AmberCreek Counseling & Recovery Services

Intake Information

Name: ______________________________ Date of Birth: _______________

Sex: ☐M ☐F Gender Identity: __________________

Marital Status: ☐Single ☐Married ☐Domestic Partnership
☐Separated ☐Divorced ☐Widowed

(If minor, please put parent/guardian information)

Phone Number: ____________________________ Texts ok? _____________

Address: ____

Email: ___________________________________ Email ok? ______________

Name of parent/guardian: ___________________________________

If you are having your child(ren) seen, do you have:

☐Joint Legal Custody ☐Sole Legal Custody

Primary Insurance

Company: ____

Primary Insured: ___________________ Date of Birth: ______________

Policy Number: ________________ Group Number: _________________

Do you have secondary insurance?: ☐Y ☐N

Emergency Contact: ____

Phone: __________________ Relationship: _________________________

AmberCreek Counseling & Recovery Services

Billing Policies and Financial Agreement

AmberCreek Counseling & Recovery Services requires payment of either a session fee, co-pay, or co-insurance at time of service. All fees are due at the beginning of each session. The client is always responsible for payment of costs incurred for services regardless of benefits. This means that if a claim from this office is denied, you are responsible for paying the remaining balance of the bill.

Initial________

AmberCreek offers a sliding fee scale/payment plan. Please inquire about this prior to your session so we can take care of all business before your session.

Initial________

Our fees are as follows: Individual Evaluation session $160.00; individual, couple, and family therapy- $120.00; Group therapy - $50.00. If you are using insurance, we may have a contract with your insurance and accept a different fee.

Initial_______

You must cancel at least 24 hours before the appointment. If you do not cancel more than 24 hours in advance, you will be responsible for a $65 fee prior to your next session.

Initial_______

Telephone consultations over 10 minutes are billed at $30.00 per 15-minute interval.

Initial_______

Written reports for attorneys, doctors, courts, Child Protective Services, etc. are billed at a rate of $30.00 per 15-minute interval and must be requested a minimum 5 business days in advance.

Initial______

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Any returned checks will be $35.00 plus the session fee.

Initial_______

We understand that financial problems may occur, and if so, please discuss this with your therapist.

Initial_______

If your therapist is subpoenaed by the court, court testimony is charged at a rate of $250.00 per hour including: testimony, case research, report writing, travel, depositions, cross examination, and courtroom waiting time. Payment for court services is due prior to appearance. Signing this disclosure statement gives permission to release confidential information in courtroom testimony and written reports to the court if legally requested by the court.

Initial_______

___________________________________ ____________

Patient or Legal Guardian Signature Date

AmberCreek Counseling & Recovery Services

Informed Consent

Benefit Assignment & Records Release:

This signature authorizes AmberCreek Counseling and Recovery Services to release any information regarding my medical/psychological treatment to my insurance company for the purpose of insurance collection. This signature also authorizes payment of medical benefits to be paid directly to AmberCreek Counseling & Recovery Services and/or the individual therapist as appropriate.

_________________________________ ___________

Patient or Legal Guardian Signature Date

Confidentiality and Limitations:

1) The confidentiality of counseling is protected by law except for the following exceptions:
2) Any accounts of child abuse/neglect of a child less than 18 years of age.
3) Any situation in which someone is threatening themselves or others with physical harm. This would be reported to the police or to a relative.
4) Any account of abuse, neglect, or exploitation of senior citizens.
5) When client information is court ordered to be released.

For any of the above exceptions, AmberCreek Counseling and Recover Services will only reveal the information necessary to protect you or the person in danger, or to meet legal requirements.

I have read the policies and procedures, asked any necessary questions, and understand the terms of this consent. I understand my rights and responsibilities as a client and my therapists’ responsibilities to me. I agree to these conditions and consent to treatment.

_________________________________ ___________

Patient or Legal Guardian Signature Date