Today's Date: _________________

Client Information

Client Name (Last, First MI): ____

SS # : _______ - ____ - ________ Date of Birth: _____________________ Age: ______

Phone Number: ___________________________ Alternate Phone:__________________________

May we leave a message: Yes_____ No______Email:____

Address: ____

City: _________________________ State: _____________________ Zip: ____________________

Emergency Contact:

Name: _____________________________________ Relationship to Client: _______________________

Phone Number: ________________________

Address (if different from client): ____

City: _________________________ State: _____________________ Zip: ____________________

Parent/Guardian Information (if different from Emergency Contact):

Name: _____________________________________ Relationship to Client: _______________________

Date of Birth: __________________ Phone Number: ________________________

Address (if different from client): ____

City: _________________________ State: _____________________ Zip: ____________________

Employment Information (if applicable)

Name of Employer: ____

Address: ____Phone:_________________

City: _________________________ State: _____________________ Zip: ____________________

Employed: Full Time ________ Part Time _______ Shift: Day _______ Night ______ Varied ________

Insurance Information

Type of Insurance:____

Employer:____

Name of Subscriber (please indicate if same as client):________________________DOB_______________

Relationship to Client:____

Education Information

Please list highest level of school you have attended (High School, College, Job Training, etc.)

Name of School   Years Attended   Area of Study   Graduation/Completion date

____

Military Service

Have you ever served in the military: Yes _________ No________

If so, please list what branch you served in, how long you served and when/why you were discharged:____
____
____
____
____

Medical Information

Primary Care Physician: ____ Phone: ______________________

Current Medications (Please include all prescription and over the counter medications along with the dose and frequency you take them):

____
____
____
____
____
____
____

Do you use recreational drugs? Yes ______ No ______

If so, which ones? ____

Please list any Major Illnesses, Injuries or Surgeries: ____

____
____
____

Please list any Allergies (especially to medications): ____

____
____

Please list any previous Mental Health or Substance Abuse Providers:

Name Dates Seen (ex: 2001 – 2004) Reason for seeing them

____
____
____
____
____

Is there any family history of Mental Health or Substance Abuse: Yes ______ No _______

If so, what were they? ____

____
____

Have you ever been hospitalized for Mental Health or Substance Abuse? Yes ______ No_______

If so, What for? ____

____
____

Pharmacy (Where do you want medication orders to be sent?):

Name of Pharmacy: ____

Address:_____________________________City _________________State_____Zip_______________

Phone:___________________________ Fax:______________________

Statements of Understanding

Consent to Contact: In order to evaluate our services may we have permission to contact you once you have completed your services with us with the understanding your responses will be held confidential?

Client (if 12 and older) Initials___________ Guardian Initials ____________

Referrals: I understand that it is my responsibility to obtain a referral when required by my insurance company. If I do not have a referral in place at the time of service I will be responsible for the entire fee for the services provided.

Client (if 12 and older) Initials___________ Guardian Initials ____________

Payment: I understand that full payment is expected at the time of each appointment (including co-payments, self-pay fees, no-call-no-show/cancelation fee, etc.)

Client (if 12 and older) Initials___________ Guardian Initials ____________

Medical Marijuana: I understand that Aspen will NOT prescribe Medical Marijuana.

Client (if 12 and older) Initials___________ Guardian Initials ____________

Insurance: I give my consent for Aspen Counseling to communicate with my insurance company (s) for the purpose of facilitating insurance billing and reimbursement (if applicable).

Client (if 12 and older) Initials___________ Guardian Initials ____________

If a client is a minor: I give my permission for this minor child to receive services without a parent or guardian present.

Client (if 12 and older) Initials___________ Guardian Initials ____________

Appointment Cancellations: All appointments require 24 hour notification if they need to be cancelled and rescheduled. This allows us to help ensure that other clients who may require quicker access are afforded the opportunity to see their provider as well. Failure to notify Aspen staff within this time frame will result in a no-show charge of $75.00 that must be paid prior to any new appointment being scheduled.

Client (if 12 and older) Initials___________ Guardian Initials ____________

Attendance Policy: We understand that life circumstances arise and wish to continue a productive relationship with you. This requires consistent attendance at all scheduled appointments. If you have more than one (1) no-show / no-call with less than 24 hours' notice in a three month period we will provide you with referrals and close your case to our center.

Client (if 12 and older) Initials___________ Guardian Initials ____________

Rights and Consent to Treatment: I understand that counseling is based on my attending regularly scheduled counseling appointments and talking openly with my counselor. I realize I may encounter troubling emotions in the course of my counseling. Although counseling is usually a beneficial process, I understand that there can be no guarantees concerning the outcome of treatment or the achievement of specific goals. However, I can expect to be heard and accepted as a human being of value and worth. I give my consent to the counselor to provide appropriate treatment (to me or to the minor for whom I am parent/guardian) in an ethical and professional manner. In the event of a mandated referral for services I understand that my initial attendance at this session may be verified to the appropriate representative but that any involvement past that point will require a release of information. I further understand that I must notify Aspen Counseling no less than 24 hours in advance of my scheduled appointment should I be unable to keep said appointment. I understand that if I fail more than one time to comply with this policy regarding my inability to attend a scheduled appointment I will be charged for the appointment based on the current Aspen fee schedule.

Client (12 and Older) Signature/Date:____

Guardian Signature/Date:____

I have read and understood this information: To the best of my knowledge the information provided above is correct and complete. I have read the Aspen Counseling's Notice of Privacy Practices Policies, and have read and signed the Consent to Use and Disclose Your Health Information Form. I also have read the Rights and Consent to Treatment as stated above. I understand that my counselor and I will arrive at a mutually agreeable treatment plan and an estimate of the probable duration of my counseling.

____
Client (12 and older) Signature

____
Counselor Signature

____
Client (12 and older) Printed Name

____
Counselor Printed Name

____
Date

____
Date

____
Guardian Signature

____
Guardian Printed Name

____
Date