Client Intake Information
Adult

Date_____

Name_____Sex____Age____Birthdate_____

Address_____City_____Zip_____

Language of Choice: __English __Other_____

Client Social Security #_____

Home Phone_____Work Phone_____Cell Phone_____

Email Address: _____

Due to the risky nature of technology, we cannot guarantee communication will be confidential. May we communicate with you via email? Select one: _____ No Email _____ Send Email OK

Do you want email reminders for your appointments? Select One: ____Yes ____ No

Primary Insurance Company: _____

Primary Insurance Member's Name: _____ ID # _____ Group No._____

Policy Holder's DOB _____Policy Holder's Employer_____

Secondary Insurance Company: _____

Secondary Insurance Member's Name _____ID # _____ Group No._____

Policy Holder's DOB _____

Primary Care Physician_____

Name Address City Phone

Medical History (Past - Present – Medications – Hospitalizations)_____

_____

Previous Psychological Treatment (With Whom - When – Where – Duration)_____

_____

Employer_____Education_____

Spouse's Name_____Age_____Education_____

Employer_____Work Phone_____

Brothers & Sisters_____

Children (Own – Stepchildren – Deaths – Names & Ages)_____

_____

Military Service (Service – Date – Rank)_____

Emergency Contact Person_____

Name Phone

_____

Address Cell Phone

Referral Source: _____

Reason for Seeking Treatment: _____

AGREEMENT FOR PARTICIPATION

We would like to welcome you to our office and inform you that hours of operation are by appointment from 8:00 a.m. to 5:00 p.m. Monday through Friday. Evening and Saturday hours are also available. We have a 24 hour answering service for emergency calls as well as appointment cancellations. The phone number is (616) 949-7460. If you find it necessary to cancel an appointment, we require 24 hour notice because a specific time has been set aside for you. Broken appointments, without 24 hour notice, may be charged a full fee. Please be aware that your insurance company will not pay for missed appointments.

We participate with most insurance companies and will make every effort to bill the insurance company on your behalf. However, some insurance companies may require that you file your own claim. A receipt may be given to you following your session which contains all information needed to file a claim with your insurance company. Your insurance company requires co-pays to be made at the time of service. A $10 fee may be added to your account if this co-pay is not made at your appointment time. You are responsible for all charges, in full, made to your account. Payment can be made in cash, by check or credit card. We cannot assume responsibility for accuracy in estimation of insurance benefits or for success in collection of claims.

A full counseling/therapy session typically lasts 45-55 minutes.

A fee of $20.00 will be added to your account for checks returned to us from the bank. A fee of $5.00 will be added to your account for checks that need to be redeposited.

Any unpaid balances that are sent for collection may be assessed a $5.00 fee.

The parent or guardian of a minor child who brings that child in for counseling is responsible for any charges incurred.

Please advise us of any changes in address, telephone or insurance coverage.

CONSENT FOR PARTICIPATION

I hereby authorize Claystone Clinical Associates, P.L.C. through its staff, to provide the following services: outpatient psychotherapy/counseling, psychological testing, psychiatric evaluation, case review, and/or medication review and monitoring. I understand my participation is voluntary. Practitioners at CCA maintain their own private practices as well as an affiliation with the programs and business practices of the organization. The clinical services provided are the responsibility of the individual or program practitioners who are not employees of Claystone Clinical Associates.

PRIVACY NOTICE/RECIPIENT RIGHTS

I have read and understand my rights as they have been written in the Privacy Notice and the Recipient Rights document. I understand that I may contact the Privacy Officer or the Recipient Rights advisor with any questions or concerns.

RELEASE OF INFORMATION

I hereby authorize _____ to release medical and other information as may be required by my insurance company and case management company utilized by my insurance company to obtain benefits for charges for treatment received by me or my dependents. I also authorize a quality-assurance review of my file contents, if required by my insurer, by an appropriate member of the clinical staff.
Initials_____.

I UNDERSTAND THE ABOVE POLICIES AND AGREE TO THE TERMS OF THESE POLICIES.

Name: (please print) _____

Signature: _____ Date: _____

Witnessed:_____ Date: _____

I UNDERSTAND THAT IF MY THERAPIST IS NON-PARTICIPATING WITH MY INSURANCE COMPANY, I AM RESPONSIBLE FOR TOTAL CHARGES INCURRED.

Signature: _____ Date: _____

Witnessed:_____ Date: _____

CLAYSTONE CLINICAL ASSOCIATES

2040 Raybrook SE Suite 300
Grand Rapids, MI 49546
Phone 616-949-7460
Fax 616-949-3018
www.claystoneclinical.com

COORDINATION OF CARE

This allows us to communicate with your Primary Care Physician (PCP)

This document allows for the exchange of information regarding mental health/substance abuse treatment and medical healthcare; for coordination of care purposes as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health care or substance abuse care and/or treatment (as protected under 42 CFR Part 2) such as diagnosis and treatment plan and medical information, including information regarding the presence or absence of HIV/AIDS. I understand that this authorization shall remain in effect for one year from the date of my signature below, or for the course of this treatment, which ever is longer. I understand that I may revoke this authorization at any time by written notice to my behavioral health provider. I also understand that it is my responsibility to notify this provider if I choose to change my Primary Care Physician.

I, _____ DOB: ____/_____/_____ ☐do authorize ☐do not authorize
Print client's name

_____, my behavioral health provider,
Print clinician's name

and my primary care physician, _____ /Fax _____
Name of primary care physician

to exchange information regarding mental health/substance abuse treatment and medical healthcare.

_____ _____
Address of PCP Phone Number of PCP

_____ _____
Client's (Parent or Guardian) Signature Date

_____ _____
Clinician's Signature Date

----------Behavioral Health Provider Information----------
(to be completed by the clinician)

☐ Intake/Assessment attached ☐ Treatment Plan attached ☐90-Day Treatment Plan Review

DSM IV Diagnosis Code and Name _____

Treatment Modality: ☐Individual ☐Group ☐Family ☐Medication Treatment
Other: _____ Medications managed through CCA _____

Basic Goals _____

Testing rationale _____

Identified stressors/barriers/strengths _____

Progress toward goals: ☐Initiating ☐Improving ☐ Stable ☐ Declining

Date sent to PCP _____ Sent by _____ ☐ Fax ☐ Mail

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/____

Witness:_____ Date: ___/____/_____

Claystone Clinical Associates
Credit Card Payment Form
For Ongoing Payments

1. Patient Name: _____

2. Patient's DOB: ____/____/____

3. Patient's Telephone # _____

4. The cardholders' name as it appears on the card. Check spelling

   First Name: _____ Last Name: _____

   Mailing Address of Cardholder:

   _____

   City: _____ State: _____ Zip: _____

5. Relationship to Patient (circle one): Self Dependent Spouse

6. Card Number:

   ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

   Expiration Date: ____/____ Security Code: ____ ____ ____

7. Amount of Payment: $_____

Please keep card on file for future charges. ____Yes ____No

_____

Patient/Guardian Signature

Staff Name: _____ Date: ____/____/____