BUSINESS OFFICE
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Phone: 765-450-4843
Fax: 765-450-4895
Website: www.integrityfamilycounseling.com
Email: integrityfc@integrityfamilycounseling.com

Client/Patient Information

The following information is for the identified client/patient only.

Client/Patient's Name: First _____ Last _____

Preferred First Name (if different from above): _____

Social Security Number: _____- ____ - _____ Date of Birth _____

Address _____ City _____ Zip _____

Cell Phone: _____ Email: _____

I agree to receiving appointment reminders via text message. ☐ **YES** If not checked, you will not receive reminders.

I prefer to have account statements sent by (select only ONE): ☐ **TEXT** ☐ **EMAIL**

Alternative or Home (Landline) Phone Number: _____

Sex Assigned at Birth: _____ Gender Identity: _____

Sexual Orientation: _____ Preferred Pronouns: _____

Marital status: Single Married Divorced ☐ Widowed ☐ Partner ☐ Separated ☐

Race/Ethnicity: _____

Employed: Full Time ☐ Part Time ☐ Student ☐ Not Employed ☐

Name of Employer and/or School:

_____

Emergency Contact:_____

If client/patient is a minor, please be sure to give the PARENT or other RESPONSIBLE person's contact name:

Date of Birth: _____ Phone #: _____

Relationship to Client/Patient: _____

How did you find out about Integrity Family Counseling? (friend, internet, doctor or other)

_____

Previous Counseling: ( ) Yes ( ) No

Where or with whom?_____

Personal Information

Please briefly tell us the problems you are primarily concerned about.

_____

_____

_____

Please choose any symptom you are currently experiencing. Check all that apply.

( ) Depressed mood	( ) Racing thoughts	( ) Excessive worry
( ) Unable to enjoy activities	( ) Impulsivity	( ) Anxiety attacks
( ) Sleep pattern disturbance	( ) Increase in risky behavior	( ) Avoidance
( ) Loss of interest in things	( ) Increased libido	( ) Decreased libido
( ) Concentration/forgetfulness	( ) Decreased need for sleep	( ) Hallucinations
( ) Suspiciousness	( ) Change in appetite	( ) Excessive energy
( ) Feelings of guilt/shame	( ) Crying spells	( ) Fatigue
( ) Increased irritability		

Would you consider any of those selected to be MAJOR symptoms? If so, please underline those symptoms.

Has anyone in your immediate family been diagnosed with or treated for any of the following:

( ) Bipolar disorder ( ) Schizophrenia ( ) Depression ( ) Post-traumatic stress

( ) Anxiety ( ) Alcohol abuse ( ) Other substance abuse ( ) Other _____

Have you ever been a victim or perpetrator of Sexual Abuse or Emotional/Physical Abuse: ( ) Yes ( ) No
If you answered yes, please give a brief description: _____

_____

Do you now or have you ever had feelings or thoughts of harming yourself or others: ( ) Yes ( ) No

If you answered yes, please tell us when the last time was _____

Do you use alcohol? ( ) Yes ( ) No

If you answered yes, how frequently do you drink? _____

Do you use any other substance(s) recreationally? ( ) Yes ( ) No

If you answered yes, what substance(s) do you use and how frequently do you use them? _____

Personal Information, Continued

Have you ever been arrested? ( ) Yes ( ) No

Are you currently involved with DCS or Probation?

( ) Yes, DCS/ ( ) Yes, probation/( ) Yes, both/( ) No, neither

Are you currently involved in a custody case? ( ) Yes ( ) No

Are you seeking therapy due to a court order? ( ) Yes ( ) No

Please list any medications you are currently taking and what it is for: _____

_____

_____

Who is the patient's Primary Physician? _____

Phone #: _____

Insurance Information

Please fill in as much detail as you can about current insurance coverage. WE WILL NOT BE ABLE TO SEE YOU IF WE DO NOT HAVE COMPLETED INSURANCE INFORMATION, including that of the POLICY HOLDER.
IMPORTANT: You will be responsible for reporting any changes in your insurance coverage, such as new insurance, changes in your plan, etc. Failure to do so could cause billing to be delayed and thereby denied by the insurance company. In such a case, you would be responsible for those charges which were denied.

If you have more than one type of insurance coverage you are required to report this to Integrity Family Counseling. Failure to disclose this secondary insurance will also result in delayed billing claims. Further, you might be disqualified from receiving services with us and/or must pay out of pocket for claims we cannot file.

PRIMARY Insurance Company: _____

What kind of insurance is this? ( ) Commercial/private insurance ( ) Medicaid ( ) Medicare

Name of the Policy Holder: _____ SS #: _____

Insured's Policy/Member #: _____ Group #: _____

Employer of the Policy Holder: _____

Policy Holder's Date of Birth: _____ Relationship to client/patient: _____

Secondary Insurance Information

SECONDARY Insurance Company: _____

What kind of insurance is this? ( ) Commercial/private insurance ( ) Medicaid ( ) Medicare

Name of the Policy Holder: _____ SS #: _____

Insured's Policy/Member #: _____ Group #: _____

Employer of the Policy Holder: _____

Policy Holder's Date of Birth: _____ Relationship to client/patient: _____

You will be responsible for reporting any changes in your insurance coverage, such as new insurance, secondary insurance, changes in your plan, etc. Failure to do so could cause billing to be delayed and thereby denied by the insurance company. In such a case, you would be responsible for those charges which were denied. You are also responsible for contacting your insurance company to clarify your benefits including the need for preauthorization, your deductible, copay, and coinsurance amounts. **Co-payments are expected when you arrive for your appointment.**

Who is the responsible party for any balance due after insurance reimbursement? Please give name, phone and address if other than above:

_____

_____

Signature of responsible party _____ Date _____

Client/Patient/Responsible Person HIPPA Policy & Consent Forms

Consent to Use and Disclose your Health Information (HIPPA privacy policy):

This is an agreement between you and Integrity Family Counseling. When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here: _____.

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment of administrative purposes. You will have to tell us what you want in writing. Although, we try to respect your wishes, however, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to our office. We will then stop using or sharing you PHI, but we may have already used or shared some of it, and we cannot change that.

Signature of patient or his/her personal representative:
_____

Printed name of patient or his/her personal representative: _____

Date:_____

Consent for Individual/Marital/Couple Therapy (not minor children)

Sign here for **ADULT** Client/patient

I, _____, consent to be treated as a patient at Integrity Family Counseling. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may, at times, be difficult and uncomfortable.

I understand that I am consenting and agreeing only to those mental health services that the provider is qualified to provide within:

A. The scope of the provider's license, certification, and training: or
B. The scope of license, certification, and training of those mental health providers directly supervising the services received by the patient.

Signature(s) _____ **Date** _____

Consent for Minors or Adult under Legal Guardianship:

Sign here for **MINOR** Client/patient

I/We consent that _____, may be treated as a patient at Integrity Family Counseling. At times it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the timeliest treatment for you and/or your children.

Signature(s)_____ **Date** _____

INFORMED CONSENT

Thank you for choosing Integrity Family Counseling, LLC. We realize that starting counseling is a major decision, and you may have many questions. This document is intended to inform you of our policies, State and Federal laws, and your rights. If you have any other questions or concerns, please do not hesitate to ask. We will try our best to give you all the information you need. We can provide a vast array of counseling and look forward to working with you and/or your family. All our associates have obtained their clinical degrees from accredited universities, have extensive experience working with individuals and families, and are licensed by the state of Indiana to provide mental health counseling. We are strongly grounded in cognitive behavior therapy due to its proven effectiveness but can modify our approach depending on each person and/or condition. We also adhere to a strength-based approach that dictates all treatment options, planning, and implementation be done in a collaborative effort with you and your family.

Audio/Visual: We are also committed to training new counselors to help our greater community. Because of that, any counseling session may be videotaped for supervision purposes. Those sessions will never be used for any other purpose and are permanently erased once viewed in supervision.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal and clinical records are strictly confidential, except for **a)** information shared with consultants, **b)** information (diagnosis and dates of service) shared with your insurance company to process your claims, **c)** information that is reported about neglect, physical or sexual abuse of minors, elderly, or disabled persons (by Indiana State Law, we are mandated to report), **d)** where you sign a release of information to have specific information shared, **e)** if you provide information that informs us that you are in danger of harming yourself or others, **f)** information necessary for case supervision or consultation, and **g)** when required by law.

IF AN EMERGENCY SITUATON FOR WHICH THE PATIENT, AND/OR THEIR GUARDIAN FEELS IMMEDIATE ATTENTION IS NECESSARY, THE PATIENT AND/OR GUARDIAN UNDERSTANDS THAT THEY ARE TO CONTACT EMERGENCY SERVICES AT THE NEAREST EMERGENCY ROOM OR CALL 911.

Integrity Family Counseling will follow up those emergency services with standard counseling and support to the patient and/or the patient's family.

CANCELLATIONS/NO SHOW POLICY: Please understand that **you** are responsible for notifying us of any cancellations or rescheduling needs. **Please notify our office 24 hours in advance of any cancellation. A charge may be made to you, as that time slot could have been filled by another client/patient. A fee may also be charged for multiple or consistent late cancellations.** These fees must be paid before your next appointment unless other arrangements have been made. We reserve the right to terminate your account if you have multiple No Shows, or if you fail to pay outstanding balances. Please be aware that your insurance will not cover these fees**.**

APPOINTMENTS: The initial intake appointment may take up to 60 minutes. Thereafter, most sessions will last approximately 45-50 minutes. Due to schedules for both the therapist and the patient, we do try to keep as close to the allotted time as possible.

It is the responsibility of the patient/guardian to schedule all appointments. This is not done automatically by front office staff, nor by the therapist or nurse practitioner. We are always happy to book your appointments before you leave our office. We try to accommodate your schedule as best we can.

( ) I acknowledge that I am responsible for requesting my future appointments with Integrity staff.

Our fee schedules are as follows:

Initial Intake Appointment	$200.00/hr
Individual Counseling	$175.00/session
Family Counseling	$175.00/session
Nurse Practitioner	$200.00/initial; $150.00/follow up
Psychological Testing (including administration, scoring, interpretation, presentation of results, and report writing)	$150.00/hr
Emergency Phone Consultations	$50.00/ ¼ hr
Emergency Counseling/Evaluation	$300.00
Court Evaluations and Testimony	$500.00/hr
Attendance at School Planning Sessions	$150.00/hr
Phone Consultations to Other Professionals	$25.00/ ¼ hr

Private Pay Rates are as follows:

Initial Intake Appointment	$100.00
Individual Counseling	$87.50
Family Counseling	$87.50
Nurse Practitioner Intake Appointment	$87.50
Nurse Practitioner Med/Eval Follow-up Appointment	$50.00 (as of July 18, 2022)
Letters to Attorneys, Doctors, etc. (this will be either a patient or attorney responsibility, fee to be paid prior to receiving documents)	$50.00
FMLA/Disability Paperwork (fee to be paid prior to receiving documents)	$50.00
Cancellations/No Show Fees (must be paid prior to/or at the next session)	$25.00 - $30.00

Notes – requested patient notes are $20.00 for the first 10 pages, and $.50 for each additional page. *(must be paid prior to receiving the notes.)*

( ) I acknowledge that I am responsible for paying Co-pay, Deductible, or Self Pay amounts at each appointment.

Any questions about information provided may be discussed with your therapist, or the office staff.
Thank you for choosing Integrity Family Counseling. We look forward to working with you.
Your signature acknowledges you have read this Consent.

X_____ Date: _____

Client/Patient Responsibilities

Due to the high volume of clients/patients we see at our office, we must closely monitor incidents of **no-shows, late cancellations** (less than 24 hours), **co-pays and self-pay.**

- ✓ To ensure that every person seeking our services has access to therapist, we can only see clients/patients who are truly committed to their therapy schedule.
- ✓ We also ask that each client/patient keep track of their appointments, show up on time, and stay on top of scheduling future visits. Please be aware that appointments are NOT automatically scheduled for you- **it is the clients/patients' responsibility to make these appointments**.
- ✓ Our therapists' calendars are typically full and failure to show up for appointments or cancel last minute take appointment time away from other clients/patients that could be seen otherwise. Please be courteous and respect the therapists' time and that of our many other clients/patients.

To keep consistent appointments, it is always best to stop by the front desk to make sure you have scheduled ahead.

- ✓ Please also note, once a patient has reached an amount due of $500.00 or more, services may be discontinued until a payment arrangement has been made.

Client/Patient signature_____Date:_____