1250 & 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 with you. 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 acknowledge the you've read the HIPAA regulations sheet you will be given with this letter.**

HIPAA Regulations Acknowledged (initial)**:**__________

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 as 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 $75 for any missed appointments or last-minute cancellations. As such, a credit card is required to be kept on file.**

Cancellation Policy 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 Text**

- **If you prefer voicemail, I will leave 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 Mobile Phone Number**
______________________________	______________________________
Client Name (Please Print)	**Parent / Guardian (Please Print)**
______________________________	______________________________
Client or Parent/Guardian Signature	**Date**
______________________________	______________________________
Client Email	**Client Phone (Circle: Mobile Home)**

How were you referred to Airmid Wellness?: ____________________________________

Unless you've been given the following pages at your first visit; Please complete all the information and return this form before our first session. Thank you!

V 10.20.20

Airmid Wellness
AND COUNSELING CENTER

Client Insurance and Payment Information

Client Name: ____

Name of Insured (PRIMARY CARD HOLDER): ____________________________

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

Primary Card Holder's Street Address: ______________________________

Primary Card Holder's City, State, Zip: ______________________________

Primary Card Holder's Date of birth: ________________________________

Primary Card Holder's Social Security #: _____________________________

Client's Insurance Carrier: ___________________________________

Client Insurance ID# (with letters): _____________________________

Phone # of Insurance Carrier (back of card): _______________________

☐ **Insurance Card Copied by therapist**

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 # ______________________________ **Expiration Date** __________

CVV Code __________ **Zipcode**__________________

Notes: ____

____

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:** __________

Airmid Wellness
AND COUNSELING CENTER

Client Intake Form
Adults, Adolescents & Children

Demographic Information (Please complete all items)

Date: _________________ **Preferred Name/ Nickname:** ___________________________

Client First Name: ________________________ **Last Name**___________________________

Address: ____

City, State, Zip: ____

Client Social Security#: _______________________**Client Date of Birth:** ____________ **Age:** ___

Client email: ____

Phone (Home): _________________________________ **Phone** (Cell): ________________________

Okay to leave a message: Y_____ **N**_____ **on** (Circle) **Home Cell**

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

Marital Status (Check one): ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Cohabitating

Gender: Share a word or words that reflect your internal sense of gender (ex.woman, man):

____

Check one or more options that reflect your gender: ☐ woman ☐ man ☐ non-binary ☐ transgender

☐ intersex ☐ Two Spirit ☐ non-binary ☐ transgender ☐ gender non-conforming ☐ other: __________________

Family Members: **Family of Origin - # Siblings**: ______________________

Name	Age	Gender	Relationship

Employer: ______________________________________ **Occupation:** _________________________

School (For Children and adults when applicable): _______________________ **Grade in School:** ________

Emergency Information:

Name: _______________________________________ **Phone:** _______________________________

Relationship to Client: ____

What is the reason for your visit?: ____

____

____

What do you hope to learn from our sessions?: _____________________________________

____

____

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: ____

____

Client Intake Form

Adults, Adolescents & Children (over 12)

Substance Use 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							