ALEAH MORROW, LPC

Today's Date:_____

Name:_____Age:_____

Address:_____Birth Date:_____

City, State, Zip:_____

Social Security#:_____

Telephone:_____(Home) OK to leave a message?_____

_____(Work) OK to leave a message?_____

_____(Mobile) OK to leave a message or text?_____

Email address:_____ Ok to send an email?_____

Is it OK to send a text or email appointment reminder?_____

Marital Status:_____Spouse/Partner_____

Employer/School:_____Job or School Grade:_____

How did you hear about us?_____

May we acknowledge the referral?_____

Emergency Contact Person:_____

Address and Telephone (if different than patient):_____

Insurance Information

Who is the insured Party?_____Relationship:_____

(If not you) Date of Birth:_____Policy #_____

Insurance Company:_____Authorization #_____

Address for Claims:_____Group#_____

Claims - City, State, Zip_____

Employer that provides this insurance benefit:_____

Insurance Company's Telephone #_____Effective Date:_____

Are you currently involved in any legal proceedings (e.g., a civil suit, divorce, custody case, bankruptcy, etc.) or are you on probation/parole/court ordered to be here?_____ If yes, please explain:_____

_____

Any current or past medical problems? Please explain:_____

_____

_____

Current Medications and Dosages:_____

_____

_____

Have you ever received counseling, mental health or substances abuse services in the past?_____

_____

_____

Statement of Understanding

When you call the office please leave a message. I check in frequently for messages, and will call you back as soon as possible. If you have an emergency, clearly indicate this on the voice answering service. If you have an emergency that cannot wait for a return call, seek immediate attention at the nearest emergency room, or call 911. Please let me know as soon as possible of your condition.

The counseling relationship will be kept strictly confidential with the following exceptions. If you request that I share information with someone, you will be asked to sign a release of information form. There are some circumstances under which I am mandated by law to reveal information. If there is clear or imminent danger to the client or to others, it will be necessary for me to inform the authorities. If there is information regarding sexual or physical abuse involving a minor or an elder, I must take appropriate action. Also, if I am subpoenaed to testify in any type of court hearing, I am required by law to respond to the subpoena. Additional information is provided in Notice of Privacy Practices. (HIPPA)

Fees are payable at the end of each session unless other arrangements have been made. You will be charged a $75 fee for failing to keep an appointment or cancelling less than 24 hours in advance. Your insurance will not pay for failed appointments.

If you are using insurance, insurance covers a 45-minute session. If you feel that you could benefit from longer sessions, these may be arranged by you and your therapist.

I file insurance as a courtesy to clients. It is possible that your insurance company may or may not cover services which are provided by this office. I will assist in giving information to your insurance company in order to process your claim consistent with HIPPA guidelines, but it is the client's responsibility to pay for services whether they are covered by the insurance or not.

Consent to Treatment

I have completed this form with information that is true and accurate to the best of my knowledge and fully understand and agree to these stipulations. I consent to engaging in telehealth and/or in person counseling as part of my psychotherapy. I (we) voluntarily request treatment from:_____

Signed:_____Date:_____

_____

If a minor:

Parent/Guardian signature:_____Date:_____

For Patients with Insurance

This form will allow communication with your insurance or employee assistance program regarding your need for services and about the services rendered to you, such as history, treatment plans and treatment progress.

I authorize the release of any medical or other information necessary to process this claim for me and/or my dependents. I also request payment of benefits to the provider for services.

Signed:_____Date:_____

Notice of Privacy Practices

I acknowledge receipt of the HIPPA Notice of Privacy Practices.

Signed:_____Date:_____

Consent to Keep Credit Card Information on File

I, the undersigned, hereby authorize Aleah Morrow, LPC, to securely store my credit card information for billing purposes. I understand that my credit card will only be charged for services rendered, missed appointments, or late cancellations as outlined in the practice's policies.

I acknowledge that I can revoke this authorization at any time by providing written notice to Aleah Morrow, LPC.

Signed:_____ Date: _____