Hope4Family

Christian Counseling
Hope and Help in Hard Times

Intake Packet

Date: _____

Client's name:_____
Address:_____
City:_____ State:____ Zip: _____ Phone:_____
DOB: _____Email Address_____ Cell phone:_____
Marital Status: ____Single ___ Married ____Widowed ___Legally Separated ____Divorced
Spouse/Significant Other's Name:_____

Employer:_____ Phone:_____
Address:_____
City: _____ State:_____ Zip:_____-_____

Parent/Legal Guardian, (if patient is a minor)

Mother:_____(reside in home?) ☐Yes ☐No
Father: _____(reside in home?) ☐Yes ☐No
If no, please list address & phone below:

Mother's Address:_____
City:_____ State:_____ Zip:_____ Phone:_____
Father's Address:_____
City:_____ State:_____ Zip:_____ Phone:_____
Others in Home:

Name:_____ DOB:_____ Relationship:_____

Name:_____ DOB:_____ Relationship:_____

Name:_____ DOB:_____ Relationship:_____

Name:_____ DOB:_____ Relationship:_____

Name:_____ DOB:_____ Relationship:_____

Emergency Contact: _____ Phone:_____
Address:_____

Who is Financially responsible for your Bill?_____
Please note that you are responsible for collecting court ordered payments from any ex-spouse(s), parents, etc., if they are not here to sign our financial agreement themselves. Payment is due at time of service unless other arrangements have been made in advance. Thank you.

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Consent for Treatment

As a client, your rights are guaranteed by the rules of good professional practice and by law.

You have the right:

1. To Psychological care and treatment.
2. To be advised about treatment choices and possible treatment outcomes.
3. To refuse treatment.
4. To privacy. Information about treatment is confidential and must not be released to anyone without prior written consent by you. There are, however, limits to privacy.

Limits to privacy include:

A. If you report abuse and/or neglect of a child, or if we suspect abuse, we are required and will notify authorities.

B. If you report abuse or neglect of the elderly, or if we suspect abuse, we are required and will notify authorities.

C. If you threaten to harm someone else, we are to warn the person who is in danger and report possible danger to the police.

D. If you threaten to harm yourself, we may intervene with emergency measures and/or require that you be hospitalized until treatment can be continued in a less restrictive setting.

E. The court can obtain your clinical records with a court order.

F. Ex-spouses have the right to review their child's records unless those rights have been terminated by the court.

G. All clinical records will be shredded 5 years from the date of the last session, or, in the case of a minor, 5 years after he/she turns 18.

H. For security reasons, in common areas and therapy office may be video recorded. This does not include audio recording.

Please question us if you don't understand or disagree with any condition(s) of our policy or our consent to treatment statements. Therapy is an important process and the relationship with your therapist is critical. We want to encourage and develop strong, open and caring relationships.

I give permission to Tony Wildey MFT to treat_____

_____ _____

Client (or guardian if client is a minor) Date

Please initial on the correct line if you approve the following, if applicable.

I give Tony Wildey MFT permission to thank whomever referred me to this organization. ☐ Yes ☐ No

I give Tony Wildey MFT permission to send correspondence such as billing, greeting cards, etc to my mailing address listed in this intake packet ☐ Yes ☐ No

I give Tony Wildey MFT permission to send correspondence via email such as billing. ☐ Yes ☐ No

I give Tony Wildey MFT permission to contact me by telephone; at my home ☐ Yes ☐ No;
at work ☐ Yes ☐ No; or leave messages on my answering machine/cell phone ☐ Yes ☐ No.

My numbers are listed correctly on this form to discuss billing and scheduling matters ☐ Yes ☐ No

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Payment Agreement

You are required to read, initial and sign this form prior to any treatment

Thank you for choosing us as your mental health provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy.

1.Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you only. We will provide you with an itemized receipt that you may submit to your insurance company for reimbursement.

2. Fees for services are due at the time of treatment.

3. Before we can allow any release of information about you we need a signed release of information form to be in your file.

4. We require a signed payment agreement between ourselves and the client or client's legal guardian (If client is a minor).

5. Payments will be made to Tony Wildey MFT at PayPal to tony@hope4family.com.

Missed Appointments

Please note that unless your appointment is cancelled at least 24 hours in advance, you will be charged for your appointment at the full rate. So in order to avoid payment for missed appointments, please contact Mr. Wildey prior to your appointment by at lease 24 hours.

Payment Agreement

Initial intake and assessment	$_____	Your initials_____
Each 45-50 minute session	$_____	Your initials_____
Gross Annual Income	$_____	Your initials_____
Adjusted Fee (sliding scale)	$_____	Your initials_____
Group Fee	$_____	Your initials_____

I have read and understand the financial policy and agree to these terms.

_____

_____ _____

Signature of Client or Guardian Date