*INTAKE INFORMATION*

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NICKNAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MOBILE PHONE #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHICH DO YOU PREFER? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PERMISSION TO LEAVE MESSAGES THROUGH THESE CONTACTS? **Y OR N**

HOW WOULD YOU PREFER TO RECEIVE APPOINTMENT REMINDERS?

PHONE: **Y OR N**  EMAIL: **Y OR N** TEXT: **Y OR N**

GENDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYMENT: **EMPLOYED STUDENT UNEMPLOYED**

DO YOU CONSENT TO RECORDS BEING RELEASED TO YOUR PRIMARY CARE PHYSICIAN FOR CONTINUITY OF CARE? **YES OR NO**

PRIMARY LANGUAGE SPOKEN IN THE HOME? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHO DO WE HAVE PERMISSION TO SPEAK WITH REGARDING YOU (THE CLIENT)?

(PLEASE CONSIDER DOCTORS/PSYCHIATRISTS, SCHOOL OFFICIALS, DHR, ETC)

NAME CONTACT INFORMATION RELATIONSHIP

NAME CONTACT INFORMATION RELATIONSHIP

NAME CONTACT INFORMATION RELATIONSHIP

NAME CONTACT INFORMATION RELATIONSHIP

**PARENT/GUARDIAN INFORMATION (IF CLIENT IS AN ADOLESCENT)**

\*IF THE GUARDIANS ARE NOT THE BIOLOGICAL PARENTS OF THE CLIENT, CUSTODY PAPERWORK IS REQUIRED. IF THERE HAS BEEN A DIVORCE OF THE BIOLOGICAL PARENTS, **CUSTODY PAPERWORK IS REQUIRED.**

**FATHER’S** NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOES FATHER HAVE SOLE/SHARED CUSTODY OF CHILD?\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FATHER’S ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FATHER’S EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SHOULD FATHER RECEIVE APPOINTMENT REMINDERS? **YES OR NO**

DOES FATHER HAVE PERMISSION TO REQUEST INFORMATION? **YES OR NO**

**MOTHER’S** NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_

DOES MOTHER HAVE SOLE/SHARED CUSTODY OF CHILD? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MOTHER’S ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MOTHER’S EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SHOULD MOTHER RECEIVE APPOINTMENT REMINDERS? **YES OR NO**

DOES MOTHER HAVE PERMISSION TO REQUEST INFORMATION? **YES OR NO**

**OTHER GUARDIAN’S** NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOES GUARDIAN HAVE SOLE/SHARED CUSTODY OF CHILD? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GUARDIAN’S ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GUARDIAN’S EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SHOULD GUARDIAN RECEIVE APPOINTMENT REMINDERS? **YES OR NO**

DOES GUARDIAN HAVE PERMISSION TO REQUEST INFORMATION? **YES OR NO**

**INSURANCE INFORMATION**

**FINANCIALLY RESPONSIBLE PARTY/GUARANTOR INFORMATION**

**FOR ALL CLIENTS: Please fill out the top section of this page, regardless of using insurance or not.\***

*GUARANTOR NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_*

*ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*RELATIONSHIP TO PATIENT Self Spouse Mother Father Sibling Other Relative Friend Other*

## EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***GUARANTOR AGREEMENT:*** *I certify that the above information is true and correct. I agree to take full responsibility for the entire amount due for any and all services rendered by Warrior Wellness Group, LLC. If the provider is contracted with the insurance compan y, I will be responsible for the co-pay, deductible, and non-covered services as determined by the insurance plan.*

*GUARANTOR SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

# PRIMARY INSURANCE:

## POLICY HOLDER’S NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY HOLDER’S ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY HOLDER’S DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY HOLDER’S GENDER:\_\_\_\_\_\_\_POLICY HOLDER’S EMPLOYER:\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_\_\_\_\_\_\_

DO YOU GIVE US PERMISSION TO RELEASE INFORMATION TO THE INSURANCE COMPANY FOR THE PURPOSE OF BILLING/CONTINUITY OF CARE? **YES OR NO**

# SECONDARY INSURANCE:

# POLICY HOLDER’S NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY HOLDER’S ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY HOLDER’S DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY HOLDER’S GENDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY HOLDER’S EMPLOYER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_\_\_\_

DO YOU GIVE US PERMISSION TO RELEASE INFORMATION TO THE INSURANCE COMPANY FOR THE PURPOSE OF BILLING/CONTINUITY OF CARE? **YES OR NO**

# FOR MEDICAID CLIENTS:

IF YOU ARE A CLIENT INTENDING TO USE MEDICAID BENEFITS, MEDICAID ONLY COVERS COUNSELING FOR INDIVIDUALS UNDER THE AGE OF 19. A REFERRAL IS REQUIRED FOR SERVICES TO BE COVERED. PLEASE CONTACT YOUR PRIMARY CARE PHYSICIAN TO HAVE ONE FAXED TO (844) 763-3291.

PRIMARY CARE PHYSICIAN’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY CARE PHYSICIAN’S PRACTICE NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## ALL CLIENTS MUST READ AND INITIAL (between the parenthesis) THE FOLLOWING:

**PRIVACY POLICY:** I acknowledge having been offered WARRIOR WELLNESS GROUP, LLC “Notice of Privacy Policies” and their“Client Rights Statement” (below and on following pages). My rights include the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record. These are explained in the Policy. My right to make a complaint and file a grievance has also been explained. I understand that I may revoke in writing my consent for release of my health care information except to the extent WARRIOR WELLNESS GROUP, LLC has already made disclosure with my prior consent. **( ) INITIAL**

**CONSENT FOR TREATMENT:** I hereby consent to the treatment provided by WARRIOR WELLNESS GROUP, LLC and its employees or designees. I authorize the services deemed necessary or advisable by my caregivers to address my needs. **( ) INITIAL**

**AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION:** I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of WARRIOR WELLNESS GROUP, LLC. I authorize WARRIOR WELLNESS GROUP, LLC to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that WARRIOR WELLNESS GROUP, LLC may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. **(\_\_\_\_\_) INITIAL**

PRACTICE POLICIES AND SERVICE INFORMATION

Thank you for requesting an appointment with us. We are pleased that you have chosen us and are committed to giving you the best care possible. I have enclosed several forms as well as a patient history questionnaire. All of this information is necessary for quality evaluation and management of treatment. Please complete everything included so that we can best complete in one session what otherwise might take two or three sessions. This saves you time and money as it allows me to move more quickly with an accurate assessment and treatment. I will be glad for you to keep a copy for future use with other doctors and clinicians if you so desire.

To acquaint you further with the procedures and policies of this office, I am providing the following information:

* **Appointments:** We have appointments back to back throughout each day. We do our best to be punctual for your appointment unless an emergency interrupts. We ask that you be punctual as well. **If you are late for any reason, you will receive the remainder of your scheduled time. This is necessary so that we can keep our following appointments at their scheduled time.** If you are more than 15 minutes late or more for your appointment, a $50 no-show fee will be charged to the card on file and your appointment will need to be rescheduled. **If you need to cancel an appointment, a minimum advanced notice of one full workday is required so that we will have a chance to fill that slot.** You may leave a message with the office staff or on their voicemail. We will charge TO THE CARD ON FILE a $50 no-show fee for all late cancellations or failures to show.Note: As a *courtesy*, we can, with your permission, have reminder calls, texts and emails sent to you. **YOU ARE STILL RESPONSIBLE FOR COMING TO YOUR APPOINTMENT OR CANCELING 24 HOURS IN ADVANCE, even if you do not receive a call, text or email.**
* **Psychological Evaluations:** A psychological evaluation is a formal examination of mental health. Our psychological evaluations include clinical interviews, standardized measures of intellectual ability, achievement, personality, adaptive behavior, and social, emotional, and behavioral functioning, as well as clinical observation, and a review of relevant documentation. **Please understand this is a long process**. The clinical interview(s), administered tests, and filling out of various measures may take anywhere from two to five hours. In addition, the scoring, interpretation, and report write-up make also take anywhere from two to five hours. The psychological evaluation may ultimately result in diagnosis, recommendations, and/or feedback. The reports will be drafted and completed as soon as possible, and I will make the best possible effort not to go beyond **14** days from the date of the psychological evaluation. Included in the cost of the psychological evaluation will be one courtesy 30-minute feedback session in which I review the results of the psychological evaluation with you and/or the child. The feedback session will typically be scheduled upon the completion of the psychological evaluation.
* **Emergencies:** During office hours, let the office staff know that you have an emergency and the nature of the problem and one of them will try to contact me. After office hours, please leave me a voicemail. If you need after-hours emergency interventions, call 911 or go to your nearest local Emergency Room, where the staff can offer assessment and treatment.
* **Payment:** You are fully responsible for all services rendered. Full payment is expected at the time of service, unless other contractual agreements apply. We accept Visa, MasterCard, Discover and Cash. There will be a $25 fee for payments returned as non-sufficient or non-payable. All services rendered will be billed to you, your guarantor, or some contracted insurance plans by our office staff. If you have questions regarding your account balance, you may call 205-624-2422 to speak with an account representative. *Please Note*: Billing processes may include a monthly statement, phone call, or correspondence regarding the patient due portion of the account balance. Statements, phone numbers, and correspondence will be addressed regarding the patient/guarantor address or phone numbers listed on the Warrior Wellness Group, LLC, registration form. If any of these business office procedures present a problem for you or your treatment, please discuss your concern with your therapist or the office staff.
* **Confidentiality:** Your patient records are the property of Warrior Wellness Group, LLC and shall be treated as confidential. To insure quality record maintenance and patient confidentiality, Warrior Wellness Group, LLC, will maintain your records using Therapy Notes, an online HIPAA encrypted database and mental health practice management web-based software package. To comply with State and Federal Laws regarding patient confidentiality, your records will not be released without the properly executed written consent. Everything about your care will be held in strictest confidence. If you choose to have your provider(s) keep a third party informed of your progress in counseling, it will be necessary to complete the following Release of Information form that will be kept on file.

\*\*\*\*There are some circumstances in which I am required by law to break confidentiality. As a counselor/therapist, I am both ethically and legally bound to keep in confidence any information you divulge to me. However, there are some exceptions to this confidentiality you should be aware of:

1. If you are a danger to yourself or others in the immediate future, I will take the action necessary to protect everyone involved. This may include notifying persons or agencies such as family members, friends, intended victims, employers, and/or the police.

2. If I see evidence of child abuse, elderly abuse, or abuse of a disabled person, or strongly suspect abuse in this regard is taking place, I am required by law to make a report to the Department of Human Resources in the county of residence for the child.

3. If subpoenaed to provide information in a court of law, I will first assert psychologist (psychological trainee) -patient privilege. However, I can be ordered by a judge to report what you have said to me in confidence.

* **Termination:** Ending therapy may be initiated by you as the client, or as legal guardian of the client or myself as the therapist. In either event, a final session is strongly recommended to explore the ending process itself. This can be a useful conclusion to treatment. Referrals to other providers or other suggestions can be offered at that time.
* **Telephone Calls:** I may not always be available immediately by telephone due to schedule and seeing other patients/clients. Please feel free to call our office and leave a message with office staff. I will return your call as soon as it is possible for me to do so. Please let our office know if there are other numbers to use in contacting you should a return call be made after working business hours.
* **Reports and Letters:** I have the right to bill for my time if you, another clinician, lawyer, insurance company, etc. request a letter or report. Payment is expected at the time of service. Unpaid balances will be billed to you or your guarantor from our office. Should you have any questions regarding your account balance, you may call our office at 205-624-2422. **Insurance companies may not reimburse for these fees.**

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PATIENT/GUARDIAN SIGNATURE DATE

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2. If I see evidence of child abuse, elderly abuse, or abuse of a disabled person, or strongly suspect abuse in this regard is taking place, I am required by law to make a report to the Department of Human Resources in the county of residence for the child.

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PATIENT/GUARDIAN SIGNATURE DATE