Family Service Agency
Strengthening Individuals & Families

Adult Intake Form

Client Name: _____ Birth Date: _____
Last *First* *MI* *MM/DD/YYYY*

Preferred Pronouns: _____ Preferred Name: _____

SSN: _____ Cell phone: _____ Home phone: _____

Email: _____

Address: _____
Street Address *City* *State* *Zip Code*

Employer: _____ Phone: _____

Preferred Contact Method: ☐ Home ☐ Cell ☐ Work ☐ Email Best Time to Contact: _____

Demographic Information

Sex: _____

Race: _____ Language(s) Spoken *(**Primary first)*: _____

Are you Hispanic, Latino/a/x, or Spanish origin? ☐ Yes ☐ No

If yes, please check one: ☐ Mexican/Mexican American ☐ Puerto Rican ☐ Cuban ☐ Central or South American
☐ Other _____ ☐ Unknown

Current Marital Status: _____ Highest Education Level Completed: _____

Citizenship Statue: ☐ U.S. Citizen ☐ Non-U.S. Citizen

Are you a Veteran or Military Service Member? ☐ No ☐ Veteran ☐ Active Service Member

Do you require an interpreter? ☐ No ☐ American Sign Language ☐ Foreign Language _____

Financial & Household Information

Are you currently employed? ☐ Fulltime ☐ Parttime ☐ Employed in Subaid/Support ☐ Vocational/Day Program
☐ Unemployed/laid off ☐ Not in the labor force

Do you have insurance through your employer? ☐ Yes ☐ No

If yes, list place of employment insurance is through: _____

Client Annual Income: $ _____ Household Annual Income: $ _____

	Insurance Company	Policy #	Group #
Primary			
Secondary			

Full Name of Insured Person (if not client): _____

SSN: _____ Date of Birth: _____ Phone Number _____

Mailing Address: _____
Street City State Zip Code

Email: _____

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Household Size: _____ List all individuals living in your household below.

Last Name	First Name	Age	Gender	Relationship to Client

Treatment History

Is the client currently or previously receiving mental health treatment? ☐ Yes ☐ No

If yes, where? _____ Are you willing to sign a release of information? ☐ Yes ☐ No

Is the client on any medications? (List below.) ☐ Yes ☐ No

Name of Medication	Purpose of Medication	Dosage	Effective?

Recent health problems and/or hospitalization(s)? Please list below.

Date	Concern	Other

Do you have concerns about any of the following? *(Check all that apply)*

☐ Anger Management ☐ Anxiety ☐ Sexual Behaviors ☐ Severe Mood Swings
☐ Eating Problems ☐ Fears ☐ Hyperactivity ☐ Behavior Changes
☐ Sleeping Problems ☐ Depression ☐ Alcohol/Drugs ☐ Problems at School
☐ Other

Please circle your preferred method(s) of delivery:

In office Video Phone

Person completing this form: _____ Date: _____

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Adult Symptom Checklist

Client Name: _____ Date: _____

Please indicate below if you experience any of the following and how often within the last 3 months.
M=Most of the time S= Sometimes N= Never

Symptom	M	S	N	Symptom	M	S	N
Feelings of Guilt				Feeling worthless			
Worrying				Excessive spending			
Anger				Overly tired			
Problems falling asleep				Overeating			
Problems staying asleep				Bingeing			
Afraid of leaving the house				Food preoccupation			
Feeling alone				Vomiting			
Memory loss				Sleeping too much			
Trouble making decisions				Hearing voices			
Sudden mood changes				Problems at work			
Restlessness				Nightmares			
Excessive spending				Obsessive thoughts			
Hopeless about the future				Thinking about death			
Ruminate about the past				Thinking about suicide			
Crying excessively				Feeling down or blue			
Feeling anxious				Feeling panicky			
Irritable or on edge				Phobias/fears			
Shortness of breath				Too much/ lack of energy			
Problems with gambling				Blackouts			
Stomach problems				Physical abuse of self or others			
Lying				Emotional abuse of self/others			
Uncontrolled thoughts				Sexual problems			
Uncontrolled behaviors				Relationship problems			
Problems getting along with others				Other:			
Other:				Other:			

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Consent for Services & Financial Agreement

Consent for Services

I, _____, request services from Family Service Agency's Programs:
(Client)

- Center for Counseling
- Child Advocacy Center
- DeKalb County Community Action
- Senior Services
- Youth Mentoring

I, _____, request services from Family Service Agency's Programs.
(Parent/Guardian)

1. I seek and consent to participate in services at Family Service Agency's programs.
2. I understand that developing a treatment plan with my counselor and regularly reviewing progress toward my treatment goals is in my best interest.
3. I understand that I may stop program services at any time and that I am responsible for any consequences of terminating counseling.
4. I understand that when services terminate *Agreement to Pay for Professional Services* continues to apply until my bill is fully paid.
5. I understand that my insurance company or third-party payer may receive information about the services I receive.
6. I understand and have discussed with my counselor: a) my condition, problem and/or diagnosis, b) the planned course of treatment, c) alternatives to treatment, including no treatment and d) confidentiality and the limits or exceptions of confidentiality.
7. I understand as the parent or guardian of a recipient of services who is at least 12 but under 18 years of age that my child has rights to confidentiality that are different than for a child under 12years of age, I understand the following provisions;
    a. Any minor 12 years of age or older may request counseling services without the consent of the parent or guardian.
    b. Sessions provided to a minor age 12-17 without parent or guardian consent shall be limited to not more than 7 sessions, lasting no more than 45 minutes each.
    c. If a minor child age 12-17 chooses to consent to counseling without parent or guardian consent then the parents will not be informed unless required by law.
    d. If a minor child age 12-17 chooses to consent to counseling without parent or guardian consent then the parents are not financially responsible for those sessions.
    e. Parent or guardian is not entitled access to protected health information of a child age 12-17 without the child's consent, unless required by law.
8. If the person to receive services is a minor (under the age of 18 years of age) I give permission to the program services to provide services to him or her.
9. I understand that a child age 17 or under who has been a victim of criminal sexual assault or abuse may consent to program services without parent or guardian consent.
10. I give consent for Family Service Agency to contact me for evaluative purposes.

Agreement to Pay for Professional Services

I, _____ , agree to pay the fee(s) described for these services and any additional fees described below or to pay the fee negotiated by the insurance company, Employee Assistance Program, employer, financial assistance scholarship, or third-party payer.

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Charges that may apply:

- The fee for intake or diagnostic assessment is $150.
- An individual session costs up to $150, depending on type of session and time frame of session.
- Sessions extended more than 10 minutes are charged on a pro-rated basis for the additional time.
- If I seek additional services (i.e. requesting materials for court, seeking a counselor in court) I will be charged the hourly rate of $90 for those services.
- The fee for mediation is $125 per hour which is divided equally between each party.
- The fee for phone consultation with a counselor is pro-rated based on the hourly rate of $90.
- The fee for checks returned for insufficient funds is $25 per occurrence, plus any applicable collection fees.
- If I fail to cancel an appointment less than 24 hours in advance or no show I will be charged a $25 fee.

Additional billing policies:

- I am responsible for knowing my insurance benefits and for providing accurate and timely insurance information, including completion of any authorization or approval process required by my insurance company. Any fees not covered by my insurance company resulting from not knowing benefits or providing accurate or timely information is my responsibility.
- There are some services that insurance may not cover and I am responsible for these fees or any fees denied for coverage by my insurance.
- If my insurance or other third party payer has not paid for services after two billings or denies coverage, I am fully responsible for the remaining bill for services.
- If a bill is not paid it may be sent to collections and I will be responsible for the additional 35% charged by the collection agency to collect the bill.
- I am responsible to give the Family Service Agency updated address information. Failure to do so may result in any unpaid bill being sent to collections.
- Lack of payment of the co-pay for two consecutive sessions or lack of timely payment on a pre-arranged payment plan may result in being unable to schedule another appointment with a counselor until payment is received on the account.
- Any billing questions should be directed to the Family Service Agency Business Office.
- All balances are due upon termination of services, unpaid balances will be sent to collections.

If you have additional concerns, please contact the Agency for assistance 815-758-8616.

I understand and agree to the information contained in the *Program Services* and give informed and willing consent to receive these services from Family Service Agency for myself or for the minor named above.

I understand and agree to abide by the policies contained in this Agreement to Pay for Professional Services. If applicable, my signature below authorizes my insurance to make payment directly to Family Service Agency's Center for Counseling.

Client Name (Printed) **Date**

Client Signature **Date**

Facilitator Signature **Date**

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Consent to Participate in Telehealth Appointments

I, _____ understand:

- My behavioral health professional wishes me to engage in a telehealth consultation using Zoom.
- My behavioral health professional has provided information needed to make an informed decision about engaging in Zoom technology.
- I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.
- I understand that my behavioral health professional or I can discontinue the telehealth consult/visit if it is felt that the Zoom videoconferencing connections are not adequate for the situation.
- I understand that if others are present during the consultation other than my behavioral health professional, they will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth session/room: and or (3) terminate the consultation at any time.
- In an emergency, I understand that the responsibility of my behavioral health to contact my listed emergency contact or the local first responders if there is a termination of the Zoom video conference connection.
- I have had a direct conversation with my behavioral health professional, during which I had the opportunity to ask questions regarding this procedure. My questions have been answered and the risks, benefits, and any practical alternatives have been discussed with me in a language in which I understand.

Please indicate your preference below.

☐ I have had the alternatives to a telehealth consultation explained to me and I am choosing to participate in a Zoom telehealth consultation.

☐ I have had the alternatives to a telehealth consultation explained to me and I am choosing **NOT** to participate in a Zoom telehealth consultation.

By signing this form, I certify:

- I have read or have had this form read/explained to me.
- I fully understand its contents including the risks and benefits of the procedure(s).
- I have been given ample opportunity to ask questions and that my questions have been answered to my satisfaction.

Client Signature Date

Parent/Guardian Signature (If applicable) Date

Provider Signature Date

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Family Service Agency Client Acknowledgments

Client Name: _____
Last *First* *MI*

Primary Guardian: ***(If applicable)*** _____
Last *First* *MI*

Mandatory Documents

- Notice of Privacy Practices
- Client Rights and Responsibilities
- Behavior Support and Management
- Client Grievance Process

Mandatory documents can be found by scanning the QR code located at the bottom of this page or by request from reception or designated clinician.

I acknowledge that I was given the above documents for review and offered a copy for my records. I understand and agree with the terms of these documents. I understand that I may request additional copies at any time.

Client Signature (or Parent/Guardian for child under 18)	Date
Client Signature (or Parent/Guardian for child under 18)	Date
Client Signature (Child 12 years of age or over)	Date
Staf Signature	Date

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