COUNSELING INTAKE FORM for Terri Liticker LCSW

214-587-3454 Fax 214-272-7443 tliticker@tx.rr.com

Name of client_____Date of Birth_____Date_____

If minor client parent/caregivers name _____

Is there a custody agreement that requires consent of another parent? _____

Social Security Number _____-_____-_____

Full Address_____

Primary Phone_____ Alternate Phone_____

Call Preference Cell ( ) Text ( ) I give approval for communication via Text Message _____ (initials)

I give approval for a message to be left on the number listed above _____(initials)

Emergency contact_____ Phone number_____

E-mail_____ General Health_____

Are you now under a doctor's care?_____ If yes, name of doctor_____

Reason for doctor's care_____

List any medication here_____

Have you ever been hospitalized for a mental illness?_____ Describe_____

_____

Do you take drugs?_____ If yes, what kind?_____

Do you drink?_____ How much?_____

Any Previous Therapy/Counseling?_____ If yes, describe, when, where, how long, what for_____

_____

What do you hope to achieve with therapy?_____

_____

Have you had any thoughts of suicide ____If so, when _____Do you have any thoughts now_____

Please tell anything else in the space below that you think would be helpful for me, as your therapist, to know.

_____

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Please state why you decided to come for counseling/therapy_____

How long has this been a problem for you_____

Please state what you would like to work on in therapy_____

_____

INSURANCE REQUIRED INFORMATION:

Insurance Co.: _____ Subscriber ID#: _____

Subscriber SSN: _____ Subscriber address: Same ☐ _____

Subscriber Date of Birth: _____

Customer Service phone number (usually on back of card): _____

Main Subscribers Name: _____ Plan / Group #: _____

Employer who Insurance is through: _____

Co Pay : _____ Deductible: _____Effective date of Insurance: _____

Therapists use
Authorization # (if required): _____ # of visits allowed _____

(This information is not a guarantee of coverage , we will not know your exact benefits & coverage until we receive a explanation of benefits from your insurance company after first billing.)
Do you have out of network benefits if Counselor is not a preferred provider? _____

Is the Client covered by any other insurance _____ If yes ask for another form pg 2

Personal Agreements

I understand that I may be asked to do certain "homework exercises" such as reading, praying, changing behaviors, and otherwise acting in my own best interest. I understand that I am entirely responsible for my own actions and I will always make my own final decisions regarding counseling.
I further understand that much of the work done will be to resolve issues and will depend on my honesty, and willingness to do the things I need to do to move forward even if it is painful and difficult.
I understand that whatever I say in a session is strictly confidential and will not be released to anyone without my consent unless I am violating codes of abuse, harm to myself or others.

If you are unable to keep a scheduled appointment, please let us know preferably 24 hours in advance but at least 4 hours **in advance to avoid a NO SHOW fee**. A **NO SHOW** is when a patient fails to keep a scheduled appointment. A NO SHOW will generate a **$25** fee and three no shows may require that you seek your care elsewhere.

_____(client signature and date)