SERENITY

BEHAVIORAL HEALTH SERVICES

Client Intake Form

Client Legal Name: _____ Date: _____

Preferred Name: _____ DOB: _____ AGE: _____ Gender: _____

Address: _____ CITY: _____ ZIP: _____

Email Address:_____ Phone#:_____

Okay to leave messages? Yes No Gender Identity: Pronouns:

Client's Marital Status: ___ Single ___ Married ___ Partnership ___ Divorced ___ Widowed

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Spouse/Partner:_____ Phone#: _____AGE: _____

Parent/Guardian (1): _____ Parent/Guardian (2): _____

Telephone Numbers: Cell: _____ Cell: _____

Is the counseling for:
____ Child ____ Adolescent ____ Adult ____ Family ____ Couple ____ Group Therapy

Presenting Concern:

	Abuse:(Physical/Emotional/Sexual)		ADHD/ADD		Adjustment Issues
	Addiction: Sex		Addiction: Alcohol Abuse		Addiction: Drug Abuse
	Anger Management		Anxiety		Bipolar
	Chronic Illness/Pain Mgt		Court Ordered		Cutting/Mutilation
	Death/Dying issues		Depression		Divorce/Separation Issues
	Domestic Violence		Eating Disorder		Grief/Loss
	Infidelity		Life Transitions		Pre-Martial Counseling
	Men Issues		Parent-Child Relationship issues		Relationship – Martial Issues
	Self-Esteem/Self-Worth		Stress Management		Suicide Thoughts/Feelings
	Trauma/PTSD		Women Issues		Work Related Issues
	Gender Identity		GBLTQ		Deaf/Hard of Hearing
	Sexual Orientation		School Issues		Behavioral Problems

Explain:

In the event of an emergency, who can we contact?

Emergency Contact: _____ Relationship: _____

Telephone Numbers: Cell: _____ (2) Cell: _____

623-H Park Meadow Road, Westerville, Ohio 43081 (614) 948-3273 Main (855) 740-2025 Fax

www.serenity-bhs.org

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BILLING INFORMATION

Primary Client: _____ Date: _____

Is the client Private Pay or using Health Insurance? ___ Private Pay ____ Health Insurance ____ EAP

RESPONSIBLE PARTY PERSONAL INFORMATION (Guarantor):

Person responsible for payment: _____ DOB: _____ GENDER: M F

Address: _____ City: _____ Zip: _____

Phone Number: _____ Relationship to client? Self Parent Spouse

Insurance Company: _____ Phone Number: ( ) _____

Employer: _____ ID#: _____Group #: _____

Co-Pay? _____ Deductible? _____ #Sessions allowable: _____ Rate: _____

I authorize Serenity-BHS to release only information necessary to process my service claims with my insurance company.

I authorize my insurance company to make payments for my treatment directly to Serenity Behavioral Health Services.

I understand that I am responsible for paying my deductible or co-pay (where applicable) at the time of my session.

I understand that I am responsible for giving at least a 24 hour notice if I am to miss or cancel my appointment, otherwise, I will be charged a $50 missed/cancelation fee. I understand that I will need to make such payment on or before my next scheduled appointment.

I understand that Serenity-BHS adheres to all HIPPA laws and regulations and that my personal clinical records can't be released to anyone, including my Health Insurance, primary doctors or Disability Claims Departments, without a Release of Information signed by either myself or my legal parent/guardian.

Client Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

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