NEW CLIENT INFORMATION

Therapist _____ Today's Date: _____

Client Legal Name: _____ DOB:_____

Preferred Name/ Nickname: _____

Gender Identity Choose all that apply Female Male Other: _____

Address: _____

City: _____ St: _____ Zip: _____

Is client a dependent child? (Circle) Y N Parent(s)/guardian(s) name: _____

Primary Phone: _____

Secondary Phone: _____

Email (for billing purposes): _____

Preferred Communication (Circle)

In case of an emergency, notify: Name: _____

Relationship: _____ Phone: _____

Hospital of choice: _____

Referral Source: _____

Would you like to receive our email newsletter? Like us on Facebook and Twitter!

Would you like to receive appointment reminders? Choose all that apply Phone (Text) Phone (Voice)

Cell # and/or Email for newsletter and appointment reminders if different than above:

_____

FINANCIALLY RESPONSIBLE PARTY (if someone other than client)

Name :_____

DOB_____ Relationship to Client: _____

Address (if different from client):_____

CLIENT NAME/DOB _____

PRIMARY INSURANCE INFORMATION

Name of Insured:_____ SS# _____

DOB_____ Relationship to Client: _____

Insurance Company:_____ Effective Date: _____

Policy # _____ Group Member #: _____

SECONDARY INSURANCE? Yes or No

Name of Insured:_____ SS# _____

DOB_____ Relationship to Client: _____

Insurance Company:_____ Effective Date: _____

Policy # _____ Group Member #: _____

MEDICAL INFORMATION

Have you ever received counseling before? (Where and when?) _____

_____

Date of last physical exam: _____ Height: _____ Weight: _____

Physician's Name/Office and Phone Number:

_____

_____

How would you describe your general health currently? _____

_____

CLIENT NAME/DOB _____

Are you taking any medications including supplements:

Are you currently being treated by a physician for any physical condition? _____

Have you had any serious illness? (Please list) _____

_____

Have you ever undergone any surgery? (Please list) _____

_____

Please mark all that currently apply for you:

___ Crying spells
___ Inability to have fun
___ Feelings easily hurt
___ Confidence lacking
___ Constipation
___ Feeling grouchy
___ Constantly tired
___ Poor appetite
___ Feeling depressed
___ Trouble sleeping
___ Feeling lonely
___ Loss of weight
___ Not enjoying things
___ Suicidal thoughts
___ Current ___ Past
___ Nausea and/or vomiting
___ Feelings of inferiority
___ Nightmares
___ Feeling angry
___ Concerns with alcohol/drug use
___ Others concerned about my use of alcohol/ drugs

___ Increased heartbeat
___ Constantly worried
___ Frequent sweating
___ Feelings of dizziness
___ Shaky hands
___ Stomach trouble
___ Full of energy
___ Feeling tense
___ Cold feet and/or hands
___ Feeling panicky
___ Diarrhea
___ Shy with people
___ Struggle w/handling money
___ Suicidal attempts
___ Current ___ Past
___ Concerns with medication use
___ Struggle to make decisions
___ Struggle to make new friends
___ Feeling anxious
___ Currently taking a multi-vitamin
___ Unable to think clearly/brain fog

___ Problems with finances
___ Problems with marriage
___ Work difficulties
___ Sexual problems
___ Struggle to keep a job
___ Don't like to be alone
___ Easily excited
___ Loss of sexual interest
___ Problems with children
___ Problems with parents
___ Poor physical health
___ Fighting & quarreling
___ Excessively critical of oneself
___ Impatient with people
___ Feelings of guilt
___ Currently using probiotics
___ Excessively judgmental of others
___ Feeling fearful
___ Lacking energy
___ Concerns regarding eating habits
___ Disturbing/unreal thoughts

___ Feeling misunderstood
___ Headaches
___ Worried about health
___ Trouble concentrating
___ Struggle to "get going"
___ Loss of meaning to life
___ Fainting spells
___ Phobias/strong fears
___ Muscle twitching
___ Digestive issues
___ Quick tempered
___ Easily angered
___ Extremely restless
___ Overly sensitive
___ Unresolved grief
___ Struggle to relax
___ Desire to hurt someone
___ Desire to smash things
___ Injuring oneself
___ Low self-esteem
___ Overly ambitious

Other (Please specify): _____

CLIENT NAME/DOB _____

GENERAL INFORAMTION

Welcome to the Rinehart Institute. You, or a member of your family, are about to engage in a counseling or psychotherapeutic relationship with a licensed/certified therapist. We are here to work with you in partnership to get the most out of your counseling experience. You will get out of the work what you are willing to put in. Making changes in our lives can be very challenging as well as very rewarding. We wish to take this time to inform you of the basic principles we believe are critical in developing a high-quality counseling relationship between us. Please read over this information and ask if any questions arise.

Fees:

Initial intake session: 45-55 minutes	$154.12
Individual session: 55 minutes	$149.56
NET remedies	$22.00
Nutritional Products	Priced individually
Court Fees	$150 per appearance

The first visit is thought of as a diagnostic or evaluation interview. During this session, the following decisions will be made with you:

a) type of therapy to utilize (individual, couple, etc.)
b) frequency of therapy sessions (weekly, biweekly, etc.)
c) goals to work toward in therapy (what you hope to gain from this experience)

Appointments:

Each appointment lasts approximately 45-55 minutes. At the close of each session, you may discuss future appointments with your therapist.

Cancellation Policy:

If you need to cancel an appointment, **we require at least a 24 hours in advance notice. A $50 fee will be charged if this notice is not received.** We understand that emergencies happen and they are the exception to this policy. Please be mindful that Insurance companies will not reimburse you for missed appointments.

Payment Policy:

If you don't pay in full at the time of the service, we expect your approval via signature allowing us to receive the insurance payment directly from the insurance company. We expect clients to pay their co-pay/deductible at the time services are received unless other arrangements have been made.

Insurance:

Most insurance companies will pay a portion of the fees for outpatient mental health services and the Rinehart Institute accepts many different insurances. It is the responsibility of the client to contact the insurance company to find out the details of their policy coverage. The Rinehart Institute will provide insurance billing services, but the client is **ultimately responsible** for all services, supplements, and supplies not covered by insurance. It is recommended that the client look over their insurance policy annually to be aware of changes or alterations to their policy.

CLIENT NAME/DOB _____

Confidentiality:

All information regarding the specific details and nature of your counseling or psychotherapy is maintained at the Rinehart Institute and is considered confidential. We abide by HIPAA guidelines and will not release information without your written approval. A separate release will be obtained, should medical records be requested or exchanged. However, each therapist at this office reserves the right to use specialty consultation with other therapists in the office per HIPAA's "need to know" policy and "supervision" guidelines.

If more than one adult patient, each person should check and initial the boxes below.

__ Yes __ No I acknowledge that I have read and understand all of the statements above and my signature below indicates that I agree with said statements.

__ Yes __ No I authorize the release of any medical information necessary to process the insurance claim. I permit a copy, or other facsimile reproduction, to be used in place of the original. I request that payment by my insurance company be made directly to the Rinehart Institute. I certify that the information I have reported is correct.

__ Yes __ No I have received a copy of the patient information and the HIPPA Privacy Practices.

__ Yes __ No I have received a copy of the Sexual Abuse & Misconduct Protocol.

_____ _____

Client or Guardian signature Please print and sign in pen **Date**

_____ _____

Therapist's Signature **Date**

CLIENT NAME/DOB _____

CREDIT CARD / HSA AUTHORIZATION

You have the option to have your credit card or HSA card information stored in Rinehart Institute management system for ease of paying for self-pay fees, insurance deductibles, co-payments, net remedies, or supplements.

You will have the option to make payments with a credit card even if you do not keep one on file, but you will need to provide the credit card information every time a payment is processed.

If you would like to keep a card on file, please complete and sign the below form.

Client Name: _____

Cardholder Name (if different than client): _____

Card Number: _____

Expiration Date: _____

CSV Code: _____

Billing Address: _____

_____

In signing this document, I am authorizing The Rinehart Institute to process payments for the above mentioned reasons.

Signature: _____ Please print and sign in pen

Date: _____