Ingram & Associates
LET'S TALK!
1402 Royal Palm Beach Blvd., Suite 400B, Royal Palm Beach, FL 33411
561-792-9242 Phone | 561-792-9243 Fax
www.ingramcounseling.com

ADULT INTAKE EVALUATION

Name: _____

Address: _____ City: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Can we leave a message if no one answers? ❍Yes ❍No Can we text to confirm? ❍Yes ❍No

Email: _____

Date of Birth: _____ Social Security #: _____

Referred by: _____

Emergency Contact: _____ Phone: _____

FAMILY

Mother living? ❍Yes ❍No Father living? ❍Yes ❍No

Describe your relationship with your parents: _____

_____

EDUCATION: _____

MARRIAGE

Marital Status: **S M D W** # of Marriages: _____

Spouse (ex-spouse)'s name: _____ How long? _____

Describe your relationship with your in-laws: _____

_____

Names and ages of your children:

_____ _____

_____ _____

_____ _____

HEALTH

Indicate if any of the following apply or have applied in the last six (6) months:

❑Loss of appetite ❑Unkempt appearance ❑Withdrawn ❑Sleeplessness ❑"Blahs" ❑Loss of sex drive

Health: ❍Very Good ❍Good ❍Average ❍Poor

Have you had a physical in the last year? ❍Yes ❍No Do you have any food/drug allergies? ❍Yes ❍No

Are you currently under a psychiatrist/doctor's care? ❍Yes ❍No

If yes, please describe: _____

_____

Psychiatrist/doctor's name: _____ Phone: _____

Are you currently taking medication? ❍Yes ❍No Type, dosage, usage: _____

_____

_____

Past or current history of (check all that apply):

❑AIDS	❑Chronic fatigue	❑HIV	❑Persistent flu-like	❑Thyroid problems
❑Anemia	❑Chronic pain	❑Hypertension	symptoms	❑Tuberculosis
❑Asthma	❑Diabetes	❑Liver damage	❑Seizures	❑Urinary tract infection
❑Cancer	❑Eating disorder	❑Migraines	❑STD	
❑Cardiac problems	❑Hepatitis		❑Stroke	

Do you use drugs? ❍Yes ❍No Drug(s) of choice: _____

Do you drink alcoholic beverages? ❍Never ❍Occasionally ❍Regularly

Drink(s) of choice: _____ Times per week: _____

EMPLOYMENT

Types and length of employment:

1. _____
2. _____

Current Employer: _____

RELIGION

Denomination: _____ Participation: _____

PERSONAL

What is troubling you and with whom have you discussed it? _____

_____

_____

What books, websites, workshops, seminars, etc. have you studied that deal with the reason you are seeking therapy? _____

_____

Check any you have experienced in the last six (6) months:

❑Adult child of Alcoholic	❑Change in lifestyle	❑Fear	❑Impotence	❑Sex
❑Anger	❑Children	❑Envy (Jealousy)	❑Loneliness	❑Spouse Abuse
❑Anxiety	❑Depression	❑Guilt	❑Motherhood	❑Suicidal thoughts
❑Assurance of Salvation	❑Dishonesty	❑Health issues	❑Psychotic episodes	❑Unforgiveness
❑ADD/ADHD	❑Eating Disorder	❑Homicidal thoughts	❑Rebellion	❑Violence/Rage
❑Bitterness	❑Fatherhood	❑Homosexuality	❑Recent Death	❑ _____

Do you live within your financial means? ❍Yes ❍No

Have you ever sought counseling or psychiatric help? ❍Yes ❍No

If yes, from whom and what counsel did you receive? _____

_____

I give my consent for services with Ingram & Associates and associated professional staff to include evaluation, psychotherapy, testing (if indicated), and involvement in the treatment planning process.

Signed _____ Date _____

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THERAPY / PAYMENT AGREEMENT

PURPOSE: To offer the service of professional counseling to individuals, families and children, so that relationships may be restored in a healthy manner. Further, to offer holistic therapy in an objective and understanding atmosphere.

RESPONSIBILITY OF THE CLIENT:

- **PAYMENT IS DUE THE DAY SERVICE IS RENDERED.** Cash is accepted. Checks should be made payable to Ingram & Associates (I&A). Credit cards (Visa, MasterCard, and Discover) are accepted with a minimum charge of $25.00.
- The fee is $150.00 for a 45-60 minute session. If using insurance, your copay and/or co-insurance is due the day service is rendered. (Insurance information must be presented on or before the date service is rendered. We will not bill insurance retroactively.) All phone calls lasting more than 5 minutes will be charged at full session fee in 15 minute increments.
- Cancellation of a session must be made at least 24 hours (one business day, or by Friday for a Monday appointment) prior to the scheduled appointment, or you will be billed a **$50.00 no-show/late cancellation fee for the first offense**. **For each missed appointment thereafter, you will be billed $75.00.** ***Appointment confirmation calls/texts are a courtesy. If you do not receive a confirmation call or text, you are still responsible for your scheduled appointment*****.** Clients who miss two consecutive appointments will not be rescheduled until the no-show/late cancellation fees are paid.
- A **$25 NSF charge** will be assessed to all returned checks in addition to the amount of the check. We report to the local district attorney's office checks that are not paid within two weeks of being returned to our office.
- Grievance Policy and HIPPA Notice are published in a book located in our lobby. Forms are also available from the Office Manager.
- If a counselor receives a witness/records subpoena, the client will be notified so that his/her attorney can take whatever action is deemed necessary. If the client desires the subpoena be honored, a signed release is required. Therapeutic fees associated with any court proceeding are $250 per hour with a minimum of two (2) hours. If court date is cancelled within 24 hours, a fee of $150 will be charged.
- A signed release is required for any record or information to be released from I&A to the court, another counselor, family members, attorneys, doctors, etc.
- ***If client's insurance changes for any reason, it is client's responsibility to alert I&A and provide our office with a copy of the new card. I&A will not retroactively bill insurance companies*****.** Client is fully responsible for any charges not covered for any reason by their insurance carrier. If not paid according to terms, the client understands that our office reports to an outside collection agency. In the event that your account is turned over for collections, client agrees to pay all additional fees assessed in the collection of debt. These fees include collection agency and attorney fees. An invoice may be sent to your home for any outstanding balance.

RESPONSIBILITY OF THE THERAPIST:

- Therapists work according to the guidelines of the State of Florida. Mental health counseling results cannot be guaranteed.
- The therapist will listen, analyze, evaluate and suggest alternative courses of action in any given difficulty.
- The counselor/client relationship is one of trust and confidentiality. Therefore, all records shall be accessible only to the counselor unless ordered by the Court. Under ethical standards, the therapist will break confidentiality if a client is in danger to self or others; is involved in criminal action; if ordered by the Court; or when it is at the best interest of a child who is a victim of abuse, according to Florida Statutes.
- Counseling sessions will be held to 45-60 minutes. Because of scheduling, this will be strictly enforced.
- The acceptance of clients is at the sole discretion of the counselor and in accordance with the policies herein.
- Outside assignments may be made by the counselor for the express purpose of directing the client toward development of both the physical and spiritual body and are regarded as a necessary part of healing.

Signature: _____ Date: _____

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INSURANCE AUTHORIZATION FORM

Client Name: _____ Gender: ❍Male ❍Female

Date of Birth:_____ Client SS#: _____

Insurance Carrier: _____

Client Insurance ID: _____Group #: _____

Client Relationship to Insured: _____

Insured Name: _____ Gender: ❍Male ❍Female

Date of Birth:_____ Insured SS#: _____

Address: _____

City, State, Zip: _____

Insured Employer: _____

Insurance Carrier: _____

Insured Insurance ID: _____Group #: _____

Ingram & Associates will bill most insurance carriers for you if proper paperwork is provided to us. Any outstanding balances, co-payments and deductibles are due prior to you appointment. Since your agreement with your insurance is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, fees are due and payable in full from you.

TO SUBMIT CLAIMS TO INSURANCE: I hereby authorize Ingram & Associates to apply for benefits on my behalf for covered services rendered by the practice, and request that payments are made directly to Ingram & Associates. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information, for any related claim. I permit a copy of this authorization to be used in place of the original. I understand and agree that all co-payments are due at the time of service. I have read the above financial policy for payments for professional fees and understand and agree to pay for services not covered by my insurance company for any reason.

Signature: _____ Date: _____

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Coordination of Care between Health Care Providers and Release of Information

Date: _____

Primary Care Physician (PCP) or Psychiatrist: _____

Address: _____

Phone: _____ **Fax:** _____

Re: _____ **Client's DOB:** _____
(Client)

Dear Dr. _____:

The above-named client has identified you as their PCP/Psychiatrist. We have discussed the importance of coordinating an individual's total health care across health care professionals. This client has given their consent for me to contact you, introduce myself as the behavioral health care practitioner and work directly with you when necessary.

At the present time, this client has been in care with me since _____.

The above-named PCP/Psychiatrist is authorized to release protected health information related to the evaluation and treatment of the abovementioned client.

Client Authorization
I hereby authorize above-named PCP/Psychiatrist to release verbally and/or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified Client. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request. This consent expires upon the termination of treatment.

Disclosure may include the following verbal and/or written information:

❑ **Summary of treatment records and contact dates.**
❑ Other _____

❑ I hereby refuse to give authorization for any release of information.

_____ _____
Signature of Client, Parent, Guardian or Authorized Representative **Date**
If signed by a guardian or authorized representative, please provide legal documentation that proves such authority under state law (i.e. Power of Attorney, Living Will, or Guardianship papers, etc.)

Sincerely,

Clinician
Ingram & Associates Counseling & Consulting, Inc.,