1260 Old York Road in the Hartsville Professional Village, Warminster, PA office 215-293-0744 fax 215-293-0745

WELCOME!

I look forward to traveling down a positive and rewarding road together. I hope that our journey will lead you to a better place in your life. It is important that I share some office policies with you.

First, our conversations are completely confidential. Without your written consent, I cannot and will not even acknowledge that we are working together. Please read the HIPAA regulations sheet you will be given with this letter.

I am reachable at the phone number listed below and try to return calls within a day. **Please add my private cell phone number to your contacts, so that it is readily available should you need to reach me.** You will frequently get my voice mail since I don't take phone calls during client sessions. Since I am not reachable 24 hours a day, emergency situations should be addressed at your nearest hospital emergency room.

Please understand…I frequently turn away new clients when my schedule is full, and I decline requests for the appointment time, which has been set-aside specifically for you. So, if you need to cancel an appointment kindly give me 24 hours notice. Unfortunately, health insurance does not cover missed appointments, so you will be responsible and charged $30 for any missed appointments or last-minute cancellations. As such, a credit card is required to be kept on file.

Acknowledged (initial)**:**____________

If you are using your health insurance and problems arise with securing payment, you hold the primary responsibility for contacting the insurance company. Ultimately, payment responsibility lies with you.

What is your preferred method of contact (circle answer)**:**

Phone/voicemail **Email**

If you prefer voicemail, is it acceptable to leave a (circle answer)**:**

Detailed message **Just my name and phone number**

Please understand that privacy on the web is not guaranteed.

Lastly, if I encounter you outside of my office, I will not acknowledge you unless you greet me first. Although I'll be happy to see you, I do not want to compromise your privacy.

So, "business" aside, I welcome you to what I hope will be an enriching experience for you!

______________________________________ ______________________________________

Therapist Name **Therapist Private Cell Phone Number**

______________________________________ ______________________________________

Client Name (Please Print) **Parent / Guardian (Please Print)**

______________________________________ ______________________________________

Client or Parent/Guardian Signature **Date**

______________________________________ ______________________________________

Client Email **Client Phone (Circle: Cell Home)**

Unless you've been given the following pages at your first visit; you may prepare ahead and save time at our first session by downloading and printing the forms from our website. Please complete all the information and bring them with you when we meet. Thank you!

Airmid Wellness
AND COUNSELING CENTER

Client Insurance and Payment Information

Client Name: ____

Relationship to Primary Insurance Cardholder: __________________________________

Street Address: ____

City, State, Zip: ____

Phone (best contact): (_______)____

Email: ____

Client date of birth: ________________ Marital Status: ________________

Client Insurance ID# (with letters): ____

Phone # of Insurance Provider Services & Mental Health (back of card):
____

Name of Insured (Primary Card Holder): ____

Primary Card Holder's Relationship to Client (If other than client): ______________________

Insured's Street Address: ____

Insured's City, State, Zip: ____

Insured's date of birth: ____
_

Insured's Social Security #: ____

Credit Card to be used for Missed Appointments or Past Due Client Payments:
Card Type: ❏ VISA ❏ MasterCard ❏ AMEX ❏ Discover
Cardholder Name(as it appears on the card) _________________________________
Card # ____________________________ Exp. Date _____________ CVV Code _____

I authorize the release of any information necessary to verify and process insurance claims. I fully understand that I am responsible for all charges not covered by my insurance carrier. I am aware that an agent of my insurance company, third-party payer and insurance administrator may be given information about the type(s), cost(s), date(s) and providers of any services or treatments I receive.
I authorize payment directly to Airmid Wellness and Counseling Center, LLC.

I authorize the use of this signature on all my credit card and insurance submissions.

Signature of Insured/Guardian: ____

Date: _________________________

Client Intake Form
Adults, Adolescents & Children

Demographic Information
(Please complete all questions on this form)

Date: ______________________

Client Name: ____

Address: ____

City, State, Zip: ____

Phone (Home): _________________________________ Phone (Cell): ____________________
Okay to leave a message: Y_____ N_____

Client Date of Birth: ___________________________________ Age: _____________________

Guardianship (For children and adults, when applicable): ___________________________________

Marital Status (Check one): ☐Never Married ☐Married ☐Widowed ☐Divorced ☐Separated ☐Cohabitating

Gender: ☐Male ☐Female

Family Members:

Name	**Age**	**Sex**	**Relationship**

Family of Origin - # Siblings: _____________________

Employer: ____________________________________ Occupation: _________________________

School (For Children and adults when applicable): ______________________ Grade in School: _________

Referral Source: ____

Emergency Information:

Name: _____________________________________ Phone: _______________________________

Relationship to Client: ____

Client Intake Form
Adults, Adolescents & Children

Medical History

Source of this Information: ☐**Client** ☐**Family** ☐**Other**: ______________________________

Please list any relevant medical conditions (diabetes, hypertension, head traumas, cardiac problems, asthma or other breathing problems, cancer, etc.): ____

____

Current medications: (Include prescribed dosages, dates of initial prescription and refills and name of doctor prescribing medication): ____

____

Previous Medical History:
Allergies (Adverse reactions to medications/food/etc.): ____

Hospitalizations/Surgeries/etc.:____

____

____

Past Psychiatric History (Mental Health and Chemical Dependancy): ______________________________

Hospitalizations: ____

____

Prior Outpatient Therapy (Previous practitioners and dates of treatment): ___________________________

____

Previous Treatment Interventions: ____

____

Response to Treatment Interventions including Medications: ____________________________

____

Have you ever struggled with any of the following: ☐Eating disorders ☐Alcohol use ☐Substance abuse ☐Sexual behaviors ☐Impulsive behaviors ☐gambling ☐Shopping ☐Self-Harm ☐Other: ______________

Have you ever been exposed to or victim of any of the following: ☐Victim of Abuse (☐Sexual ☐Physical ☐Emotional) ☐Pornograpy ☐Sexual Behaviors ☐Witness to Violence ☐Self-Harm
☐Other:____

Have any of the above resulted in legal proceedings? ☐**YES** ☐**NO**

If YES, please describe: ____

____

____

Family Mental Health or Chemical Dependency History: ___________________________________

____

Airmid Wellness
AND COUNSELING CENTER

Client Intake Form

Adults, Adolescents & Children (over 12)

Substance Abuse History

(Complete for all clients age 12 and over)

Substance	Amount	Frequency	Duration	First Use	Last Use
Caffeine					
Nicotine / Tobacco					
Alcohol					
Marijuana					
Opiods / Narcotics					
Amphetamines					
Cocaine					
Hallucinogens					
Others:					

Ideations	None Noted	Thoughts Only	Plan (describe	Intent (describe)	Means (describe)	Attempt (describe)	Able to Contract for Safety
Suicidal Ideation							
Homicidal Ideation							