PRO-ACT

Client Intake Information

Client's Name (First MI Last) _____ Sex: M F Age _____

Spouse (if married) or Guardian Name_____Age _____

NOTE: CUSTODY PAPERS MUST BE PROVIDED FOR CHILD OF DIVORCED OR UNWED PARENTS

CLIENT INFORMATION:

Address (Street): _____ (City) _____ (ZIP) _____

Phone Numbers/e-mail: **(only include those that we have permission to call or leave a voice/email/text message):**

Home _____ Work _____ Cell _____

E-mail _____(for appointment reminder only)

Date of Birth _____ Marital Status _____ Date of Marriage _____

Client Social Security # _____ Occupation_____

How did you find out about PRO-ACT? _____

Religious Orientation _____Church Affiliation _____

Please make a simple statement regarding your reason for seeking counseling: _____

_____

Family Members living at home

Name: _____ Age _____ Birth-date _____ Relationship to client _____

_____

_____

_____

Insurance Information:

Policy Holder Name: _____ **Policy Holder Date of Birth:** _____

Insurance Company:_____ **Policy Holder SS #:** _____ _____

Mental Health Insurance Carrier: _____ **Mental Health Telephone #** _____

ID # : _____ **Telephone # :** _____

Group # : _____ **Insured's Employer:** _____

**********OR********

EAP (Employee Assistance Program) Information:

EAP Company: _ _____ **Phone Number:** _____

Authorization # _____ **Number of sessions:** _____

Medical/Health Information:

In Case of emergency you may call _____ Phone # _____Relationship _____

Personal Physician: _____ Phone # _____

Date of last physical: _____ Major illnesses/conditions _____

Previous Counseling: Yes No If yes, when and with whom _____

Medications you are currently taking? _____

The undersigned authorizes the release of all client information by the therapist for the purpose of pre-certification for treatment and concurrent review, to medical review agencies and/or third party payers providing coverage. Such disclosures are limited to information that is reasonably necessary for treatment planning. Also, that you authorize permission for treatment.

_____ _____

Client/Guardian Signature **Date**

PRO-ACT

2601 PASADENA BLVD, PASADENA, TX 77502

CREDIT CARD ON FILE AUTHORIZATION FORM

This form is for you to supply Professional Assessment Counseling & Training, LLC (Pro-Act Counseling) with credit card information to keep on file for the payment of **no-show and/or late cancellation fees only ($50)**. Your credit card information is **not kept on file in this office**. It is kept electronically in encrypted software and will remain on file until the expiration date. ***This page will be destroyed upon completion.

Card Information:

Card Type (Circle): Visa / MasterCard / Discover / AmEx

Name on Card: _____

Card Number: _____

Expiration Date: _____

CVV Code: _____

Cardholder Signature: _____

AUTHORIZATION:

I understand that the credit card information given will ONLY be charged if I no-show or cancel my appointment without 24 hours' notice. It will not be used at any other time unless requested by the cardholder. Insurance companies cannot be billed for these charges. Clients may revoke this credit card by submitting a written request to the address above. A new form must be submitted if any information changes. Applicant agrees to pay the cost for any returned or challenged payments. A new form must be completed for each card kept on file.

Cardholder Signature: _____

Date: _____

Statement of Understanding

I have read and understand the Pro-Act Notice of Privacy Practices, Consumer Rights and Responsibility, the Policies and Procedures, Communication Notice, Consent for Release of Information, Payment and Healthcare Operations and the Consent for Treatment forms. I understand that the above information is available online at www.pro-act.com under the Intake Forms Tab. I acknowledge that at any time, I can contact my therapist with questions about the above information.

Printed Name: _____

Signature: _____

Date: _____