/or sisters?

- ○ Yes
- ○ No

Reason for coming today

Problem or area of concern:

What previous help have you sought for this problem?

Name of Person/agency referring:

Health Information

How would you rate your current physical health?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

List all important past or present illnesses, injuries, surgeries, and/or hospitalizations:

Physician

Physician's phone number

Date of last medical examination

Month Day Year

Type a question

	Medication	Dosage	Condition	Prescribing Doctor
Med 1				
Med 2				
Med 3				
Med 4				
Med 5				

Has there been any prior treatment by a psychiatrist, psychologist, therapist, or counselor? If so, when and with whom?

Do you smoke?

- ○ Yes
- ○ No

If so how much?

Do you drink alcohol?

- ○ Yes
- ○ No

If so how much?

Do you, or have you in the past, had a drug or alcohol problem?

- ○ Yes
- ○ No

Have you had any history or treatment for this problem?

- ○ Yes
- ○ No

If yes, please explain

Emergency Contact Information

Who should we contact in case of emergency?

Name

First Name Last Name

Phone Number

Area Code Phone Number

Relationship to you

Insurance Information

Gabrielle K. Keenum, MA, LPC, NCC will file your insurance claim for you and all insurance benefits be paid directly to Gabrielle K. Keenum, MA, LPC, NCC. You will be responsible for making up the difference between the amount the insurance company pays and your fees at each visit. Please verify that the credentials of your counselor are accepted by your insurance company. Any dispute of payment will be your responsibility to negotiate with the insurance company. Please provide a copy of the front and back of your insurance card.

Name of Insured

First Name Last Name

Client's Relationship to insured:

Policy or Group Number

Insured ID Number

Insurance Company Address

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Address of Insured

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Insured Date of Birth

Month Day Year

Insured Phone

Area Code Phone Number

Insured Employer

Insurance Plan or Program Name

Is there another Health Benefit Plan?

- Yes
- No

Authorizations

I understand that I am responsible for all amounts that the insurance company does not cover. I authorize the release of any medical information necessary to process any claims for services that I receive from Mrs. Keenum. In consideration of services rendered, or to be rendered, I hereby irrevocably assign and transfer to Mrs. Keenum all rights, title and interest in the benefits payable by my health insurance company(ies) for services rendered by Mrs. Keenum. Said irrevocable assignment and transfer shall be for the recovery on said policy(ies) of insurance, but shall not be construed to be an obligation of Mrs. Keenum to pursue any such right of recovery provided. However, this assignment and transfer shall not take away my standing to make claim or sue for benefits should coverage be denied by any insurance carrier(s). I hereby authorize the insurance company(ies) herein listed above to pay directly to Gabrielle Keenum, MA, LPC, NCC all benefits due under said policy(ies) by reason of services rendered therein. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature

Date

Month Day Year

Appointments

Your time is respected and Mrs. Keenum endeavors to be on time to give you your full 50 minute session. Please give mutual respect for her professional time. A scheduled appointment reserves that time only for you.

If you need to change your appointment time, please allow 24 hours prior notification. The full session fee is charged for missed appointments and one half the full session fee is charged for late cancellations (within 24 hours of the scheduled appointment time). Insurance will not pay for these fees. These fees are the client's responsibility

Signature

Fee Policy

The standard fee for an individual session is $130 per session. The standard fee for couples is $165 per session. The intake fee is $145 for individuals and $180 for couples.

Payment is due when services are rendered. Accounts are to be kept current. If payment is not made, another appointment cannot be scheduled.

• A fee of $25 is charged for returned checks.

Signature

Court Fees

I understand that if my counselor is subpoenaed to court on my behalf or requested by me to appear:

• The fee is $300 per hour for my counselor's time, with a four hour minimum charge plus additional hours as requested by the court or your attorney.
• This fee is non-refundable for my counselor's scheduled time if court is cancelled or rescheduled and Mrs. Keenum is given less than a three business day notice.
• If travel is required out of city limits, time charged will commence at departure from city limits and continue until return to city limits.
• The fee is for the entire time spent at the court house, whether or not Mrs. Keenum testifies.

Signature

Confidentiality

I understand that all information shared with my counselor and any of her associates will remain strictly confidential and will not be released to others without my written consent, except in the following circumstances: a) the information I share pertains to the physical, sexual or emotional abuse of a minor, elderly person, or an adult who is mentally or physically unable to protect his/her own rights; b)the information I share suggests that I represent a significant danger to myself or to others; c)the records of my care are subpoenaed by a court of law, and the judge in the matter rules that the client/therapist privilege of confidentiality does not apply; d) if it is disclosed you have committed a crime or; e) defense of claims brought by a client against Mrs. Keenum.

Audio and/or video recording of sessions by either the client or the counselor is expressly prohibited without written consent.

Signature

DISCLOSURE AND CONSENT STATEMENT

The following informs you of the policies and practices of Gabrielle K. Keenum, MA, LPC, NCC. Please read the information carefully and if you have questions, please ask.

A goal of this business is to provide you with quality counseling and coaching services. However, one cannot guarantee that counseling services will be effective for you.
Mrs. Keenum has a Master's degree and is a Licensed Professional Counselor in the state of Texas, as well as a National Certified Counselor. In order to maintain a high standard of competence, she adheres to professional, legal, ethical and moral standards of her Licensing Board as well as the American Association of Christian Counselors.
Counseling is based on your presence here and talking honestly with your counselor. You may encounter troubling emotions in the course of my counseling, but you can expect to be heard and accepted as a human
being of value and worth.
There is no warranty or guarantee to a result or a cure.
Mrs. Keenum can terminate service for noncompliance with the plan of care, failure to keep appointments, violent behavior, threats of violence or involvement in criminal behavior.
Carrying of concealed weapons on the premises of the counseling practice is expressly forbidden. The counselee agrees not to bring any weapons into the building housing this practice.

I have read and fully understand the statements in this document and the policies stated regarding counseling. I am giving my consent to Gabrielle K. Keenum, MA, LPC, NCC to provide professional counseling services, including assessment and treatment. I will be provided a copy of this form at my request.

Signature

Date

Month Day Year

Counselor Signature

Date

Month Day Year

Parental Consent: (To be completed by a legal guardian with rights of decision-making authority for clients under the age of 18. If the right for decision-making authority for mental health treatment has been granted by a court, a copy of the court order must be provided.) I give my authorization for Gabrielle K. Keenum, MA, LPC, NCC to provide professional counseling services for the minor child named in this intake form.

Signature

Date

Month Day Year