HEARTJOURNEY, LLC
INTAKE FORM

Section I: General Information:

Today's Date:________________Date of Birth:____________________________Age:_______

Legal Name:____

Address:____
(Street) (City) (State) (Zip)

May we send bills to you at your home? Yes No

If no, please provide an alternate address:____

May we send Informational mailings to your home? Y N

Are you currently employed? Y N Employer:___________________________________

PHONE: Please provide us with phone numbers that we may use to contact you.

HOME	**CELL**	**WORK**
( )	**( )**	**( )**
May we leave a message? Yes No	May we leave a message? Yes No	May we leave a message? Yes No

May we text appointment reminders? Y N
May we Email you? Y N
If yes, please print your email address clearly: ____
**** Please note e-mail correspondence is **NOT** considered to be a confidential medium of communication

Marital Status: Single Partnered Married Separated Divorced Widowed

If Married:Spouse's Name: ________________________________ Date of Birth: _____________________

Please List: Please List:

CHILDREN'S NAMES	AGE	STEP-CHILDREN'S NAMES	AGE

Other Members In Household:

Name____ Relationship_______________________________

Name____ Relationship_______________________________

Religion/Spirituality:
Is your faith an important part of your life? Y N
Would you like your faith to be incorporated into a part of your counseling sessions? Y N
Religious Affiliation: ________________________________

(PLEASE ALSO COMPLETE BACK OF THIS SHEET)

HEARTJOURNEY, LLC INTAKE FORM(CONTINUED)

SECTION II: PRESENTING PROBLEM AND HISTORY

Please give a brief description of the main concern that is bringing you here today.

Please check any of the concerns that apply to your presenting concern:

√	CONCERN	Current level of distress This concern is causing you (Please Circle)	How long has this concern been bothering you? (Please check appropriate box)				
			1 month or less	Several Months	A Year	Several Years	All My Life
	Addictions (Other than alcohol or drugs)	Low Medium High					
	Alcohol or Drug	Low Medium High					
	Anger	Low Medium High					
	Anxiety, Fears or Nervousness	Low Medium High					
	Compulsive Behavior	Low Medium High					
	Cutting or Self Injury	Low Medium High					
	Depression or Sadness	Low Medium High					
	Eating Concerns/Body Image	Low Medium High					
	Emotional Abuse	Low Medium High					
	Family Problems	Low Medium High					
	Financial Problems	Low Medium High					
	Grief/Loss	Low Medium High					
	Intimate Relationship	Low Medium High					
	Job/Work Stress	Low Medium High					
	Legal	Low Medium High					
	Medical/Health	Low Medium High					
	Mood Swings	Low Medium High					
	Obsessive Thoughts	Low Medium High					
	Panic Attacks	Low Medium High					
	Parenting Concerns	Low Medium High					
	Phobias	Low Medium High					
	Physical Abuse or Assault	Low Medium High					
	Physical Pain Where?	Low Medium High					
	Relationship Concerns	Low Medium High					
	Sexual Abuse or Assault	Low Medium High					
	Sexuality Concerns	Low Medium High					
	Sleep Difficulty	Low Medium High					
	Suicidal Thoughts	Low Medium High					

HEARTJOURNEY, LLC INTAKE FORM(CONTINUED)

SECTION III PREVIOUS COUNSELING and MEDICAL HISTORY

Have you ever been in counseling before? Y N
If yes,
Who did you see?____ Where?__________________________

How long ago did you see them? __________________________

Was that counseling helpful to you? Y N

Have you ever had any previous suicidal thoughts or attempts? Y N

Do you have any thoughts or plans of suicide now? Y N

Name and location of your Primary

Physician:____

Is there a family history of any problems with any of the following?

Alcohol/ Drug/suicide/heart disease/cancer/anxiety/depression/thought disorders (schizophrenia, bipolar)/ADHD/Allergies/other addictions (shopping, gambling, sex, internet)

Others not mentioned above: ____

____

Please rate your health: Excellent Good Average Poor

(PLEASE ALSO COMPLETE THE BACK OF THIS SHEET)

HEARTJOURNEY, LLC INTAKE FORM (CONTINUED)

SECTION V ALCOHOL AND DRUG USE

Do you drink alcohol? Y N
If yes, how often do you drink?

☐Rarely ☐Monthly ☐Weekly ☐Daily or Almost Daily

Do you use recreational drugs? Y N
Please list:____
If yes, how often do you use?

☐Rarely ☐Monthly ☐Weekly ☐Daily or Almost Daily

Do you think your drug or alcohol use is a problem you would like to discuss with your counselor? Y N

SECTION IV MEDICATIONS

Are you on any medications? Y N
If so, what are they and for what condition?

____

____

SECTION VI TREATMENT GOALS

List three goals that you would like to achieve with your counselor

1.____

2.____

3.____

Did someone refer you here? How did you hear about us? ___________________________________

____

HEARTJOURNEY, LLC

FEES AND PAYMENT OPTIONS

Consultation and therapy visits last 55 minutes. The cost per session is as follows:

- $200.00 for the intake session
- $175.00 for subsequent sessions
- Visits that go beyond 55 minutes will be charged accordingly.

LATE CANCELLATION FEE: Your appointment time is reserved for you. If you cannot use that time, please call 24 hours in advance or there will be a $135.00 charge assessed to your account

METHOD OF PAYMENT

(Please choose Option I or II)

OPTION I

_____Private Pay (No insurance is being processed). Payment is due in full the day of service.

I understand that $ __________is due the day of my session. Any amount that is left unpaid the day of session is subject to additional $50.00 charge for processing and billing. Late fees will also be applied if payment is not received within 30 days. Failure to comply with payment of services is subject to collection proceedings and credit reporting.

____ _____________________

(Signature) (Date)

OPTION II

_____Insurance (Please pay your co-payment or portion that applies to unmet deductible the day of session)

I hereby authorize HeartJourney to furnish information necessary for billing which my insurance carrier(s) may require concerning psychotherapy services rendered by myself or my dependents HeartJourney. I hereby assign HeartJourney all payments rendered to myself or my dependents for psychotherapy services.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT THAT MY INSURANCE DOES NOT COVER.

Any balance that your insurance has not covered will be billed to you on a statement, subject to late fees if not paid by the due date. Failure to comply with payment of services is subject to collection proceedings and credit reporting. Failure to keep an appointment or to give sufficient notice of cancellation will result in a $135.00 charge which is not covered by insurance or Wisconsin Medical Assistance.

***Please be aware that in furnishing billing information to your insurance company(s), HeartJourney may be required to release confidential information regarding your treatment. It is possible that by furnishing this information to your Insurance Carrier(s) your confidentiality could be put at risk. HeartJourney will do its best to maintain your confidentiality. If HeartJourney is asked to furnish information on specific sessions, you will be notified and have the opportunity to know what information is being released.

I understand and agree to the above authorization and terms for the length of my treatment. I understand that my Insurance carrier will be billed _________________ per session. I understand that HeartJourney cannot guarantee my insurance coverage and I am responsible for any balance that insurance does not cover. I will furnish HeartJourney with the necessary information to file claims. It is my responsibility to keep HeartJourney informed of any changes in carriers or coverage. I will also notify HeartJourney if I wish to discontinue filing insurance claims for my sessions.

____ _____________________

(Signature) (Date)

***PLEASE PROVIDE US WITH A COPY OF YOUR INSURANCE CARD. IF YOU HAVE A COPAYMENT OR IF YOU KNOW THAT YOUR SESSION IS GOING TO APPLY TO DECUCTIBLE WE ASK THAT YOU PAY THIS THE DAY OF YOUR SESSION. THANK YOU.

HeartJourney

INFORMED CONSENT

1. If an emergency occurs during regular office hours call HeartJourney and leave a voicemail Your therapist will return your call as soon as possible.

2. HeartJourney is not able to be a crisis center. You may leave a voicemail for your therapist at any time after office hours. Messages are returned as soon as possible.

3. In case of an emergency after hours, call Great Rivers Crisis Line at 211. If you feel that medical attention or hospitalization may be necessary, go to the nearest hospital emergency room.

4. I understand that information regarding my counseling at HeartJourney may not be released unless I give my written consent.

5. I have the right to a copy of my treatment records both during treatment and after discharge (at a reasonable cost) providing I contact my therapist and give reasonable notice.

6. HeartJourney will take all measures to protect your confidentiality under Professional Ethics and Wisconsin and Federal law. There are, however, certain exemptions to this protection of confidentiality, such as when a clinical therapist becomes aware of the possibility of physical, emotional and/or sexual abuse to a minor; or becomes aware of your intent to harm yourself or another person. In cases such as these, your therapist has the legal obligation to report to the proper authorities or the duty to warn without consent.

7. Confidentiality cannot be guaranteed on any correspondence between yourself and HeartJourney Staff via Internet. Should you contact your therapist via the Internet, in order to protect your confidentiality, he/she may choose to respond to your Email via phone.

8. If you are between the ages of 14 and 18, you have the right to determine the release of your records and to sign a Release of Information for these records on your own behalf.

9. I have received and have had explained to me a description of clinic services, costs, treatment time frame, Patient Rights and Grievance information and information sheet. I have the right to discuss alternative methods of treatment and have access to those methods and services. I also understand that psychotherapy can help relieve symptoms of psychological, emotional, and social stresses and that not following through with the treatment plan may result in the return of symptoms. I understand any questions I may have concerning this information will be addressed by my therapist at the time my treatment plan is developed.

10. I give my consent for an evaluation session(s).

____________________________________ ________________________

Client Signature Date

____

Parent/Legal Guardian Signature

____

Clinic Representative