PROfessional Assessment Counseling & Training, LLC

Client Intake Information

Client's Name (First MI Last) ______________________________ Sex: M F Age _________

Spouse (if married) or Guardian Name____Age ___________________

NOTE: CUSTODY PAPERS MUST BE PROVIDED FOR CHILD OF DIVORCE OR UNWED PARENTS

Address (Street): ____ (City) _____________ (ZIP) ______________

Phone Numbers/e-mail: **(only include those that we have permission to call or leave a voice/email/text message):**

Home _________________ Work _______________ Cell ________________ e-mail ______________________________

Date of Birth ________________ Marital Status ______ Date of Marriage ____/_____/____

Client Social Security # _____________________ Occupation_________________________

How did you find out about PRO-ACT? ____

Religious Orientation _____________________________ Church Affiliation _________________________

Please make a simple statement regarding your reason for seeking counseling: __________________________________

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Family Members living at home

Name:	Age	Birth-date	Relationship to client

Insurance Information:

Policy Holder Name: ____________________________ **Policy Holder Date of Birth:** _______________

Insurance Company:_________________________________ **Policy Holder SS #:**

Mental Health Insurance Carrier: _____________________ **Mental Health Telephone #** ____________________________

ID # : _________________________ **Telephone # :** __________________________

Group # : ________________________ **Insured's Employer:** _______________________________________

***********OR**********

EAP (Employee Assistance Program) Information:

EAP Company: _ ____________________________ **Phone Number:** ____________________________

Authorization # ________________________ **Number of sessions:** ______________

Medical/Health Information:

In Case of emergency you may call __________________________ Phone # ________________Relationship _____________

Personal Physician: ______________________________________ Phone # ____

Date of last physical: __________________ Major illnesses/conditions ____

Previous Counseling: Yes No If yes, when and with whom ___________________________________

Medications you are currently taking? ____

The undersigned authorizes the release of all client information by the therapist for the purpose of pre-certification for treatment and concurrent review, to medical review agencies and/or third party payers providing coverage. Such disclosures are limited to information that is reasonably necessary for treatment planning. Also, that you authorize permission for treatment.

____ ____________________________

Client/Guardian Signature **Date**

PRO-ACT

2601 PASADENA BLVD, PASADENA, TX 77502

CREDIT CARD ON FILE AUTHORIZATION FORM

This form is for you to supply Professional Assessment Counseling & Training, LLC (Pro-Act Counseling) with credit card information to keep on file for the payment of **no-show and/or late cancellation fees only**. Your credit card information is not kept on file in this office. It is kept electronically in encrypted software and will remain on file until the expiration date.

Card Information:

Card Type (Circle): Visa / MasterCard / Discover / AmEx

Name on Card: ____

Card Number: ____

Expiration Date: ____

CVV Code: ____

Cardholder Signature: ____

AUTHORIZATION:

I understand that the credit card information given will ONLY be charged if I no-show or cancel my appointment without 24 hours' notice. It will not be used at any other time unless requested by the cardholder. Insurance companies cannot be billed for these charges. Clients may revoke this credit card by submitting a written request to the address above. A new form must be submitted if any information changes. Applicant agrees to pay the cost for any returned or challenged payments. A new form must be completed for each card kept on file.

Cardholder Signature: ____

Date: ____

PROfessional **A**ssessment **C**ounseling and **T**raining
2601 Pasadena BLVD, Pasadena, Texas 77502
Phone 713-475-0072 FAX 713-472-8684
http://www.pro-act.com

Statement of Understanding

I have read and understand the Pro-Act Notice of Privacy Practices, Consumer Rights and Responsibility, the Policies and Procedures, Communication Notice, Consent for Release of Information, Payment and Healthcare Operations and the Consent for Treatment forms. I understand that the above information is available online at www.pro-act.com under the Intake Forms Tab. I acknowledge that at any time, I can contact my therapist with questions about the above information.

Printed Name: ____

Signature: ____

Date: ____

Steve Christopherson, MS, LPC, NCC
Executive Director

Dusti Nettles-Graham
Office Coordinator

Nicky Williams
Intake Specialist

CLINICAL STAFF

Mary Helen Morosko, MA, LMFT,CHT
Sandra Dwyer, M Ed, LPC
Jamee Wilson, MA, LPC
Angela Waggoner, MS, LPC, NCC
Stacy Anderson, MA, LPC
Jacqualine C. Truitt, MS, LPC, LMFT, NCC
Tara Warner, MS, LCDC, LPC-Intern