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:____

Telephone: Home:_________________ Cell:___________________
Work:____________________________

Birthday:________________________ SS#:____________________
DL#:____________________________

Emergency Contact:
____Telephone:______________________

Client's Employer/School:
____

Referred By:____

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#:_________________

<u>Financial Responsibilities</u> (Please initial)

Co -payments are due at the time of service. ______

I hereby assign payment of insurance benefits directly to Miracles Incorporated While Miracles Incorporated 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 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. ______

If your portion of the bill is not paid within 90 days from the last date it was incurred a letter will sent giving you 14 days to pay your account or to arrange for a payment plan. If you do not respond you will be sent to collections. ______

A 1% interest will be added to your portion of the bill that remains unpaid after 30 days.______

Returned check fees $35.00 and the check amount.

You will be charged **$75** for missing an appointment: no show/ not giving at least 24 hours prior notice to canceling an appointment. ______

I HAVE received the treatment agreement and disclosure statement I understand and agree to abide by my financial responsibilities. I understand that information will be released to my insurance company, if necessary, and any charges that my insurance company will not cover I am responsible for.

To enable my therapist with accurate and confidential services please complete the following:

Please be aware that fax transmissions arrive at Miracles Incorporated office and are distributed to the individual therapist. Confidentiality is maintained with these records, as with all records in our office.

Messages regarding appointments may be left on my voice mail. ______ Yes ______ No

The following individuals may schedule and or confirm appointments:

____

____

____

Client Name: Medicaid #: Date:

HIPAA LAW: Notice of Privacy Practice Acknowledgement

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 who 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: ____

Consent for Treatment of Minors/(only fill out for under 18)

I (guardian name)___________________________________ give my consent that (therapist) ____________________________, will be conducting psychotherapy with (minor name) _____________________________________. My relationship to the client (parent, uncle, foster parent, etc.)______________________. I was also notified that all material discussed during psychotherapy sessions is confidential an can be released only with the permission of the holder of the privilege. I have been informed of the limitation to confidentiality in Office Policies form, which I have read and signed.

In the case of a minor special sensitivity may be required in releasing information about certain topics such as drugs and sex. I will accept (therapist) ______________________ judgment in regard to releasing or sharing information obtained during the course of psychotherapy with the minor that may endanger or jeopardize the patient's well-being.

____

Signature (Guardian) Date

____

Printed Name Relationship Date

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

Client Name: Medicaid #: Date:

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

Trustworthy	Listens Well	Kind	Playful
Good sense of humor	Flexible	Spontaneous	Open to Grow
Courageous	Forgiving	Enjoys learning	Creative
Exercises	Calm	Fun	Resourceful
Happy most of the day	Good communication skills	Living on Purpose	Living to Fullest Potential
Up to Date	Decisive	Organized	Keeps Word
Confident	Financially Stable	Does not make assumptions	Does not take things personally
Do your best most of the day	Friendly	Team Player	Relaxes
Eats nutritional foods	Articulate	Generous	Accepting

Needs Assessment: Please check individual items you want to address.
Please circle the two most important.

Marriage concerns	Intimacy	Career/Job	Improve communication skills
Health problems	Concentration	Bowel trouble	Stomach trouble
Self-esteem	Hopelessness	Guilt	Sexual problems
Temper	Depressed	Self-Control	Drugs use
Harm to self	Finances	Impulsivity	Alcohol use
Harm to others	School issues	High energy	Low energy
Suicidal	Unhappy	Headaches	Lack of focus
Lack of motivation	Memory	Legal matters	Anger
Sleep problems	Repetitive thoughts	Dreams	Abuse
Educational needs	Nightmares	Trauma	Nervousness
Anxiety	Fears	Physical fighting	Shyness
Meaningless	Crying spells	Appetite/weight	Unresolved grief
Spiritual concerns	Use of time	Panic	Negative
Eating/food/hoarding	Stress	Infidelity/affairs	Parenting needs
Jealousy	Divorce/transition	Housing	Non-compliance

Health Information:

List all current medications & vitamins:
____
____
____

List all current health problems including allergies:
____
____

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

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

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

I give my consent or do not give consent (circle) for my therapist, _______________________ to release my records to my primary physician to discuss my treatment:

Sign____Date_______________________

Risk Assessment

Suicidal Ideation - None noted Thoughts only Plan Means Attempt Able to contract

Homicidal Ideation - None noted Thoughts only Plan Means Attempt Able to contract

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:
____

Frequency of Alcohol use:

_____never ______ less than 1 time/month ______1-4 times per month _____ 2-3 times per week ______ daily

Usual Alcohol Consumption:

______ never _______ 1-2 drinks per sitting ______3-4 drinks per sitting ________ 5 or more drinks per sitting

Frequency of use to levels of intoxication:

______ never ______ 1 time/month ______ 2-4 times per month ______ 2-3 times per week ______ daily

Self-perception of alcohol use:(check all that apply)

___ Occasional or social ___ Problem use ___ Psychological dependence

___ Addicted-cannot stop ___ Does not want to stop ___ Motivated to stop

History of treatment attempts:(check all that apply)

___ None ___ Stopped on own ___ Attended AA/ other 12 step program

___ Attended outpatient program ___ Attended inpatient program ___ Attended community-based program

Please describe any drug-related problems:(e.g. legal, job, physical, or social)____

Self-perception of Drug Use:(check all that apply)

___ Occasional or social ___ Problem use ___ Psychological dependence

___ Addicted-cannot stop ___ Does not want to stop ___ Motivated to stop

History of treatment attempts:(check all that apply)

___ None ___ Stopped on own ___ Attended NA/ other program

___ Attended outpatient program ___ Attended inpatient program ___ Attended community-based program

List a community resource you are currently benefitting: ____________________________________

Risk Factors to Include:

Non-compliance with treatment Domestic Violence Eating Disorder

AMA/elopement potential Child Abuse Suicidal/Homicidal

Prior behavioral health inpatient admissions Sexual Abuse Other:

Legal information:

Do you have a probation officer or case worker? If yes, what is his/her Name, Phone number, and Address:

Do you have an attorney? If yes, what is her/her Name, Phone number, and Address:

Marital Information:

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

If "other" please explain:

____

List dates and lengths of any previous marriages:

____

Write 3 of your beliefs that support your life:

____

____

Signature of Understanding

Client Name: Medicaid #: Date:

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 Signature of Client (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