Alliance Counseling Services

Faith-Based Counseling for the Whole Family

Auchter & Good LLC

CLIENT INFORMATION

Name _____ Today's Date _____

Address _____ Date of Birth _____

_____ SS# _____

City State Zip

Phone (Hm) _____ (Cell) _____ (Wk) _____

Phone # where we may leave a message _____

Email Address _____

How did you hear about Alliance Counseling Services? _____

Place of employment _____ Occupation _____

Educational background 1) years _____ 2) degree(s) _____

Marital status: ❑ single ❑ engaged ❑ married ❑ separated ❑ divorced ❑ widowed

Names and ages of children under your care _____

Primary Physician _____

Last examined by a doctor _____ Current medications _____

_____

Past psychiatric medications _____

Major health problems currently being treated _____

Family history of psychiatric illness _____

Briefly describe your reason for seeking psychiatric/psychological counseling _____

_____

Have you ever received psychiatric/psychological counseling before? _____

If yes, please explain _____

_____

ALLIANCE COUNSELING SERIVCES
AUCHTER & GOOD LLC

Client Name: _____

Please circle any of the following that pertain to you or family members (circle with an **F** for family member):

Nervousness	Depression	Fears
Shyness	Sexual problems	Suicidal thoughts
Separation/Divorce	Finances	Health problems
Drug/Alcohol use	Nightmares	Friends
Parenting	Self-control	Unhappiness
Anger/Temper	Stress	Work
Sleep	Headaches	Tiredness
Relaxation	Memory	Ambition
Energy	Appetite	Making decisions
Legal matters	Inferiority feelings	Concentration
Loneliness	Career choices	Children

Is there anything else you would like us to know? _____

Religious affiliation (optional) _____

Contact in case of emergency:

Name _____ Relationship _____

Phone (Hm) _____ (Cell) _____ (Wk) _____

INSURANCE INFORMATION

Name of Insured _____ Relationship _____

Insurance Company _____

ID # _____ Group # _____

DOB _____ SS # _____

Secondary _____

ID # _____ Group # _____

Client Name: _____

AUTHORIZATION TO RELEASE OR EXCHANGE CONFIDENTIAL INFORMATION
FOR ADMINISTRATIVE PURPOSES ONLY

This form provides authorization for information to be released/exchanged in accordance with Florida Statutes and Florida and Federal Administrative Rules and Regulations.

I, (printed name of client) _____ hereby authorize **Alliance Counseling Services** and/or (Alliance Counseling Professional) _____ to release, obtain, and exchange the following information to the following individual(s):

Name: _____
Phone: _____
Relationship: _____

Initial each category for which you authorize release of information:

- ❑ Schedule/Reschedule Appointments
- ❑ Pick up Prescriptions/Medication
- ❑ Discuss billing/payment information
- ❑ Other as specified: _____

_____

Name: _____
Phone: _____
Relationship: _____

Initial each category for which you authorize release of information:

- ❑ Schedule/Reschedule Appointments
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- ❑ Discuss billing/payment information
- ❑ Other as specified: _____

_____

I understand that I have the right to refuse to sign this form and that I may revoke this authorization at any time (except to the extent that the information has already been released) by sending written notification to the above named Alliance Counseling professional. I understand that I can obtain a copy of this authorization. If not revoked, this consent will automatically expire at the end of the calendar year. If another termination date is preferred, I will indicate that date here _____.

Signature of Client or Client's Representative	**Date**
Printed Name of Client	
Signature of Witness	**Date**
Printed Name of Witness	

ALLIANCE COUNSELING SERIVCES
AUCHTER & GOOD LLC

Client Name: _____

COUNSELING POLICIES AND CONSENT FOR TREATMENT

CONFIDENTIALITY

The relationship between client and counselor is both legally and ethically confidential. This means that any and all information given to the counselor during session cannot be divulged by the counselor without your written consent. The law requires a counselor to disclose information without your authorization in only a limited number of situations including: 1) to report abuse or neglect of a child or elderly person, 2) in response to a court order, and 3) to prevent or lessen a serious imminent threat to the health or safety of yourself, another individual, or the public. Fortunately these circumstances are infrequent.

Use of Emergency Contact: By signing this form you authorize us to communicate with the Emergency Contact you have designated if we believe you are at risk or need to contact you in the case of an emergency.

Use of Electronic Mail: Please be aware that email may not be private or confidential.

In Consultation and/or Supervision: In the interest of providing you the best care, your counselor may confer with another Alliance Counseling Services professional. Your confidentiality will be maintained.

POSSIBLE RISKS OF TREATMENT

Counseling can have both risks and benefits. At times, the counseling process may elicit uncomfortable feelings. Challenges may arise that affect the individual or his/her relationships. Personal commitment to working through those issues in counseling has been shown to have many benefits over time.

CHECK-IN & PAYMENT

Please arrive on time and come with your payment ready, sign-in, pay at the check-in window, and have a seat in the waiting room. Your counselor will come to greet you. Full payment is expected on the day of service and can be made by cash, check, or charge. We accept Visa or MasterCard.

APPOINTMENTS AND CANCELLATIONS

Your appointment is a commitment between you and your therapist. Initial evaluations are 55 minutes. Counseling sessions are generally 45-55 minutes in duration. Child and adolescent sessions may vary in duration. Cancelling your appointment **48 hours** in advance allows us to provide care for others as needed. **Late cancellations or missed appointments, unless caused by a true emergency, will be charged a fee of $85.00.**

EMERGENCIES

The Alliance Counseling Services does not provide emergency services. If you have an urgent concern we will schedule an appointment for you as soon as possible. In the case of an emergency, please go to the nearest emergency room or call 911.

By signing this form:

1) I signify that I have read, understand, and agree to abide by the above policies, and
2) I hereby give my consent to treatment by Alliance Counseling Services.

_____ _____

Signature of Client or Client's Representative **Date**

_____

Printed Name of Client

ALLIANCE COUNSELING SERIVCES
AUCHTER & GOOD LLC

Client Name: _____

FINANCIAL POLICIES AND AGREEMENT

PAYMENTS

Full payment is expected at the time a service is rendered and can be made by check, cash, or charge. We accept Visa and MasterCard. **Late cancellations ore missed appointments, unless caused by a true emergency, will be charged a fee of $85.00.**

INSURANCE

If we accept your insurance, we will bill your insurance company on your behalf. All insurances vary and Alliance Counseling Services cannot guarantee what services will be covered. Co-pays/co-insurance/deductibles are determined by your insurance company and your plan. You are responsible for your deductible and co-payment amount and any balance your insurance does not cover. Your insurance will not take responsibility for missed appointments.

MEDICARE CLIENT

You will be responsible for paying the portion not covered by Medicare, unless you have secondary insurance that covers the services rendered.

By signing this form, I accept financial responsibility for all services rendered and missed appointment charges. I also authorize the release of any medical information necessary to file this claim with my insurance carrier and/or Medicare and request payment for this claim be made to Alliance Counseling Services on my behalf. If the claim reimbursement check is sent directly to you, the full amount must be paid to Alliance Counseling Services immediately and a copy of the claim receipt must be provided.

_____ _____

Signature of Client or Client's Representative **Date**

_____

Printed Name of Client

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

HIPPA requires that Alliance Counseling Services inform you of our privacy practices. These practices are included in the intake paperwork, are posted on the wall in our waiting room, and are available to you in print at your request.

I acknowledge that the Notice of Privacy Practices of Alliance Counseling Services has been made available to me.

_____ _____

Signature of Client or Client's Representative **Date**

_____

Printed Name of Client

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (e.g. power of attorney, healthcare surrogate, etc.).