COUNSELING SERVICES OF DOTHAN

*Jeff Justice, LPC *Tim Faulk, PhD, LMFT *Randall Jordan, Psy.D *Larry Beauchamp, LMFT
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1450 Ross Clark Circle, Suite # 3
Dothan, AL 36301
(334) 794-2113 Phone
(334) 702-1220 Fax

New Patient Intake Paperwork:

Patient Name: _____
Patient's Guardian Name (s): _____
Date of Birth : _____/_____/_____ Patient SSN: _____-_____-_____ M or F

Address: **(Please include ENTIRE ADDRESS ie: house number, street, city, state, and zip)**
_____
_____

Home Number: _____-_____-_____ Cell Number: _____-_____-_____
Best Number To Call For Confirmations: Home Cell (Please Circle One)
Patient Employer or School: _____

Please List Names/Relationships Of Anyone You Would Like To Have Access To Patient Information:

Name:	Relationship To Patient:
_____	_____
_____	_____
_____	_____

Insurance Information:

Primary Insurance: _____
Contract #: _____ Group #: _____
First & Last Name Of The Insured If Different Than The Patient:
_____
Insured Date Of Birth: _____/_____/_____ Insured SSN: _____-_____-_____
Relationship To The Insured: _____

Secondary Insurance (If Applicable): _____
Contact #: _____ Group #: _____
First & Last Name Of The Insured If Different Than The Patient:
_____
Insured Date Of Birth: _____/_____/_____ Insured SSN: _____-_____-_____
Relationship To The Insured: _____

Referring And/Or Current Doctor: _____

I, _____ give permission for the above said doctor to receive communication regarding care, and/or testing.
Patient Signature: _____ Date: _____

Please Read:

I understand that due to the limitations of confidentiality:

1. If we learn of child abuse, or abuse of disabled adults, we are required by law to report it to the proper authorities.
2. If, in our judgment, a client is a danger to himself, and/or others we will call the proper authorities.
3. If we are required to presents records to comply with a court order, it is our legal obligation to do so.
4. If you are a minor (under the age of 14 for mental health purposes), special care will be taken to protect the information you provide, however, your parent(s)/legal guardian's are legally entitled to the information you provide.

Financial Statement:

We do file ALL insurances, however, we collect all co-pays, and/or deductibles not covered by your insurance at the time of your visit. If payment, arrangements need to be made, please discuss this with the insurance department at the time you check out. Please understand verification of insurance is never a guarantee of payment, and if your insurance does not cover you will be responsible for the remaining charges. Please understand we will work with you as best as we possibly can, but if the account becomes delinquent it will be placed with **Prim & Mendheim, LLC** for collection purposes with interest accruing on the balance at the rate of 1.5%. You will also be responsible for reasonable collection costs as well as attorney fees.

Payment Options:

We do accept Visa, Mastercard, and Discover cards. A $40.00 service charge will be charged for a returned check, and no post-dated checks, or starter checks will be accepted.

In Case Of Emergency:

If an emergency occurs after business hours (8:00 am-5:00 pm Monday-Thursday, and 8:00am-2:00pm on Friday), and you need to contact your counselor, please call 334-794-2113, and listen to the message. Please leave a message on the voicemail of the counselor you are contacting, and they will receive a notification on their cell phone.

HIPAA Policy:

Effective September 23, 2013, all healthcare providers must be compliant with the final regulations released for all Health Information Portability Accountability Act known as HIPAA. We can not release any information without the explicit permission of the patient except in certain circumstances ie: a court order. A paper copy of the HIPAA practices is available upon request. Please feel free to ask the office staff for a copy if you would like.

By signing below, I acknowledge I have read all of the above, and agree there upon.

Patient Signature: _____ Date: _____

CURRENT SYMPTOMS – CHECK ALL THAT APPLY:

Patient Name: _____ **Age:** _____

_____ Please Check If You Are Here For A Pain Management Evaluation Only (You May Skip The Symptoms)

_____ Depression	_____ Mood Swings
_____ Loss of Interests	_____ Anger
_____ Crying Spells	_____ Irritability
_____ Appetite, or Weight Loss/Gain	_____ Decreased Concentration
_____ Hopelessness	_____ Helplessness
_____ Low Self Esteem	_____ Lowered Hygiene
_____ Isolating Self	_____ Thoughts of Death/Dying/Suicide
_____ Problems Sleeping	_____ Nightmares
_____ Fatigue/Loss of Energy	_____ Excess Worry
_____ Racing Thoughts	_____ Spending Sprees
_____ Sexual Promiscuity	_____ Legal Problems
_____ Impulsive Behaviors	_____ Easily Distracted
_____ ADHD	_____ Road Rage
_____ Violence Towards Others	_____ Victim of Abuse
_____ Bulimia/Anorexia	_____ Hallucinations
_____ Scared	_____ Feeling Like Someone Is After You
_____ Anxiety/Panic Attacks	_____ Obsessive Thinking
_____ Social Anxiety	_____ Compulsive Behaviors
Other: (Please Describe):	_____

Additional Notes/Information: _____