Client Information

Name	
Cell #	*(*See HIPAA release to use unsecure communications below)*
Home #	
Email	*(*See HIPAA release to use unsecure communications below)*
Mailing Address	
DOB or SSN	

"Opt in" to receive email and text communications:

By providing my email address, I am authorizing **Crosscurrent Counseling and its contracted billing administrator (DBA: Shawnea Roberts)** to use email and text messaging as a form of communication with me. I understand that email and text messages may include personal health information (to include, but not limited to, name, appointment date/time, and type of service).

I am aware that email and text communication can be intercepted in transmission or misdirected. Opting in for email and text messaging indicates my acknowledgement and acceptance of risks associated with unsecure communications.

You may receive appointment reminders by text and email, with your permission. Please note that this is not a guaranteed form of confidential correspondence.

_____***I would like to allow text communications***

_____***I would like to allow email communications***

_____***Do not contact me by text / email***

Client Signature _____ ***Date*** _____

CROSSCURRENT COUNSELING & PSYCHOTHERAPY

Payment Information & Financial Policy

Client Information

Client Name			
Address	Street		
	City	State	Zip
Employer			
Phone Numbers	Hm	Wk	Cell
Date of Birth			
Soc. Sec. #			
Parent/Guardian			
Spouse			
Emergency Contact	Name	Number	Relationship
Email ***(for billing correspondence)***			

Payment Options

- ☐ I wish to apply insurance benefits using the information I list below. My co-pay is $_____.
- ☐ I do **not** wish to bill insurance, and I elect to pay "out of pocket." My session fee is _____.

Insurance Information

Primary Insurance			
Group #			
ID #			
Subscriber	Name	SSN	DOB

(must provide if referral/ pre-authorization/pre-certification is required for coverage)

Primary Care Physician Practice Name Address / Phone #	

Financial Policies

All co-pays and self-payments are due at time of service. Charges to client accounts may include: session fees, full session fee charged for failure to cancel with 24 hours notice, full session fee charged for "no shows" (including arriving more than 15 minutes late), and fees for other services requested by client (consultation, phone appointments, research, letter & report writing). Each of these charges is explained within the informed consent document which is reviewed and signed at intake.

Client maintains ultimate responsibility for checking behavioral health coverage prior to service. Client is responsible for attaining referral if needed from Primary Care Physician (PCP). Crosscurrent Counseling & Psychotherapy will assist by submitting claims as a courtesy to the client, however the client is responsible for remaining balance after insurance is billed under all circumstances. Patient or guardian is responsible for any balance not covered by insurance(s) within 60 days. All balances left unpaid after 90 days from date of service will be turned over for collections.

Client or guardian *(circle)*:	
Signature:	
Date:	

CROSSCURRENT COUNSELING
& PSYCHOTHERAPY

Payment Method

All co-pays and out-of-pocket payments are due at time of service. Please check your preferred payment method below.

☐ CHECK Checks payable to Crosscurrent Counseling

☐ **CARD** No transaction fee

CREDIT CARD INFORMATION TO BE FILLED OUT BY CLIENT:

Name on Card: _____ Card Type: _____

Acct #: _____ Exp Date: _____ Security Code _____

Mailing address on account: _____

_____ Home phone__ _____

Check one:

☐ I authorize Crosscurrent Counseling to charge my account balance in full ONLY on each date I have provided my signature above.

☐ **I wish leave my card information "on file" with Crosscurrent Counseling (and its contracted billing administrator) so that my card may be charged in accordance my service agreement to include late policy, cancellation policy, and "other services" charges.**

Authorized Signature _____Date _____

KATE HERMANSON, LPC, NCC
CROSSCURRENT COUNSELING
& PSYCHOTHERAPY

www.crosscurrentcounseling.com
counseling.billing@gmail.com
757-478-5524

CROSSCURRENT COUNSELING
& PSYCHOTHERAPY

Client Medical Treatment Information

Client Name _____Date_____

Primary Care Physician	**Other physicians:**
Name: _____	Name/Phone:_____
Address: _____	Name/Phone:_____
Phone: _____	Name/Phone:_____

List any health problems for which you have recently received or are currently received treatment:

_____
_____
_____

List any medical hospitalizations :

_____
_____
_____

History of significant illness or injury:

_____
_____
_____

List all medications that you are currently taking (OTC and prescription):

_____ _____
_____ _____
_____ _____

History of head trauma? (Circle one) YES NO
If yes, please explain:

_____
_____

Are you pregnant? YES NO

History of tobacco use (please circle all that apply): cigarettes cigars pipe chewing other
Are you **currently** using any of the above items that you circled? YES NO

Is there anything else we need to know about your medical history? Please use the back of this form if necessary.

_____
_____

CROSSCURRENT COUNSELING & PSYCHOTHERAPY

Client Name _____

Please place a mark next to the symptoms that fit your recent experience.

Unhappiness Depressed mood Frequent crying/tearfulness Low energy Difficulty concentrating Indecisiveness Hopelessness Worthlessness Poor appetite Overeating sleeping too much Unable to go to sleep Unable to stay asleep Lack of interest/pleasure in activities (including sex) Loneliness	Often interrupts others Difficulty sustaining attention Procrastination Easily distracted Impulsivity Inability to concentrate Unable to be still Inability to focus Difficulty organizing Starts but doesn't finish task Indecisiveness Bedwetting Fire setting Stealing Physical fights
Suicidal thoughts Suicidal attempts Homicidal thoughts Homicidal attempts Self-destructive behavior including cutting, burning oneself	Argumentative Destruction of property Nightmares Obsessive thoughts Withdrawal from friendships Decrease in socialization
Excessive worrying Fearful of_____ Panic attacks Racing /pounding heart Hot flushes Shortness of breath Trembling Headaches Stomachaches Feeling like you are going crazy	Hypervigilence Easily startled Memory problems Flashbacks Intrusive memories Numbness Inability to have loving feelings Feeling detached from oneself Compulsive behavior Poor impulse control
Racing thoughts Agitation Decreased need to sleep Outbursts of anger Feeling on top of the world Increased energy Poor judgment Sexual indiscretions Bad business ventures Buying sprees Activities with potential for harm Not doing homework or assigned tasks Late for school or work	Difficulty with any of the following: caring for children cleaning the house cooking meals driving the car running errands functioning at work functioning at school performing personal hygiene/dressing self eating properly taking medications as prescribed exercising getting out of bed

_____

Date

Client Name _____

Using the rating scale described below, please evaluate your use of the substances listed on the lower part of the page or the impact of a given substance on your life.

Rating Scale

10 = Have never used or considered using this substance; no impact on my life
9 = No negative impact on my life
8 = Very little negative impact on my life
7 = Slight negative impact on my life
6 = Moderate negative impact on my life
5 = Significant negative impact on my life
4 = Some people say this is causing me major problems
3 = Interferes with my daily functioning or health
2 = Use daily; sometimes poses a danger to me or to the welfare of others
1 = Use almost continuously; poses a constant danger to me or to the welfare of others

Types of Substances Used

	Smoking cigarettes		Sniffing glue or other inhalants
	Chewing tobacco		Taking speed or another stimulant
	Smoking cigars		Using LSD or other hallucinogens
	Smoking pipes (tobacco)		Using PCP
	Drinking beer		Taking heroin or a similar narcotic
	Drinking wine		Using sedatives or tranquilizers
	Drinking hard liquor		Other:
	Smoking marijuana		Other:
	Using cocaine		Other:

FORM 6.13. Alcohol and Substance Use Questionnaire. From *Outcomes and Incomes* by Paul W. Clement.