THRIVE
COUNSELING & CONSULTING, PLLC®

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NEW CLIENT INTAKE PACKET

COUPLES

CONFIDENTIAL INFORMATION

THRIVE
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REGISTRATION FORM

Please make sure our office staff copies your insurance/ID card

SECTION I: Patient/Client Information Date:_____

Name:_____ Nickname:_____ Age:_____Gender: _____ Race:_____

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

Cell Phone: _____ Work Phone: _____ Other Phone: _____

The best number to contact me (or parent) is: ☐ Home Phone ☐ Work Phone ☐ Cell Phone

Can we contact you by email? *Email address*: _____

I agree that Thrive may text me for appointment coordination and reminders: *Y / N*

Date of Birth: ____ / ____ / ____ Social Security #: _____

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If student, name of school: _____ City/State: _____ FT / PT

Emergency Contact: _____ Relationship: _____Phone: _____

Best weekdays and times for you to schedule appointments: _____

Is anyone living in your household (partners, friends, children, &/or spouses) currently receiving care at Thrive? *Y / N*

Has anyone living in your household (partners, friends, children, &/or spouses) received care at Thrive in the past? *Y / N*

SECTION II: Responsible Party – Spouse or Parent/Guardian info, If client is a child

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name (printed): _____ SSN: _____

Address (If different than above): _____

City: _____ State: _____ Zip: _____ Phone: _____

Employer: _____ Work Phone: _____

SECTION III: Insurance Information

Please circle one: Aetna • BCBS • Cash • Cigna • Tricare Prime • Tricare Prime Retired
Tricare Standard • Tricare Standard Retired • Other: _____

Name of Insured (Sponsor): _____ DOB: _____

Relationship to Patient: _____

Sponsor SSN: _____ Name of Employer: _____ Work Phone: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group #: _____ ID #: _____

By providing this information, you are authorizing us to bill your insurance(s) for services provided to you for your family members.

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO *IF YES, COMPLETE THE FOLLOWING:*

Insurance Company: _____ Group #: _____ ID #:_____

YOU MUST inform us immediately if there are any insurance changes, or you may be responsible for payment.

Client Signature **Date** _____ / _____ / _____

Updated 6.20.19

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ADULT SELF-ASSESSMENT

Name: _____ **DOB:** _____ / _____ / _____ **Age:** _____ **Gender:** M / F

How did you hear about Thrive (check one)?

- ❑ Our website
- ❑ Referred by medical professional
- ❑ Referred by other professional
- ❑ Psychology Today
- ❑ Referred by a friend or family member
- ❑ Referred by a church: _____
- ❑ Social media
- ❑ Military resource
- ❑ Other _____

Marital Status (circle one):

Single/never married • Married • Separated • Divorced • Widowed • Living with someone

Please circle ALL of the following that describe how you have been feeling lately:

anxious • depressed • frightened • guilty • angry • ashamed • aggressive • resentful • worthless
sad • tearful • irritable • confused • extreme up • extreme down • jealous • hopeless • helpless

Describe any other feelings you have had: _____

Briefly describe your problem as you understand it: _____

_____

Do you participate in regular exercise? ❑ Yes ❑ No **Hobbies:** _____

Describe your current working environment: _____

Have you had any changes in your sleeping habits? ❑ Yes ❑ No **Describe:** _____

Have you had any changes in eating habits? ❑ Yes ❑ No **Describe:** _____

THOUGHTS: Please check any of the following that apply to you:

- ❑ I sometimes hear voices, even though no one nearby is talking to me.
- ❑ I sometimes want to kill myself.
- ❑ I sometimes feel that forces outside of me control me.
- ❑ I sometimes feel that other people control my thoughts.
- ❑ I sometimes have the same thought over and over and cannot control it.
- ❑ I sometimes feel that someone is out to hurt me or to do something against me.
- ❑ I sometimes am unable to control my behavior.
- ❑ I sometimes wish I were dead.

Please list your Therapy Goals:

_____

_____

_____

Client Signature: _____ **Date:** _____ / _____ / _____

Updated: 1.29.20

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NEW CLIENT SIGNATURE PAGE

ADULTS 18+

NAME: _____ **DOB (mm/dd/yy):** _____ / _____ / _____

1. The information provided on the registration is true to the best of my knowledge.
2. By my signature, I authorize Thrive Counseling & Consulting, PLLC therapists to treat myself or the above-named family member. In the event that I or my family member change therapists, I understand that I must sign a new and specific Release of Information to any new therapist to be authorized access to my progress notes and clinical file.
3. I hereby acknowledge that I have received, read, and understood Thrive Counseling & Consulting, PLLC's Client Handbook, which includes: Client Rights & Responsibilities Policy, Social Media & Client Communication Policy, Notice of Privacy Practices (HIPAA), and Office Information & General Policies. I understand that if I have any questions regarding the notice of my privacy rights or any other policies in the handbook, I can contact the owners of Thrive Counseling & Consulting, PLLC.
4. I understand that if I refuse treatment, my therapist shall determine whether treatment in some other modality is possible. If I refuse treatment via other modalities, I may be discharged from services.

Client Signature *Date*

❑ Client refuses to acknowledge receipt of Notice of Privacy Practices *Staff Member Signature*

Thrive Counseling & Consulting, PLLC seeks to help each client achieve their goals. If you don't understand the following, please discuss with your therapist or with administrative staff before you sign.

1. Thrive Counseling & Consulting, PLLC is the corporation that does business.
2. Each individual therapist is either a contractor or employee of the above corporation
3. It is our intention at Thrive Counseling & Consulting, PLLC that you get the help that you need. It is therefore important that your therapist is a good fit for you or your family member. **Please let your therapist know exactly what your expectations are and what changes you are looking for. Do this during your first session. If you believe at some point that it is not a good fit, we encourage you to speak to your therapist first to see if adjustments can be made.** If you discover it is still not a good fit, please ask your therapist for a referral to another therapist at Thrive Counseling & Consulting, PLLC who may be a better fit.

I have read & understood the above.

Client Signature *Date*

Name of Primary Care Physician/Clinic: _____

(If you do not have a PCM, or do not want us to communicate with your PCM, write "None" and sign)

Client Signature *Date*

Please sign under ONLY ONE of these choices:

SELF-PAY CLIENTS ONLY: I attest that:

a. I do not have insurance coverage; OR
b. I have insurance coverage but choose not to use it, and in doing so I am waiving any right to reimbursement; OR
c. I have insurance coverage, but understand that my services are not covered by the plan.
d. I agree to pay the rate as disclosed in my therapist's professional disclosure.

Client Signature *Date*

INSURANCE CLIENTS ONLY: I authorize any insurance benefits to be paid directly to Thrive Counseling & Consulting, PLLC, or any of its contract therapists who provide services to me or my family members. I understand that I am financially responsible for any balance. I also authorize Thrive Counseling & Consulting, PLLC (or the entities listed above) and/or my insurance company to release information required to process my claims.

Client Signature *Date*

Updated 1.30.20

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INTERNAL COUPLES RELEASE OF INFORMATION & CONFIDENTIALITY AGREEMENT

By my signature below, I agree that when my clinician meets with me or my spouse/partner separately, the clinician is still working on behalf of the relationship for the identified client. I also understand that during these individual sessions, the focus will remain on improving my goals for the relationship that have been established, and not on assisting me with my individual goals.

Further, **I understand that what I say in the individual sessions is not required to be kept confidential from my spouse/partner.** My clinician will determine when, or if, the issue(s) arising in individual sessions will be brought into the couple's therapy sessions.

If I want confidential, individual sessions, I agree to notify my clinician and he/she will assist me in finding a new clinician for my individual issues who is not related to the couple therapy sessions I have with my spouse/partner.

My signature says that I understand that information talked about by either client or spouse cannot be used in any legal proceedings regarding the marriage, including child custody, nor will the undersigned clinician release any information without approval signatures from both client and spouse/partner.

_____ / _____ (BOTH INITIAL)

With my signature, I also agree to allow my spouse/partner to schedule or cancel appointments and to make payments toward my account with Thrive Counseling & Consulting, PLLC.

Identified Client

Printed Name *Signature* *Date*

Client's Spouse/Partner

Printed Name *Signature* *Date*

Clinician

Printed Name *Signature* *Date*

Updated 4.9.19