Intake Summary and Case Formulation

Client: _____

Date of birth: _____ Age: ____

Address: _____ Apt.: _____

City: _____ State: _____ Zip:_____

Cell Phone: _____ Other Phone: _____

e-mail: _____

Insurance Company: _____

Member ID: _____

Partner:

Partner: _____

Date of birth: _____ Age: ____

Address: _____ Apt.: _____

City: _____ State: _____ Zip:_____

Cell Phone: _____ Other Phone: _____

e-mail: _____

Insurance Company: _____

Member ID: _____

For Minor Clients:

Name: _____

Parent's Name: _____

Date of birth: _____ Age: ____

Address: _____ Apt.: _____

City: _____ State: _____ Zip:_____

Cell Phone: _____ Other Phone: _____

e-mail: _____

Insurance Company: _____

Member ID: _____

Consent to Treatment

I acknowledge that I have received, have read and understand the "Notice of Privacy Practices."

I do hereby seek and consent to take part in the treatment at Counseling ABQ.

I am aware that I may stop my therapy at any time. The only thing I will still be responsible for is paying for the services I have already received.

I agree that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel and do not show up, I may be charged the full amount for that appointment, including the insurance company portion of the payment. Counseling ABQ may waive the fee if the cancellation is due to inclement weather, illness or an emergency.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

_____ _____

Signature of therapist Date

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

Agreement to Pay for Professional Services

I request that my therapist at Counseling ABQ, provide professional services to

_____
(your name or person receiving therapy)

and I agree to pay this therapist's fee of $100 per session or the amount of insurance payment and co-pay.

I agree that I am responsible for the charges for services provided by this therapist to me (or this client), although other persons or insurance companies may make payments on my (or this client's) account.

I understand that if payment for the services I receive is not made, the therapist may stop my treatment.

I agree that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel and do not show up, I may be charged the full amount for that appointment, including the insurance company portion of the payment. Counseling ABQ may waive the fee if the cancellation is due to inclement weather, illness or an emergency.

I understand that if I do not show up for sessions without notification or have late cancellations for non-emergency reasons for a total of 3 sessions, my therapist may cancel all future sessions and refer me to another counseling agency or therapist.

_____ _____
Signature of client (or person acting for client) Date

_____
Printed name

Counseling ABQ
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