



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!

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: _____

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 CohabitingGender: 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: Including Children Family of Origin - # Siblings: _____

<u>Name</u>	<u>Age</u>	<u>Gender</u>	<u>Relationship</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 Dependency): _____

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) Pornography 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					
Opioids / 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							