CORE COUNSELING

New Client Questionnaire

This questionnaire requests information about you and your treatment needs. Please take a few moments to complete the form. If the person seeking care is a minor, the parent or guardian should complete this form. If you have any questions, I will be happy to answer them during our session. Thank you for choosing Core Counseling Services and I look forward to working with you to help you achieve your treatment goals.

Client Name: _____ Today's Date: _____

Date of Birth: _____ E-Mail Address: _____

Street Address: _____ City/State/Zip Code: _____

Best Contact Phone #: _____ Alternate Phone #: _____

Preferred Method of Contact: ☐ Phone ☐ Text ☐ E-Mail

Emergency Contact: _____ Phone: _____

Who referred you to our practice (Name & Specialty)? _____

_____

Insurance Information: Policy Holder: _____ Relationship: _____

Policy Holder's Social Security Number: _____ Date of Birth: _____

Insurance Company: _____ Provider Phone #: _____

Member ID: _____ Group #: _____

Relationship Status: ☐ Single ☐ Married ☐ Re-Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner

Name of Spouse/Significant Other: _____

Date of Birth: _____ Best Contact Phone #: _____

Job Status: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Student ☐ Other: _____

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Name of Employer and/or School: _____

Occupation: _____

Education (last year completed): ☐ No Formal Schooling ☐ Middle School (Grade: _____)

☐ High School/GED (Grade: _____) ☐ College (Years: _____) ☐ Graduate School (Years: _____)

Do you have any children? ☐ Yes ☐ No

If yes, please list birthdates and gender: _____

_____

Please list the people living in your household and their relationship to you: _____

_____

Date of last physical examination: _____

Please list any medications and/or supplements you are currently taking:

Medication	**Condition**	**Dosage (mg)**	**Frequency**	**Approximate Start Date**

Primary Care Physician: Name: _____ Phone: _____

Psychiatrist: Name: _____ Phone: _____

May we contact your doctors? ☐ Yes ☐ No

Previous Mental Health Treatment (within past 2-years): ☐ Yes ☐ No

If yes, please provide the following:

Check all that apply: ☐ Psychiatrist ☐ Psychologist ☐ LCPC/LCSW-C ☐ School Counselor ☐ Other

Mental Health Provider's Name: _____ Phone: _____

Type of treatment requested at that time (i.e., individual, couples, family, group): _____

Please describe your current reasons for seeking treatment. If there is an event that triggered your decision, please list the event: _____

_____

_____

_____

What results do you hope to obtain from counseling? _____

_____

_____

_____

Please list any current medical problems: _____

_____

_____

_____

Financial Terms

The fee schedule for our services is as follows: $200 for an initial consultation, $180 for a 55-minute psychotherapy session, $140 for a 40-minute psychotherapy session, and $135 for a marriage counseling session. In most cases these services are covered by your insurance, with the exception of marital counseling. The information provided is not a guarantee of benefits until the insurance company processes the claims. Your insurance carrier will be billed for you and Core Counseling Services will be paid directly by the carrier. You will be responsible for any applicable deductibles and co-payments, due at the time of service. If you are not eligible for benefits at the time services are rendered, you are responsible for full payment.

A scheduled appointment means that time is reserved for you. To cancel or reschedule an appointment, please contact us as soon as possible at (410) 560-6135. If an appointment is missed or canceled with less than 24-hours' notice, **you will be billed directly for a fee of $75.00**. Healthcare plans do not cover payment for missed appointments; therefore, you are responsible for payment in full. Please understand that other clients are often waiting to be seen and could have used your time with enough advanced notice.

Credit Card Easy-Pay Consent & Payment Policy

We require that you provide us with a valid credit card number to keep on file. Please provide the following information to be kept in your confidential and secure file:

Credit Card Holder's Name (as it appears on the card): _____

Billing Zip Code: _____ Card Holder's Social Security #_____

I authorize Core Counseling Services to charge my credit card for balances due including copayments/deductible and missed appointment fees to be charged after each visit.

Credit Card Number: _____ Expiration Date: _____

Security Code on the back of the card: _____

Please check one: ____ Visa ____ Mastercard ____ Discover ___American Express ___ HSA

Card Holder's Signature: _____ Date: _____