

COUNSELING ASSOCIATES LLC NEW CLIENT QUESTIONNAIRE & INFORMED CONSENT

INSTRUCTIONS: Please answer these questions to help assist us in understanding the client's needs and concerns. When we agree to treat a couple or a family, we consider that couple or family to be the client. For the purpose of this form, you must choose who the "client" will be. Usually, it is the individual covered by insurance if you have insurance coverage.

Please check the category below that best matches the client's treatment request.

- Individual Adult Issues
 Child/Adolescent Issues

- Couple/Marriage Issues
 Family Issue

CLIENT INFORMATION:

Client Name (First) _____ (MI) _____ (Last) _____
Address _____ City _____ State _____ Zip _____
Phone #s (Hm) (____) _____ (Wk.) (____) _____
(Cell) (____) _____ Marital Status _____ Sex: F M Age _____
Date of Birth ____/____/____ Email Address: _____

PARTNER OR PARENT/LEGAL GUARDIAN INFORMATION

If minor is in state custody, the state representative must complete the appropriate questions within this section.

Client Name (First) _____ (MI) _____ (Last) _____
Address _____ City _____ State _____ Zip _____
Phone #s (Hm) (____) _____ (Wk.) (____) _____
(Cell) (____) _____ Marital Status _____ Sex: F M Age _____
Date of Birth ____/____/____ Relationship: Spouse Parent/Legal Guardian Other Specify: _____

EMERGENCY CONTACT:

Primary Emergency Contact:

Name: _____ Relationship: _____
Phone Number: _____

Secondary Emergency Contact:

Name: _____ Relationship: _____
Phone Number: _____

OTHER PARTICIPATING FAMILY MEMBER (Use other side of paper if needed.)

_____ Name	_____ Relationship to Client	_____/_____/_____ Date of Birth
_____ Name	_____ Relationship to Client	_____/_____/_____ Date of Birth
_____ Name	_____ Relationship to Client	_____/_____/_____ Date of Birth

EMOTIONAL/PSYCHIATRIC HISTORY

Has the client had outpatient psychotherapy? No Yes *If yes, please explain below:*

Previous Provider Name and Agency: _____

City: _____ State: _____ Phone No. (____) _____

Month/Year: ____/____ to Month/Year: ____/____ Diagnosis: _____

Treated for: _____ Beneficial? No Yes

PRESENTING PROBLEM

Please check all that are areas of concern for the client:

- | | |
|---|--|
| <input type="checkbox"/> Addiction and/or Substance Abuse | <input type="checkbox"/> Medical Issues |
| <input type="checkbox"/> Anger Management Problems | <input type="checkbox"/> Memory Problems |
| <input type="checkbox"/> Anxiety, Stress, and/or Panic *GAD-7 | <input type="checkbox"/> Mood Problems/Mood Swings |
| <input type="checkbox"/> Attachment Problems | <input type="checkbox"/> Obsessions and/or Compulsions |
| <input type="checkbox"/> Behavior/Conduct Problems | <input type="checkbox"/> Parenting |
| <input type="checkbox"/> Depression *PHQ-9 | <input type="checkbox"/> Relationship Concerns/Conflict |
| <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Sexual Concerns and/or Dysfunction |
| <input type="checkbox"/> Eating Problem/Disorder | <input type="checkbox"/> Sleep Difficulties/Disturbance |
| <input type="checkbox"/> Grief/Loss | <input type="checkbox"/> Social Discomfort/Isolation |
| <input type="checkbox"/> Irritability/Agitation | <input type="checkbox"/> Suicidal and/or Homicidal Thoughts* |
| <input type="checkbox"/> Low Self-Esteem | <input type="checkbox"/> Trauma* |

Does the client have additional primary concerns or symptoms not previously identified in the prior list? No Yes If yes, please explain below:

* Suicidal and/or Homicidal Thoughts	Past Month		Lifetime	
	Yes	No	Yes	No
1) Have you wished you were dead or wished you could go to sleep and not wake up?				
2) Have you actually had any thoughts of killing yourself?				

When was first and last time you had these thoughts: _____

Trauma History: Have you experienced any of the following?

- | | | | |
|--------------------|--|--------------------------|--|
| Physical Trauma: | Yes <input type="checkbox"/> No <input type="checkbox"/> | Emotional Trauma: | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Sexual Trauma: | Yes <input type="checkbox"/> No <input type="checkbox"/> | Victim of a Crime: | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Domestic Violence: | Yes <input type="checkbox"/> No <input type="checkbox"/> | Witnessed someone die: | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Natural Disaster: | Yes <input type="checkbox"/> No <input type="checkbox"/> | Military Related Trauma: | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Accidents: | Yes <input type="checkbox"/> No <input type="checkbox"/> | Abandonment/Neglect: | Yes <input type="checkbox"/> No <input type="checkbox"/> |

If yes, feel free to explain below:

Family Mental Health History:

- | | |
|---|--|
| <input type="checkbox"/> Addiction and/or Substance Abuse | <input type="checkbox"/> Anxiety Disorder |
| <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Mood Problems/Mood Swings | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Suicide thoughts/attempts |
| <input type="checkbox"/> Grief/Loss | <input type="checkbox"/> Anger Management Problems |
| <input type="checkbox"/> Parenting Issues | <input type="checkbox"/> History of Mental Health Hospitalizations |

Explain History: _____

MEDICAL HISTORY

Overall, how is the client's current health? Excellent Good Fair Poor

Has the client received a thorough medical exam within the past year? No Yes

If yes, please complete the following information:

Provider: _____ Month/Year of Exam: ____/____

Findings: Normal Abnormal If abnormal, explain below:

Has the client had any serious accidents, surgeries, and/or hospitalizations within the past year? No Yes If yes, please explain below:

Females Only:

Is the client pregnant? N/A No Yes If so, how far along is the pregnancy? _____ weeks/months

MEDICATION INFORMATION

Is the client currently taking any medication? No Yes If yes, explain below:

Medication Name _____	Dosage _____	Prescribed For _____	No <input type="checkbox"/> Yes <input type="checkbox"/>
			Beneficial?
Medication Name _____	Dosage _____	Prescribed For _____	No <input type="checkbox"/> Yes <input type="checkbox"/>
			Beneficial?
Medication Name _____	Dosage _____	Prescribed For _____	No <input type="checkbox"/> Yes <input type="checkbox"/>
			Beneficial?
Medication Name _____	Dosage _____	Prescribed For _____	No <input type="checkbox"/> Yes <input type="checkbox"/>
			Beneficial?

Does the client have any additional issues or concerns not previously identified by any of the prior questions? If so, please explain below:

INFORMED CONSENT

The client requests and consents to the following services:

- Mental health evaluation
- Counseling/Psychotherapy (individual, couples, family, or group)
- Psychosexual evaluation, interpretation of results, & preparation of reports
- Substance abuse/addiction evaluation, interpretation of results, & preparation of reports
- Family systems evaluation, interpretation of results, & preparation of reports
- Child custody evaluation, interpretation of results, & preparation of reports
- Educational services
- Other services: _____

The client understands that s/he may withdraw from treatment at anytime. However, if the client decides to do this, the client will discuss that plan with the representative of Counseling Associates LLC before acting on it. Counseling Associates LLC has further disclosed to the client scheduling, fees, and policies regarding confidentiality, payment, missed appointments, matters relating to insurance, and if applicable, preauthorization and utilization reviews.

CLIENT FINANCIAL INFORMATION, FINANCIAL AGREEMENT & INSURANCE COMPANY RELEASE

NEW CLIENT FINANCIAL INFORMATION: *In order to fill out the form completely, you will need to have a copy of your insurance card(s), the subscriber's date of birth, and the subscriber's social security number. The client's social security number and date of birth are also required regardless of age, for insurance company identification purposes.*

Client Name (First) _____ (MI) ____ (Last) _____

Address: _____ City: _____ State: _____ Zip: _____

SS#: ____ - ____ - ____ DOB: ____ / ____ / ____

Home #: (____) ____ - ____ Work #: (____) ____ - ____ Cell #: (____) ____ - ____

If you do not have or you do not wish to use insurance coverage, please skip to the Responsible Party for Payment section.

PRIMARY INSURANCE

We must have a copy of this insurance card, or we may not be able to bill the insurance carrier properly.

Name of Insurance: _____ Phone #: (____) ____ - ____

Address: _____ City: _____ State: _____ Zip: _____

Subscriber's Name: (First) _____ (MI) ____ (Last) _____

SS#: ____ - ____ - ____ DOB: ____ / ____ / ____ ID Number: _____ Group Number: _____

Relationship to Client: Self Spouse Parent/Legal Guardian Other Specify: _____

Insured Through: Self Employer Employers Name: _____

SECONDARY INSURANCE

We must have a copy of this insurance card, or we may not be able to bill the insurance carrier properly.

Name of Insurance: _____ Phone #: (____) ____ - ____

Address: _____ City: _____ State: _____ Zip: _____

Subscriber's Name: (First) _____ (MI) ____ (Last) _____

SS#: ____ - ____ - ____ DOB: ____ / ____ / ____ ID Number: _____ Group Number: _____

Relationship to Client: Self Spouse Parent/Legal Guardian Other Specify: _____

Insured Through: Self Employer Employers Name: _____

RESPONSIBLE PARTY FOR PAYMENT if different from client

Client Name (First) _____ (MI) ____ (Last) _____

Address: _____ City: _____ State: _____ Zip: _____

SS#: ____ - ____ - ____ DOB: ____ / ____ / ____

Home #: (____) ____ - ____ Work #: (____) ____ - ____ Cell #: (____) ____ - ____

Relationship to Client: Spouse Parent/Legal Guardian Other Specify: _____

FINANCIAL AGREEMENT

To make sure we are operating on the same agreement regarding sessions, we have defined the following guidelines. Once you have agreed upon an appointment time, you are responsible for that time. If you foresee that you cannot keep the appointment time, you will need to give us at least a 24-hour cancellation notice, or you will be charged for the time. Medical emergencies are acceptable for short notice (please call one of our offices and leave a message if you have a medical emergency cancellation).

Our fees are fair and competitive. Here are our standard rates:

- Initial Evaluation: \$275.00
- Individual Psychotherapy, 45-50 minutes: \$225.00
- Couples or Family Psychotherapy, 45-50 minutes: \$250.00
- Group Psychotherapy, 45-50 minutes: \$135.00
- Court Proceedings (Minimum): \$1,000.00

Full payment is due at the time of service unless we are a participating member to your insurance plan. Insurance coverage is a contract between you and your insurance company. It is your responsibility to know and provide the limitations on your plan's coverage. In some cases, we may be a party to this contract. Please ask if we are a participating member to your insurance plan, otherwise, deductibles and reduced benefits may apply. Your

copayment is due at the beginning of each session. Fees will vary with the type of services provided. Cash or check is accepted. Please make checks payable to Counseling Associates LLC. Our service charge for returned items is \$55.

We will handle your claim according to our agreement with your insurance company. You must notify us of any changes in your coverage within 15 days of the change. We will not become involved in disputes between you and your insurance company (i.e., deductibles, co-payments, coverage changes, secondary insurance) other than to supply factual information as necessary. You are responsible for all non-contractual fees unpaid by your insurance company.

I understand that I may be charged the price of a full session for missing an individual session if I fail to give 24-hours advanced notice.

IMPORTANT INSURANCE QUESTIONS

- Does your policy cover individual counseling? No Yes
- Does your policy cover family counseling? No Yes
- Does your policy cover couples counseling? No Yes
- Do you have to get prior authorization for counseling? No Yes
 - If so, how do I go about getting authorization?
- Are there a maximum number of sessions covered per year? No Yes
 - If yes, what is the limit? _____
- Does your counselor have to be a provider with your company in order for your sessions to be covered? No Yes
- Do you have to get a referral from your primary care physician for counseling? No Yes
- How much of your deductible have you met at this time? \$ _____ of \$ _____
- What is your benefit year? Calendar Year Fiscal Year
- What is your financial responsibility (i.e., co-pay, co-insurance) after your deductible has been met? \$ _____/per session.
- Does your company use an employee assistance program that you have to use before starting counseling sessions through your plan's coverage? No Yes

COLLECTION

Timely payment is expected. In the event that your balance goes unpaid, we will turn your account over to a collection agency. Any fees incurred by us to collect on your bill will be your added responsibility.

Please direct all billing inquiries to our billing staff at (406) 996-1034.

Legal Proceedings:

If you become involved in legal proceedings that require participation by your Therapist and/or the Clinical Director of Counseling Associates LLC, you will be expected to pay for all the Therapist's/Clinical Director's professional time, at their clinical hourly rate as noted above, including preparation and transportation costs, even if the Therapist is called to testify by another party. You will also be expected to pay any legal costs incurred by Counseling Associates LLC in responding to the legal proceedings. Minimal costs for legal proceedings will be \$1000.00 but is not limited to this amount.

AUTHORIZATION & INSURANCE COMPANY RELEASE OF INFORMATION

I/We hereby authorize Counseling Associates LLC to disclose to my/our insurance company(s), listed above, only the following information: patient name, date(s) of service, service(s) provided, and diagnosis, to be used for the purpose of insurance evaluation and reimbursement, unless otherwise specified in a separate authorization to disclose additional clinical information.

This information will be disclosed to the above insurance company from records whose confidentiality is protected by Montana and/or federal law. These regulations prohibit the above insurance company from making any further disclosure of this information without prior written consent. I/We understand that I/we have no obligation whatsoever to disclose any information from my/our record. I/We understand that I/we may revoke this consent at any time by notifying Counseling Associates LLC or the above-noted person, organization, or agency, in writing and/or by specifying an event or condition upon which my/our consent will expire without revocation. I/We have read or had this form read and explained to me and I/we understand its contents.

I/We have completed the above to the best of my/our ability and fully understand the importance of this relationship. I/We have reviewed the terms in the document and agree to abide by the terms as outlined for services provided by Counseling Associates LLC. With my/our signature I/we give my/our consent to provide the necessary information for all billing of the services rendered.

_____	____/____/____
Client Signature	Date
_____	____/____/____
Client Signature	Date
_____	____/____/____
Parent/Legal Guardian Signature <i>mandatory if client is a minor</i>	Date
_____	____/____/____
Representative of Counseling Associates LLC	Date

A copy of this legal document has been requested by the client/responsible party/parent-legal guardian:
No Yes . Given by: _____, _____.
Initials Date