Grace&Truth Christian Counseling, LLC

To make our first meeting more productive, please give accurate and complete responses to every section of this form. If necessary, write additional information in the margins.

PERSONAL AND FAMILY INFORMATION

Date: _____

Name (Designated client):_____Date of Birth:_____

Age:_____ Mother's Name (only if client is a child or teen): _____

Father's Name (only if client is a child or teen):_____

Address:_____ City_____State_____

Zip Code _____

Phone (Home)_____(Cell)_____(Work)_____

Email: _____

Employer_____Position_____How long_____

Church Home:_____

Marital Status:
Single, never married_____;Engaged_____;Living together without marriage_____; Separated_____;

Divorced_____ how long_____; Widow(er)_____ how long_____; Married_____ how long_____

Spouse's Name: _____Date of Birth _____

Spouse's Phone: _____Age:_____

Spouse's occupation: _____ Employer_____

How long married to this spouse_____; Total number of prior marriages for you_____
Total number of prior marriages for your spouse_____

COUNSELING HISTORY

Have you previously sought counseling? Yes_____ No _____

Therapist _____Profession_____From_____To_____

Therapist _____Profession_____From_____To_____

How satisfactory was your experience(s)?_____

_____

Are you presently working with any other Counselor or Psychologist? Yes_____ No _____

For what reason? _____Professional's name_____

Are you involved in any other counseling or support group? Yes ____ No _____ Specify_____

MEDICAL INFORMATION

Family Physician _____Psychiatrist_____

Are you taking any prescription drugs? Yes_____ No _____ If Yes, state the drug name(s), type and for what purpose?_____

_____

Who prescribed the drug(s)?_____

Describe your physical health? Very good_____ Good_____ Adequate_____ Poor_____Declining_____

Current medical problems and/or medications _____

_____

Please list any sleep disturbances_____

Have you ever been hospitalized for mental illness or substance abuse? Yes____ No_____ If Yes, for what reason?_____How long in treatment?_____

CONSENT FOR TREATMENT

I/We give permission to Grace& Truth Christian Counseling, LLC to provide counseling to me/us.

As a client of this office, it is your right to have the content of your therapy sessions held in confidence with these exceptions, in which I am mandated by law to report:

1) if you intend suicide, or if you intend to do serious physical harm to yourself,
2) if you intend homicide,
3) if a child, elderly person, or disabled person is being abused or has been abused, or
4) in the case of exploitation by a mental health professional
5) if you sign a release form for me to divulge any or all information.

In some cases, the Missouri courts have held that if an individual intends to take harmful or dangerous action against another individual, it is the counselor's duty to warn the person and/or the family of the person who is likely to suffer the results of harmful behavior.

Every effort will be made to resolve these issues before such a violation of confidentiality takes place. Every effort will be made to prevent an attempted suicide or a dangerous action against another person.

Professional consultation:
In following ethical and professional standards, occasionally therapists consult with other professionals to gain other perspectives and ideas on how to best serve you. Unless you have signed a release, no identifying information is shared during these consultations.

By signing below, I affirm that the information given on this form is true and complete.

I have read and agree to the above policies, procedures and statements.

Signature of Client	Printed name of client	Date
Signature of Client	Printed name of client	Date
Signature of Counselor	Date	

INSURANCE (If applicable)

Name of Insurance: _____ ID # _____

Primary Card Holder: Self _____ Spouse _____ (If yes, please indicate spouse's name and date of birth below)

Spouse's Name _____ Date of Birth _____

Do you know if you have a deductible? Yes _____ No _____ If not, do you know your co-pay? Yes _____ No _____ If yes, what is it? _____

PAYMENT AGREEMENT

( ) Insurance ( ) Self-Pay

I, the undersigned, agree to the terms of payment established below. Additionally, I understand there is a **24-hour cancellation policy** and I realize that I am responsible for the payment of any missed appointments or late cancellations. I realize my credit card or debit card will be charged for the late cancellation or missed appointment.

Session Fee: _____

Late Cancelation Fee _____

Please note, if utilizing insurance, there is a **$2.50** charge for billing and submission of insurance claim for each counseling session. Also know that from time to time, your counselor may need to advocate on your behalf. This may include services such as, but not limited to, phone contact, consulting with physicians, providing written reports, appearing in court, etc. Fees for such services are charged at a rate of $**135.00** per hour**.**

I agree to pay for any above mentioned services provided.

Signature Date

ELECTRONIC PAYMENT AUTHORIZATION

Please complete the following information. Session fees for all clinical treatment as well as missed appointment charges will be deducted from the account designated on this form. Forms of payment accepted: Visa, Mastercard, and Discover. This form will be securely stored in your clinical file and may be updated upon request at any time.

CLIENT INFORMATION:

Client Name:_____

Responsible Billing Party Name (as shown on Credit Card/Account):_____

Billing Address (as registered with Credit Card Company/Bank):

_____

_____

Mobile Number:_____Home Number:_____

FORM OF PAYMENT:

Check One: Credit Card:_____ Debit Card:_____

ACCOUNT INFORMATION:

Card Type (Visa, Mastercard, or Discover):_____

Card #:_____

Expiration Date:_____

Three Digit Card Code (Located on Back of Card):_____

_____

Client Signature Date