NEW CLIENT INFORMATION
(Please Print)

Date _____/_____/_____

Client Name _____M / F Date of Birth ____/_____/_____

Address _____ City/State _____ Zip_____

Social Sec. # _____ (must complete to file insurance)

Home ( ) _____ Work( ) _____ Cell ( )_____

Email Address:_____

Circle One: Minor Single Married Divorced Separated Widow Living Together

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Employer _____ Years with employer _____

How did you hear about us? _____

IF CLIENT IS A MINOR

Legal guardian's name_____
Address _____ City _____ State _____
Zip _____
Home ( )_____ Work ( ) _____ Cell ( ) _____
_____

HOUSEHOLD INFORMATION **(List all who reside in the home)**

Name	**Role (Husband, wife, child, etc.)**	**Date of Birth**
_____		_____/_____/_____
_____		_____/_____/_____
_____		_____/_____/_____
_____		_____/_____/____
_____		_____/_____/_____

INSURANCE & FINANCIAL INFORMATION

Responsible Party: Name _____Relationship _____
Address _____ City _____ State _____
Zip _____
Home ( ) _____ _____ __Work ( ) _____ ____ _ _
Cell ( ) _____

Do you have insurance? Yes ___ No ___ We must have a current copy of your card on file.
Client's relationship to insured _____
Primary Insured name _____ S.S.# _____
DOB _____
Employer: _____
Insurance Company:

_____

EMERGENCY CONTACT INFORMATION:

In the event of an emergency, please contact:

Name _____ Relationship _____
Day # _____
Evening # _____
Primary Care Physician _____
Phone # _____

PRESENTING PROBLEM(S)

Please describe your reasons for seeking counseling (include date/month the problem started)._____

Have you experienced suicidal thoughts or thoughts of harming self or others? If so, please explain:

_____
_____

Has there been an event which made these issues or problems surface?
Yes _____ No _____
Please describe:

_____
_____

Please indicate the severity in which your problems are affecting the following areas:

	No effect	Little effect	Some effect	Much effect	Significant effect
Marriage/ Relationships	1	2	3	4	5
Family	1	2	3	4	5
School/Job Performance	1	2	3	4	5
Friendships	1	2	3	4	5
Hobbies	1	2	3	4	5
Financial Situations	1	2	3	4	5
Physical Health	1	2	3	4	5
Anxiety level/ Nerves	1	2	3	4	5
Mood	1	2	3	4	5
Eating Habits	1	2	3	4	5

If your eating habits are affected, please describe:
_____

Sleeping Habits	1	2	3	4	5

If your sleeping habits are affected, please describe:_____

Sexual Functioning	1	2	3	4	5
Ability to Concentrate	1	2	3	4	5
Ability to Control Temper	1	2	3	4	5
Spirituality	1	2	3	4	5

SUBSTANCE ABUSE HISTORY

Have you ever abused drugs? Yes _____ No _____ Have you ever abused alcohol? Yes _____ No _____
Please describe:

_____

Do you drink coffee? Yes ___ No ___ How much? _____ How often? _____
Do you smoke cigarettes? Yes ___ No ___ How much? _____ How often? _____
Do you drink alcohol? Yes ___ No ___ How much? _____ How often? _____

MEDICAL HISTORY

Please list any prescription medication you currently use: (Name, dosage, frequency)

_____

Please list any over-the-counter medications you currently use: (Name, dosage, frequency)

_____

Describe any medical or psychiatric conditions of your parents and/or siblings:

_____

Who is your primary care physician:

_____

Do you have any allergies? Yes _____ No _____ Please describe any known allergies:_____

PSYCHIATRIC HISTORY:

Have you ever received psychiatric or psychological treatment before: Yes ___ No ___
What type of care did you receive? Inpatient _____ Outpatient _____ Both _____
Are you currently seeing a Psychiatrist? Yes _____ No _____
Psychiatrist Name:_____ Phone #:_____
Outpatient: Therapist _____
Time Frame:_____
Inpatient: Where _____
Month/Year _____/_____
Who was your therapist or doctor?_____
Did your doctor prescribe medication at that time? Yes ___ No ___ Not applicable ____
Prescription _____Dosage _____

Fee Policy

As a service to you, our office will verify your coverage including your deductible and co-payment, as well as out-of-network benefits if we are not a provider with your insurance company or third party carrier your benefits have been carved out to. We will also file your insurance claims unless you tell us otherwise. We request that you also confirm these provisions with your insurance company. Your insurance policy is a contract between you and the insurance company. Therefore, you, as the insured, are responsible for payment of amounts refused or determined unnecessary by your insurance company.

All insurance benefits will be assigned to Paul Allen Shearer, LPC. This assignment will remain in effect until revoked by client in writing. Although it is possible that mental health coverage deductible may have been met elsewhere, this amount will be collected until the deductible payment is verified by the insurance company.

Clients are responsible for payment at the time of services. We accept cash, personal checks, MasterCard and Visa. If we have not received verification of benefits from your insurance company at the time of your first appointment, the full fee will be charged. If you have overpaid, you will be reimbursed.

OFFICE FEES

Initial Evaluation	-	$150
Individual Therapy	-	$100
Missed Appointment	-	$100
Less than 24 hr Cancellation	-	$100

I understand that I am financially responsible to Paul Allen Shearer, LPC for the charges incurred by myself and/or my dependents.

Signed:_____Date:_____

Credit Card Authorization

I authorize Paul Allen Shearer, LPC to keep my signature on file and to charge my Visa/MasterCard account for recurring charges of $100 for missed appointment or less than 24 hour cancellation notice.

I understand this authorization is valid for two years unless I cancel the authorization in writing. I promise not to dispute charges (charge back) for sessions I have received or that I have not cancelled 24 hours prior to a scheduled session. I further authorize Paul Allen Shearer, LPC to disclose information about my attendance/cancellation to my credit card issuer if I dispute a charge.

Cardholder
Signature:_____

Client Name:_____

Cardholder Name:_____
Please Print

Cardholder Billing
Address:_____

City:_____ State:_____ Zip:_____

Account #:_____
Expiration Date:_____

Cancellation Policy

It is our policy to charge the FULL FEE for missed appointments or appointments that are not cancelled at least 24 hours in advance. If our offices are closed, you may leave notice of cancellation on our voice mail. The time has been reserved exclusively for you and your courtesy to notify of cancellations allows us to offer that time to someone else.

Release of Information Authorization to Third Party

I authorize Paul Allen Shearer, LPC to disclose case records, such as diagnosis, summaries, psychological evaluation, case material and other requested information, to the insurance company for the purpose of receiving payment directly to our office. I understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits.

Acknowledgement of Review of Notice of Privacy Practices

I have been given the opportunity to review the Notice of Privacy Practices, which explains how my personal health information will be used and disclosed.

Confidentiality

Our office protects the confidentiality of counseling sessions. A signed "Release for Information" form is required in order to release any information about a client. All information between counselor and client is considered confidential unless:

1. The client presents a physical danger to self or others.
2. The probability of client suicide.
3. Child/Elder abuse/neglect is suspected.
4. A court order has been issued.
5. The client is a non-emancipated minor – in which case the parents or guardians have the right to access the client's records.

In the first three cases, the counselor is required by law to inform potential victims and legal authorities so that protective measures can be taken.

Consent for Treatment

I certify that I have read this agreement and understand the office policies and hereby give my consent for Paul Allen Shearer, LPC to provide me with counseling services.

_____

Client Name (Please Print)

_____ _____

Signature of Client or Personal Representative **Date**