2025 Intake/Update Forms

Client Information

Full Name: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Phone Number: _____

DOB: _____ Social Security Number: _____

Marital Status: S M W D Gender Identity: _____

Name of Guardian: _____ Guardian's DOB: _____

Guardian's Phone # _____ Guardianship/Documentation: Y or N

Insurance

Primary Insurance Company: _____

Address of Insurer: _____

Phone Number of Insurance Company: _____

Member ID #: _____ Group #: _____

Group Name: _____

Responsible Party: _____DOB: _____

Relationship to client: _____SSN: _____

Secondary Insurance Company: _____

Address of Insurer: _____

Phone Number of Insurance Company: _____

Member ID #: _____ Group #: _____

Group Name: _____

Responsible Party: _____DOB: _____

Relationship to client: _____SSN: _____

Consent for Treatment

I voluntarily agree to receive mental health assessment, care, treatment or services and authorize my therapist to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment, or services that I receive through Searching 4 Life's Missing Pieces, LLC at any time. I also understand that there are no guarantees that treatment will be successful. By signing this Informed Consent to treat, I the undersigned client acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything that is unclear.

Client/Guardian Signature: _____ **Date:** _____

Acknowledgement of Informed Consent for Technology-Assisted Counseling

I have read and agree to the terms listed above in the informed Consent. I understand that psychotherapy treatment will be considered to take place in the State of Ohio (USA). I understand that telephone/online psychotherapy is not a substitute for medication management under the care of a psychiatrist, psychiatric nurse practitioner, or doctor. I understand that online and telephone therapy is not appropriate if I am experiencing a crisis of having suicidal or homicidal thoughts. In case of emergency situations, I will contact the resources listed in Section H above. I understand my signature is an agreement for psychotherapy services conducted with Searching 4 Life's Missing Pieces, LLC.

Client/Guardian Signature: _____ Date: _____

Authorization to Warn or Inform Third Parties

If my therapist reasonably believes that I am a danger, physically or emotionally, to myself or another person, by signing this informed consent, I specifically consent for the therapist to attempt to warn the person in danger and to attempt to contact any person in a position to prevent harm to myself or another person, in addition to medical and law enforcement personnel, and the following persons.

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Notice of Privacy Practices

I hereby acknowledge that I have received and was given an opportunity to read a copy of Searching 4 Life's Missing Pieces, LLC 4 Life's Missing Pieces' Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact my therapist at s4lmpllc@gmail.com or at 937-469-8145.

Client/Guardian Signature: _____ Date: _____

Client Acknowledgement of Statement of Fees

I hereby acknowledge that I have read the Statement of Fees. I acknowledge that **I am personally responsible** for the fees charged for receiving services at Searching 4 Life's Missing Pieces, LLC 4 Life's Missing Pieces**. I understand that insurance claims are submitted only as a service. I also understand that I must give a 24-hour notice of cancellation or a fee of $45 will be charged to my credit card for failing to attend an appointment that I have made.**

Client/Guardian Signature: _____ Date: _____

Credit Card Guarantee

Searching 4 Life's Missing Pieces, LLC 4 Life's Missing Pieces requires a credit card guarantee for your account. Permission to Bill Credit Card

I am voluntarily offering this credit card guarantee if my managed care or insurance company denies my claim, or if I neglect to pay my co-payments, or for any other reason payment for services is not made. I am authorizing Searching 4 Life's Missing Pieces, LLC to bill my credit card for any outstanding balance.

Card Type: □ **Master Card** □ **Visa** □ **American Express** □ **Discover** □ **Other**

Name on Card: _____

Card Number: _____

Expiration Date: _____ CVV Security Code: _____

Authorization to Release Information

□ Assessment
□ Continuing Care Plan
□ Current Treatment Plan
□ Current Treatment Update
□ Diagnosis
□ Discharge/Transfer Summary
□ Presence/Participation in Treatment
□ Progress in Treatment
□ Psychosocial Evaluation

I authorize Searching 4 Life's Missing Pieces, LLC. To release/receive the files listed above **to/from the following office:**

Name: _____

Address: _____

Specialty: _____

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment, and when appropriate, coordinate treatment services.

I understand that I have a right to revoke this authorization, in writing at any time by sending a request to s4lmpllc@gmail.com. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

I further understand that Searching 4 Life's Missing Pieces, LLC. will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

- Searching 4 Life's Missing Pieces, LLC. reserves the right to disclose information as permitted in this authorization in a manner we deem to be appropriate and consistent with applicable law, including, but not limited to verbally, in paper format, or electronically.
- Federal law prohibits the person or organization to whom disclosure is made from making further disclosure of information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42C.F.R Part 2.

Client/Guardian Printed Name: _____

Client/Guardian Signature: _____ Date: _____