



**TO HELP WITH YOUR FIRST SESSION, PLEASE FILL OUT THE FOLLOWING INFORMATION AS COMPLETELY AS YOU CAN.**

Counselors Name: \_\_\_\_\_

**PLEASE NOTE: ALL INFORMATION WILL BE KEPT CONFIDENTIAL**

Date: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Name: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Your Phone#: (home) \_\_\_\_\_ (work) \_\_\_\_\_

(cell): \_\_\_\_\_

Email Address: \_\_\_\_\_

Your Employment/Job Title: \_\_\_\_\_

Person responsible for your bill, if different than above:

Name/Address: \_\_\_\_\_

**If using Insurance, you must also complete the “Insurance Questions Form”)**

Last year of school completed: \_\_\_\_\_ or **GED** College: 1 2 3 4 Degree: \_\_\_\_\_ Other: \_\_\_\_\_

Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Remarried \_\_\_\_\_ Widowed \_\_\_\_\_

Total number of prior marriages for you \_\_\_\_\_ for your spouse \_\_\_\_\_

Spouse’s name: \_\_\_\_\_ Age of spouse: \_\_\_\_\_ #of yrs. married \_\_\_\_\_

Spouse’s employment: \_\_\_\_\_

**WHOREFERRED YOU TO US?** \_\_\_\_\_

Is it ok to call your home & leave message: Yes \_\_\_ No \_\_\_; your office: Yes \_\_\_ No \_\_\_

Person to contact in case of an **emergency (name/phone)**: \_\_\_\_\_

BRIEFLY describe your reason for seeking counseling: \_\_\_\_\_  
\_\_\_\_\_

Do you have children? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes: First Name Age Sex Relationship to you Live in your home? (biological/step/adopted/foster)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Parents'**: (Father) Age: \_\_\_ or \_\_\_ Deceased (Mother) Age: \_\_\_ or \_\_\_ Deceased

Number of **Brothers**: \_\_\_\_\_ Number of **Sisters**: \_\_\_\_\_

Has anyone in your family ever had **counseling** before? If so, for what? \_\_\_\_\_

\_\_\_\_\_

Any history of **drug/alcohol abuse** with father, mother, siblings? \_\_\_ Yes \_\_\_ No

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Any history of **physical** or **sexual abuse** to your or brothers/sisters? \_\_\_ Yes \_\_\_ No

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Do you use **alcohol** or **drugs**? \_\_\_ Yes \_\_\_ No If yes, describe frequency and type:

\_\_\_\_\_



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Have you ever experienced any **sexual difficulties**: \_\_\_\_ Yes \_\_\_\_ No If yes, describe:

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Have you ever had **counseling** before? \_\_\_\_ Yes \_\_\_\_ No If yes, describe and list counselor:

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Describe any **major changes** that have occurred to you or your family in the last few years?  
(moves, changes in number of family members, marital status, situation or income)

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List any **major health problems** for which you have received treatment for in the last 24 months:

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**Primary Care Physician:** \_\_\_\_\_ Phone: \_\_\_\_\_

Are you taking any **prescription drugs** at this time? \_\_\_\_ Yes \_\_\_\_ No

If yes, what type, for what purpose, and who prescribed? \_\_\_\_\_

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PLEASE CIRCLE ANY OF THE FOLLOWING **PROBLEMS** WHICH PERTAIN TO YOU:

Nervousness	Depression	Fears
Shyness	Sexual Problems	Suicidal Thoughts
Separation	Divorce	Finances
Drug Use	Alcohol Use	Friends
Anger	Self-Control	Unhappiness
Sleep	Stress	Work
Relaxation	Headaches	Tiredness
Legal Matters	Memory	Ambition
Energy	Insomnia	Making Decisions
Loneliness	Inferiority Feelings	Concentration
Education	Career Choices	Health Problems
Temper	Nightmares	Marriage
Children	Appetite	Stomach Problems

**Family Concern Counseling**

*Phone (219) 476-3190*

*Fax (219) 477-5646*

<http://www.familycounsel.org>

*2004 Valparaiso St*

*Valparaiso, IN 46383*

<http://www.valparaisocounseling.com>



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## NOTICE OF PRIVACY PRACTICES CONSENT FORM

Effective April 14, 2003 a federal regulation, commonly known as the “HIPAA Privacy Rule”, requires that we must provide all of our clients with a detailed notice, in writing, of our privacy practices. We have this lengthy “*Notice of Privacy Practices*” available in our waiting room and it is also on our web site: [www.valparaisocounseling.com](http://www.valparaisocounseling.com) or [www.familycounsel.org](http://www.familycounsel.org). A written copy of this policy is available upon request.

I understand that as a condition to my receiving treatment, Family Concern Counseling may use or disclose my personally identified health information for treatment, to obtain payment for the treatment provided, and as necessary for the operations of this office. These uses and disclosures are more fully explained in the Privacy Notice that has been provided to me, and which I have had the opportunity to review.

I understand that the privacy practices described in the “*Notice of Privacy Practices*” may change over time, and that I have a right to obtain any revised Privacy Notices, if requested. I also understand that I have the right to request FCC to restrict how my health information is used or disclosed. FCC does not have to agree to my request for the restriction, but if FCC does agree, FCC is bound to abide by the restriction as agreed.

Finally, I understand that I have the right to revoke/withdraw this consent in writing, at any time. My revocation/withdrawal will be effective except to the extent that FCC has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if I withdraw my consent.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



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## FCC Appointment Confirmation Consent Form

**In accordance with FCC's policy, there is a charge for missed appointments  
(whether appointments are confirmed or not)  
that are not canceled with 24 hour's notice.**

I, \_\_\_\_\_, do NOT want my appointments confirmed.

I, \_\_\_\_\_, hereby give permission for my counselor or FCC staff, on  
occasion, to confirm any of my counseling appointments via: (pick *ONE*)

\_\_\_\_\_  
(INITIAL) E-mail: \_\_\_\_\_@\_\_\_\_\_

\_\_\_\_\_  
(INITIAL) Telephone number(s): ( ) \_\_\_\_\_ HOME

( ) \_\_\_\_\_ CELL

( ) \_\_\_\_\_ WORK

If someone else -ANYONE else, presently or in the future, answers at **ANY**  
of these phone numbers listed above

**OR**

If voicemail / answering service/answering machine picks up:

\_\_\_\_\_ It **IS** permissible to leave a message, OR

\_\_\_\_\_ It is **NOT** permissible to leave a message

\_\_\_\_\_  
Signature

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Spouse (if applicable)

Date \_\_\_\_\_

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# HEALTH INSURANCE INFORMATION

Dear Client, we look forward to seeing you and we will gladly file your sessions with the counselor to your insurance company, however, we do not verify coverage or call to get the information concerning your coverage for you. You must **call** the phone number(s) on your health insurance card to get the following information **PRIOR** to your first session. **You must call the number on your insurance card and ASK THESE QUESTIONS;**

**Without ALL questions on this form answered by your Insurance Company you will be responsible for the full session fee.**

THANK YOU

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

SS #: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_ Effective date: \_\_\_\_\_

Insured's ID number \_\_\_\_\_

Group Numbers: \_\_\_\_\_

What is the Address for **Mental Health** Claims?

\_\_\_\_\_  
\_\_\_\_\_

Do I have **mental** out-patient benefits? Yes \_\_\_\_\_ No \_\_\_\_\_ (if not stop)

Is (give counselors name) on my provider list? Yes \_\_\_\_\_ No \_\_\_\_\_

If not, do I have any "out of network" benefits? Yes \_\_\_\_\_ No \_\_\_\_\_  
(Write what those benefits are on the back of this form)

Do I have a separate mental health deductible? Yes \_\_\_\_\_ No \_\_\_\_\_  
If applicable, how much of that deductible have I met? N/A \_\_\_\_\_ or \$ \_\_\_\_\_

What is my co-payment for **mental health**? \$ \_\_\_\_\_ per session

How many sessions are allowed per calendar year? \_\_\_\_\_  
(If applicable) do I have marital counseling benefits? Yes \_\_\_\_\_ No \_\_\_\_\_

Is prior authorization needed for counseling? Yes \_\_\_\_\_ No \_\_\_\_\_ (if not stop)

Authorization number? \_\_\_\_\_ how many sessions are authorized? \_\_\_\_\_

For what dates are those sessions authorized? From: \_\_\_\_\_ To: \_\_\_\_\_

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process claims.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_  
INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the counselor who provided the service.