OFFICE USE ONLY

Intake Counselor:____Ongoing Counselor:

Today's Date:						
PATIENT INFORMATION						
Patient's Last Name:	First:		Middle:	• Mr. • Mrs.	• Miss • Ms.	Marital Status (circle one) Single / Mar / Div./Sep / Wid.
Is this your legal name?	If not, what is your legal name?	(Former name):	Birth date: /	/	Age:	Sex: • M • F
• Yes	• No					
Street Address:		Social Security no.:		Home Phone no.: ( )		
P.O. Box:	City:		State:	ZIP Code:		
Cell Phone no.: ( )		Email Address:		Cell Carrier:		
Referred to clinicby:		Referral's PhoneNumber:				
By signing here, I accept that Sharika Pruitt, LPC can contact the referral source for referral acknowledgement and treatment planning.						
Client/Parent orGuardianSignature:_______ Date:						
INSURANCE INFORMATION						
(Please provide insurance card to Therapist prior to intake session)						
Person responsible for bill:	Birth Date: / /		Address (if different):	Home Phone no.: ( )		
Occupation:	Employer:		Employer Address:	Employer Phone no.: ( )		
Please indicate primary insurance:						
Subscriber's Name:	Subscriber's S.S. no.:	Birth Date: / /	Policy no.:	Group no.:	Co-payment: $	
Patient's relationship to subscriber:	• Self	• Spouse	• Child	• Other		
Name of secondary insurance (if applicable):	Subscriber's Name:		Policy no.:	Group no.:		
Patient's relationship to subscriber:	• Self	• Spouse	• Child	• Other		
IN CASE OF EMERGENCY						
Name of local friend or relative (not living at same address):	Relationship to patient:		Home Phone no.: ( )	Work Phone no.: ( )		
I, (*please initial*)____ , authorize Crossroads to Pathways Counseling to contact the emergency contact if unable to reach me at any given number.						
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Crossroads to Pathways Counseling, Therapy Appointment, CCC Systems or insurance company to release any information required to process my claims. By signing below I have also agreed that I have read all forms including the Client Rights, Informed Consent, and the HIPAA Notice of Privacy Practices and understand I can request a copy of those at any time. *Client/Parent orGuardianSignature Date*						

Client Signature	Date	CPT Codes	Begin Time	End Time	Fee Paid

Sharika Pruitt, LPC, NCC

Fee Agreement

- While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date that services are rendered. It is your responsibility to know any stipulations of your insurance such as co-pay amount, need for referral forms, deductibles, and need for treatment pre-authorization. For example, your insurance company may require that you have your sessions authorized prior to being seen for the first time. You will need to check for and obtain initial authorizations otherwise you will be responsible for the payment. In addition, you will need to keep track of the number of sessions allowed; if this amount is exceeded you will be responsible for the payment.
- Please bring all paperwork including insurance authorizations to my attention at the beginning of your session. I prefer that all such work be done in your session so that you are fully aware of and can participate in what is written. If you give me the paperwork at the end of a session, I may not be able to complete it during the session, and I charge for paperwork that is done outside of sessions.
- Please inform me immediately of any change in insurance coverage, employment, address, and phone numbers. Changes in insurance coverage could result in your sessions not being reimbursed by your insurance company, and then you would be responsible for the charges.
- Co-payments, in the form of cash, debit or check, are due at the beginning of each session. There is a $25 charge for a returned check.
- Your appointment time is reserved for you; I do not double book appointments. Therefore, I have to charge you if you fail to show up for an appointment or if you cancel less than 24 hours before the appointment. You will be billed for the full cost of the session ($95) since this charge cannot be billed to your insurance company.
- If you are paying out of pocket, an initial session (lasting 1 hour) will cost $140 and each follow-up session will cost $95.
- Other expenses:
  - For unpaid charges over 30 days old (from the date of the first billing), a service fee of 2% of the balance per month will be applied. A past due account may cause interruption of service.
  - $25 for paperwork completed outside of a session.
  - $85 for a written report for any purpose (this fee must be paid before the report is released to you).
  - $25 per 15 minute increments for a phone call lasting longer than 15 minutes.

I have read the above information. I understand and agree that regardless of my insurance status I am ultimately responsible for the balance of my account for any professional services rendered.

Client Date

Counselor Date

Sharika Pruitt, LPC, NCC

General Information

1. I provide 24 hour emergency call service for after hours and weekends. The answering service phone number is 256-393-0705. This service is provided for **true emergencies ONLY** such as one experiencing severe side effects of a medication. In these circumstances, it may also be appropriate to go to the emergency room.

2. Initial sessions are 1 hour, and follow-up appointments last 55 minutes.

3. I will keep all information that you provide me confidential, and this obligation of mine will last indefinitely. The only times that I will reveal confidential information are if you sign a release of information, if you are in an emergency situation (for example you are being admitted to a hospital), if I am required by law, and if your insurance company requires it for reimbursement. You may choose not to authorize the release of information to your insurance company; however, this may prevent you from using your insurance benefits. Your signature below indicates your willingness to disclose the needed information to your insurance company so that you may use your benefits.

4. In addition, I will provide you with information about your diagnosis and treatment.

Client Date

Counselor Date

Crossroads to Pathways, LLC

124 North 5th Street
Gadsden, AL 35901
256-393-0705
www.crossroadstopathwaysllc.com

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to the Counseling Center by other individuals or agencies. Such requests should be referred to the original individual or agency.

I ______________________________________ authorize the Counseling Center to:

_____ Release to:
_____ obtain from:
_____ Exchange with:

____
____
____
____

the following information pertaining to myself:

_____ treatment summary
_____ history/intake
_____ diagnosis
_____ psychiatric evaluation/medication history
_____ dates of treatment attendance
_____ other (specify) ______________________________

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) ______________________________

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event ____. (See back for authorization extension).

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

____ Social Security #:___________________________
Signature of Client Date OR
Date of Birth: ______________________________

____
Signature of Witness Date

RECORD OF AUTHORIZATION EXTENSIONS

I hereby confirm that I have reviewed this consent form and agree to its extension for an additional:

Check One:
_____ 6 months OR
_____ Other (specify) ___________________________

_______________________________________ _________________________________
Client Date Witness Date

Check One:
_____ 6 months OR
_____ other (specify) ___________________________

_______________________________________ _________________________________
Client Date Witness Date

Check One:
_____ 6 months OR
_____ other (specify) ___________________________

_______________________________________ _________________________________
Client Date Witness Date

Optional Client Symptom Self Evaluation

Completed by Client

Please Print Legibly – Information Remains StrictlyConfidential

WHAT CONCERERNS DO YOU CONTINUE TO HAVE ABOUT HOW YOU ARE FEELING?

Symptoms (please mark all that apply):

Emotional: **Physical:**

☐ Feeling of extreme happiness ☐ Lack of enjoyment of usual activities ☐ Lack of energy
☐ Feeling of extreme sadness ☐ Increased use of alcohol / drugs ☐ Dry mouth
☐ Feeling stressed ☐ Avoiding things ☐ Memory problems
☐ Feeling nervous or anxious ☐ Trouble performing your job ☐ Chronic weakness
☐ Feeling fearful ☐ Poor interpersonal skills ☐ Chronic pain
☐ Excessive worry ☐ Reckless behavior ☐ Muscle tension / aches
☐ Indecisiveness ☐ Trouble concentrating ☐ Numbness
☐ Depression ☐ Not getting along with friends / family ☐ Sweating / clammy hands
☐ Easily irritated ☐ Hearing voices ☐ Nerve problems
☐ Paranoid thoughts ☐ Fear of situations where escape is difficult ☐ Trembling / twitching
☐ Self-esteem problem ☐ Obsessions or compulsions ☐ Hot flashes
☐ Feeling guilty ☐ Thoughts about hurting yourself ☐ Dizziness
☐ Sudden feelings of panic ☐ Thoughts about hurting others ☐ Frequent urination
☐ Perfectionism ☐ Thoughts about killing yourself ☐ Stomach or bowel problem
☐ Change in sleeping habits ☐ Thoughts about killing others ☐ Weight changes
☐ Procrastination ☐ Suicide attempts ☐ Change in eating habits
☐ Crying spells ☐ Acting violently ☐ Self-starvation
☐ Problems with anger ☐ Intrusive thoughts ☐ Chest pain
☐ Exaggerated startle response ☐ Shortness of breath ☐ Heart symptoms
☐ Trouble swallowing ☐ Change in sexual interest

HOW LONG HAVE YOU HAD THE SYMPTOMS CHECKED ABOVE? *(APPROXIMATE DATE SYMPTOMS BEGAN)*

ANY DETERIORATION IN JOB / SCHOOL PERFORMANCE DUE TO THE PROBLEM?

___Attendance ___Absences Mon/Fri.'s ___Tardiness ___Decrease in productivity
___Erratic Behavior ___Conflict with Supervisors ___Discipline ___None
___Conflicts with Fellow Employees

CONSEQUENCES OF DETERIORATING PERFORMANCE ON WORK OR SCHOOL:

On a Scale of 1-5, how would your rate your distress? (l is low, 5 is severe distress)

Medical Condition You Have: (If yes check)
___Diabetes ___ High Blood Pressure ___Heart Disease
___Blood Problems ___Bone/Joint Problems ___Brain Problems
___Skin/Hair/Nail Problems ___Liver Disease ___Respiratory Problems (Breathing)
___Genital ___Kidney/Bladder ___Cancer
___Allergies ___Eyes ___Autoimmune
___Chronic Pain ___Gastrointestinal ___Head Injury

Other health problems not listed above:

Sleep Problems:

Appetite Problems:

Past Health Problems (include difficulties with developmental milestones under age 18)

Medication currently using: If NONE, write your initials here

Medication	**Dosage**	**Time Taken**	**Prescribing Doctor**	**Reason Prescribing**

Medication Allergies: If **NONE**, initial here___________If yes what:

PAST TREATMENT INTERVENTIONS:

Date	**Medical & Surgical**	**Provider/Program/Hospital**
Date	**Psychiatric**	**Provider/Program/Hospital**
Date	**Chemical Dependency**	**Provider/Program/Hospital**

Medical Conditions that Run in Your Family: (If yes check)

___Diabetes ___ High Blood Pressure ___Heart Disease
___Blood Problems ___Bone/Joint Problems ___Brain Problems
___Skin/Hair/Nail Problems ___Liver Disease ___Respiratory Problems (Breathing)
___Genital ___Kidney/Bladder ___Cancer
___Allergies ___Eyes ___Autoimmune
___Chronic Pain ___Gastrointestinal

HEALTH HABITS INFORMATION:
For the following questions please base your answers on **the past month** (approximately).

Y N Have you participated in regular exercise/sports/recreation (about 3 times/week) to keep fit?
Y N Have you been dieting to lose weight?
Y N Have you smoked cigarettes on a daily basis?
Y N Have you experienced any increased feelings of sadness or hopelessness?
Y N Have you felt more anxious or worried than usual?

How often in the past month did you drink alcohol? (Circle your answer):
A) I do not drink at all
B) About once a month.
C) Two to three times a month.
D) One to three times a week.
E) Once a day or more.

For the **past month**, please fill in a number for each day of the week indicating the **typical number of alcohol drinks** you usually consume on that day.

Day of Week	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Number of drinks:							

Y N In the past **year** have you used any illicit or non-prescription drugs?
Y N During the past **month** have you participated in leisure/social/spiritual activities?

Have you ever had a DUI? _____No _____Yes: Details: ___________________________________

Y N "In the past year, have you ever drunk or used drugs more than you meant to?" Or "have you spent more time drinking or using than you intended to?"
Y N "Have you ever neglected some of your usual responsibilities because of using alcohol or drugs?"
Y N "Have you felt you wanted or needed to ***cut down*** on your drinking or drug use in the last year?"
Y N "Has anyone objected to your drinking or drug use?"
Y N "Have you ever found yourself preoccupied with wanting to use alcohol or drugs?"
Y N "Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom?"

FAMILY RELATIONSHIPS (Members of the family you are/were close to)

Name	**Relationship**	Age (or Year of Death)	**Quality of Relationship:** **Excellent, Good, Fair, Bad**	**Lives with you:**
				Y N
				Y N
				Y N
				Y N
				Y N
				Y N
				Y N
				Y N
				Y N

RELATIONSHIP HISTORY: (List all marriages & divorces and/or lived together relationships)

Partner's First Name	**Indicate:** Married (M) Live together (LT)	Length of Relationship	**Reason ended**

WORK HISTORY: (Start with most recent)

Place	**Position**	From	**To**	**Reason ended**

PERSONAL & FAMILY HISTORY:

Were you or any family member physically abused? YES NO (circle)

If yes: Self - family (circle one or both)

Were you or any family member sexually abused? YES NO (circle)

If yes: Self - family (circle one or both)

Were you or any family member emotionally abused? YES NO (circle)

If yes: Self - family (circle one or both)

Have you or any family member had a problem with drugs or alcohol? YES NO (circle)

If yes: Self - family (circle one or both)

Have you or any family member ever tried to commit suicide? YES NO (circle)

If yes: Self - family (circle one or both)

Is there any history of anxiety, depression or mental illness in your family? YES NO (circle)

If yes: Self - family (circle one or both)

COMMENTS: