Mark and Janet Campbell
Counseling and Therapy Services

jmcampbelltherapy@gmail.com
(814) 580-9169

Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Phone (Home/cell): _____ **May we leave a message? Yes** □ **No** □

Marital Status: Single □ **Married** □ **Separated** □ **Divorced** □ **Widowed** □

Employer: _____ **Job title:** _____

Highest grade completed: _____**Who suggested you contact us:** _____

Please briefly describe your reason for seeking therapy: _____

Primary Care Physician? _____

PRIMARY INSURANCE INFORMATION:

Insurance Company Name: _____

ID Number: _____Group Number: _____

Insurance Guarantor Name and DOB (*if different from patient*): _____

Relationship to Client: _____ CoPay: $_____

SECONDARY INSURANCE INFORMATION:

Insurance Company Name: _____

ID Number: _____Group Number: _____

Insurance Guarantor Name and DOB (*if different from patient*): _____

Relationship to Client: _____ CoPay: $_____

Please see reverse side

CURRENT HOUSEHOLD MEMBERS

Name	Age	Relationship
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Are your parents alive? _____

What is your relationship with them? _____

_____

CURRENT MEDICATION

Medication	Dose	Reason	Prescribing Physician

PAST BEHAVIORAL HEALTH/SUBSTANCE ABUSE TREATMENT

Date	Reason	Facility/Provider	Helpful?

Please see reverse side

Cancellation Policy

If you are unable to attend an appointment, we kindly request that you give us 24 hours advanced notice. We often have people waiting to be seen and if you give us advanced notice, we can sometimes offer that time slot to another waiting patient.

No shows (not coming to an appointment and not notifying your counselor prior to the appointment time) will result in a "No Show" fee of **$50.00** being billed directly to you. This is not covered by your insurance.

We do appreciate your help in keeping our practice running timely and efficiently.

Client Signature (Parent/Guardian if under 18) Date

Please see reverse side

Consent for Treatment
And Limits of Liability

Limits of Services and Assumption of Risks:
Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy.

Limitations of Confidentiality:
What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written, may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect
If you disclose a plan or threat to harm yourself or another person, the therapist is required to warn the possible victim and/or the proper authorities.

Abuse of Children or Vulnerable Adults
If you disclose, or it is suspected, that there is abuse or neglect of children, elderly, or disabled persons, the therapist must report this information to the appropriate state agency and/or legal authorities.

Insurance Providers
Insurance companies and other third-party payers are given information that they request regarding services to the clients. They type of information they might request include: types of services, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

By signing the form below, I agree to the assumption of risk and limits of confidentiality and understand their meanings and ramifications.

Client Signature (Parent/Guardian if under 18) Date

Please see reverse side