Registration Form

Client Information

Last Name: _____

First Name: _____Middle: _____

Date of Birth: ____/____/____ Age: _____ Social Security Number _____-_____-_____

Address : _____

City: _____State: _____ Zip : _____

Primary Contact Phone Number : (_____) _____-_____ OK to call ? ☐ Yes ☐ No
Email Address:_____ OK to use? ☐ Yes ☐ No

Marital Status: _____ Spouse's Name: _____

Employer (or school): _____
Occupation (or grade): _____

Person Responsible For Payment
Insurance Information

Primary Insurance Co: _____
Insured Name: _____
Date of Birth: _____
Employer: _____
Policy ID #: _____
Group #: _____
Phone Number: (____)_____

Secondary Insurance Co: _____
Insured Name: _____
Date of Birth: _____
Employer:_____
Policy ID #:_____
Group #: _____
Phone Number: (____)_____

For Office Use Only
Insurance Verification
Call Date:_____
Spoke To: _____
OP MH Benefits: _____
CoPay: $_____
Deductible: $ _____Met? _____
Pre Cert Required? ☐ Yes ☐ No
USO Required? ☐ Yes ☐ No
Family Tx? ___ Marital Tx?____
Auth Number: _____
# of Visits:_____from:____to:_____
_____
_____
_____
_____
_____
_____
_____

Confer Consulting Services 6407 Constitution Drive Fort Wayne, IN 46804
260-414-4809

Consent For Services

Please Read Carefully and Initial Each Paragraph

Treatment Choice/Involvement
_____I understand that I have made a voluntary choice to be involved in treatment. I understand that treatment is a cooperative effort between myself and the therapist to resolve my difficulties. I also realize that during the course of my treatment, material may be discussed which may be upsetting in nature and that this may be a component to aid in resolving my problems.

_____ I understand my right to withdraw my consent to treatment at any time.

Acknowledgement of Receipt of Notice of Privacy Practices
_____I have been offered a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. (Copies in plastic protector at back of clipboard).
_____Accepted _____Declined

Mental Health Provider Qualifications
_____I understand that the theoretical basis of my treatment will be solution focused therapy that may involve my active participation in a variety of techniques and assignments. I agree to discuss with my therapist any problems or concerns I have about the treatment process. I understand that my therapist cannot guarantee outcomes of my treatment process.

Risks and Benefits of Treatment
_____I understand that I will be actively involved in the various steps in treatment planning including being informed of the risks and/or benefits of receiving or not receiving such treatment or alternatives. I further understand that my case may be reviewed with a clinical supervisor for the purpose of ensuring an appropriate and effective treatment plan and to meet the requirements of some insurance carriers.

Confidentiality
_____I understand that I have the right to confidential maintenance of all identifying treatment information and that no disclosure of such information will be made without my written consent except in the following cases; 1) When there is a danger to self or others 2) When there is a court order mandating release of information 3) When there is a suspicion of child or elder abuse or neglect.

_____I authorize Confer Consulting Services to release necessary medical information to appropriate third parties for reimbursement purposes or to entities authorized to conduct utilization reviews.

Fees
_____I understand that fees and/or copays are expected at the time of service. I further understand that it is my responsibility to verify benefits, participating providers and credentialing requirements with my insurance company.

Cancellations
_____I understand that a 24 hour cancellation notification is required. I am aware that failure to give proper notification will result in a late cancellation fee and that I am fully responsible to pay that fee.

_____I have read and understand the contents of this form.

Signed:_____ Date:_____

Witnessed: _____ Date: _____

Date: _____

Client Questionnaire

Name:_____ Date of Birth: _____Age:_____
Race: _____ Gender: □ Male □ Female Marital Status: _____

Who referred you to Confer Consulting Services?_____

What is the reason you are seeking counseling at this time?
_____
_____
_____
_____

Circle any of the following symptoms that you have experienced in the last 3-6 months:

Trouble falling asleep/staying asleep
Sleeping too much
Increase in appetite/weight gain
Decrease in appetite/weight loss
Fatigue
Too much energy
Loss of interest in things
Sad/depressed/feeling down
Frequent crying
Guilty feelings
Hopeless feelings
Helpless feelings
Thoughts of death or suicide
Seeing or hearing things that are not real
Anxiety/nervousness
Fearful feelings
Irritable
Feeling restless or edgy
Fear of losing control
Memory problems
Concentration problems
Trouble making decisions
Decrease in sex drive
Violent or aggressive behavior
Repetitive behaviors
Excessive drinking/drug use
Bingeing or purging
Restrictive eating

Primary Care Physician:_____ Phone number:_____

Current Medications:	Prescribing Physician:	Medical Condition:

How much do you smoke per day?_____ □ None
How much caffeine do you drink per day?_____ □ None
How much alcohol do you drink____per day? ____per week? ____per month? □ None

Have you served in the military? □ No □ Yes. Branch/dates of service/type of discharge:
_____

Where were you born? _____Who raised you?_____
Significant childhood experiences:_____
_____
_____
_____

Names/Ages of brothers and sisters:

Name	Living?	Age	Marital Status	Number of children	Mental Health Issues	Alcohol/ Drug Issues

Highest grade in school completed: _____
Marital History: □ Never married List dates of marriages and divorces if applicable:
_____
_____

Names /ages of children (include stepchildren):

Name	Age

:
Legal history: □ None _____
_____

Spiritual issues or concerns:_____
Do you attend church/synagogue? □ No □ Yes, where?_____
Have you experienced verbal, physical or sexual abuse? □ No □ Yes, describe:_____
_____
_____

MAP

Confer Consulting Services

Cheryl Perry Confer, LMHC
260- 414-4809

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