Adult Intake Form

Alexander J. Muzichuk, M.A., PLPC
- ✓ Individual Counseling
  Children • Adolescents • Adults
- ✓ **Marriage & Family Counseling**

Date:_____ Name:_____

Date of Birth:_____ Age:_____ Gender:_____

Address:_____

City:_____State:_____Zipcode:_____

Home Phone:_____ Work Phone:_____

Email:_____

Occupation:_____ SS#:_____

Education:_____ Marital Status:_____

Spouse/Partner's Name:_____ Age:_____

List Children (name and age): _____
_____
_____

Other Significant People in your Life: _____
_____
_____

Name of Medical Doctor:_____

Indicate any Health Problems: _____
_____

Medications Taking:_____

Previous Therapy? When and Where? _____
_____

Previous Psychological Evaluation? _____

Do you have a Current or Past Mental Health Diagnosis? _____
_____

Fee and Payment Information

Fees for services are due and payable on the day of service unless other arrangements are made prior to the time of service. Cash, credit card, and checks are accepted. Insurance plans are accepted on case-by-case bases. Clients should consult their insurance provider for information regarding co-payment, deductible, and number of authorized sessions. Regardless of what an insurance company states to this office or you about payment for services, this is not a guarantee of payment for services. You are still responsible for full payment for counseling services even if an insurance company states they will pay and do not. A copy of the insurance card should be on file with this office. The average session time lasts 45-50 minutes. The standard fee per session is $90.00. Certain financial brackets may enable a sliding fee scale. A sliding fee application must be completed and proof of income must be on file to qualify for sliding fee scale.

Medicaid
Name on Medicaid Card:_____

Medicaid Number:_____ Birth Date:_____

Private Insurance
Name of Responsible Party on Insurance Card:_____

Card Holder Social Security #_____Client SS#_____

Insurance Company/Plan:_____

Individual #_____ Group #_____

Insurance Company Billing Address & Phone Number: _____
_____
_____
_____
_____

Court Related Records, Testimony, and Appearance

If the therapist is requested or subpoenaed at any point in time to appear in court or participate in court related activities, the client will be responsible for payment reimbursement of the therapist's time which will be billed at the normal office session rate of $90.00 per hour. Travel time spent to and from court or other venues related to court activities will be considered part of the hourly time billed. If records or documents are requested or subpoenaed, a reasonable fee will be charged for providing a copy of your records or a summary of those records which would include cost of copying, postage, and preparation or an explanation or summary of the information.

I have read and understood the above related fee payment information and court related information and agree to the terms defined by this office.

_____	_____	_____
Client Name	Client/Guardian Signature	Date