Miracles Counseling Centers, INC
(P) 704-664-1009/ (F) 704-664-1029

134 Professional Park Dr. St.400
Mooresville, NC 28117

518 Highway 16N
Denver, NC 28037

We are so glad you are here!

Therapist Name: ____________________________________ Date:________________

Individual Intake

Client's name:____

Address:____City:_____________________Zip:_____________

Telephone: Home:_________________ Work:_______________________ Cell:________________________

Birthday:________________________ SS#:____________________ DL#:____________________________

Emergency Contact: ____Telephone:______________________

Client's Employer/School: ____

Email address:____

Insurance

Check Type of Insurance: ☐ Private ☐Medicaid ☐NC Health Choice ☐EAP ☐None

Insurance Company: ______________________________________Policy Holder:_________________________

Relationship to Insured:____________________________________ Insured's D.O.B.: ______________________

Policy #:________________________________Group #:_____________ Insured's SS#:_____________________

EAP Authorization Number_________________________________ EAP Phone #:_________________________

Financial Responsibilities (Please initial)

- Co -payments and deductibles are due at the time of service. _______
- I hereby assign payment of insurance benefits directly to Miracles Healing Centers. While Miracles Healing Centers will bill my insurance company, I will be responsible for any charges incurred if my insurance company does not pay. _________
- It is my responsibility to inform my therapist of any changes to my insurance coverage. I am financially responsible for any lapses in insurance coverage ______
- While miracles counseling centers will provide me with a courtesy insurance benefits check, I am still responsible for understanding what my insurance covers and verifying this coverage. ____
- It is my responsibility to contact my insurance company to obtain the proper authorizations if required. If I fail to do this and charges are denied I will be responsible for all charges. _______
- I will be billed for phone consultations, letters, or medical record copies at the therapists standard rate by 15 minute increments._____
- If my portion of the bill is not paid within 90 days from the last date it was incurred a letter will be sent giving you 14 days to pay my account or to arrange for a payment plan. If I do not respond I will be sent to collections. _____
- A 1% interest will be added to my portion of the bill that remains unpaid after 30 days.________
- Returned check fees are $35.00 and the check amount. ___________
- You will be charged $75 for missed appointments without providing 24 hour notice of cancellation _____
- Messages regarding appointments may be left on my voicemail. ________ Yes _______No
- I give permission for text message reminders of my appointments to be sent. __________
- I give permission for email reminders of my appointments to be sent. _______

Client Name: Medicaid #: Date:

What brings you to counseling and what goals/skills do you hope to gain?

Strengths Assessment: Please circle all items that you think apply to you.

Family Support	Stable Employment	Religious/Spiritual Community	Participation in Hobbies
Physical Health	Financially Stable	Spontaneous	Creative
Courageous	Forgiving	Enjoys learning	Confident
Exercises	Calm	Fun	Resourceful
Trustworth	Good communication skills	Kind	Accepting
Flexible	Decisive	Organized	Generous
Describe Other Strengths:			

Please check behaviors and symptoms that are of concern to you:

__Aggression
__Antisocial behavior
__Alcohol dependence
__Anger
__Anxiety
__Avoiding people
__Chest pain
__Cyber addiction
__Depression
__Disorientation
__Distractibility
__Elevated mood
__Withdrawing
__Loneliness
__ Gambling
__Hallucinations
__Heart palpitations
__Hopelessness
__Impulsivity
__Irritability
__Judgment errors
__Phobias/fears
__Recurring thoughts
__Sexual addiction
__Sexual difficulties
__Sick often
__Sleeping problems
__Thoughts disorganized
__Trembling
__Dizziness
__Drug dependence
__Eating disorder
__Memory impairment
__Mood shifts
__Panic attacks
__Worrying
__Fatigue

__Other (specify): ____

Client Name: Medicaid #: Date:

Health Information:

Name of your Primary Care Physician: ____________________________May we contact? Y/N
Phone number: ______________________________ When were you last seen? _________________

Are you receiving care by a Psychiatrist? **Y** **N** Who?
____

List all current medications & supplements:

____
____
____

List all current health problems including allergies:

____
____
____

Past psychiatric history hospitalizations (mental health and chemical dependency):

____
____

Prior outpatient therapy (include previous practitioners, dates of treatment, previous treatment interventions, response to treatment and/or medications:

____
____

Drug and Alcohol Assessment

Are drugs or alcohol used by yourself or someone else a significant factor in why you are coming to our office?

Y / N If yes , self / other and their relationship to you ______________________________________

Have you ever felt that you should cut down on your drinking? **YES** **NO**

Have you ever felt bad or guilty about your drinking? **YES** **NO**

Has anyone in your life asked you to cut down on your drinking? **YES** **NO**

Have people annoyed you by criticizing you of your drinking? **YES** **NO**

Do you use any drugs? **YES** **NO**

Does drug use impact your relationships or work functioning? **YES** **NO**

Is any kind of substances a method for you in dealing with stress? **YES** **NO**

Risk Assessment

Have you ever felt suicidal? **YES** **NO**

Have you ever injured yourself by cutting, hitting, or other means? **YES** **NO**

Have you ever felt like hurting others? **YES** **NO**

List a community resource you are currently benefiting: ____________________________________

Marital & Family Information:

Married: ____ Divorced: _______ Living together: _____Separated: _______ Single: _______

If "other" please explain:

____

List dates and lengths of any previous marriages:

____

____

Children's Name & Ages:

____

____

Any family history of mental health issues? Describe

____

____

Signature of Understanding

Please sign below to indicate that "I have read the above policies, and I understand and agree to comply with them. The information shared is true and accurate. I further agree that I am personally responsible for all financial obligations incurred. I also consent to receive treatment by a Miracles Counseling Centers provider."

____

Printed Name (or guardian if client is under the age of 18)

____ ____________________

Client or guardians Signature Date

FOR OFFICE USE ONLY	
Disclosure Statement signed – Y/N	Insurance card copied- Y/N
CCA completed & signed – Y/N	Treatment Plan completed & signed- Y/N
Intake paperwork with HIPAA & Minor consent form completed & signed – Y/N	Service Request Order signed- Y/N/not applicable
LOCUS/CALOCUS score sheet – Y/N/or not applicable	Release Form to speak with Physician- Y/N/not appl.
Billing Diagnosis is:	For Billing: Consumer is entered into system – Y/N

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(P) 704-664-1009 (F) 704-483-3782

Notice of Privacy Practice Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to….

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers why may be involved in that treatment directly or indirectly.
- Obtain payments from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I understand that a professional entity has the right to change its Notice of Privacy Practices from time to time and that I may contact that professional at the address above to obtain a current copy of this information.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide such restrictions.

Client Name (please print):____

Signature:____

Date:____

Name/Relationship to Client (please print):____