GENESIS COUNSELING GROUP, S.C.
890 Elm Grove Rd. Suite-205 Elm Grove, WI 53122 (262) 780-0991

Date:_____

INITIAL INTERVIEW FORM

CLIENT INFORMATION:

NAME: _____
PHONE: {W}_____ {H} _____ {Cell} _____
ADDRESS:_____ CITY:_____ ZIP: _____
SEX: Male _____ Female _____ SS#.:_____
DATE OF BIRTH: _____
OTHERS LIVING AT HOME: _____
EMPLOYER: _____
POSITION/TITLE: _____
HOW LONG HAVE YOU WORKED THERE: _____
EDUCATION: _____
PRIMARY PHYSICIAN: _____
LIST ANY SIGNIFICANT HEALTH PROBLEMS: _____
_____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING & THE DOSAGE:_____
_____

HAVE YOU BEEN IN THERAPY BEFORE? YES_____ NO_____
IF YES, WHEN:_____
NAME OF THERAPIST: _____
GIVE BRIEF DESCRIPTION OF ISSUES WORKED ON:_____
_____
_____

REFERRED BY: (therapist, physician, church, friend, etc.}:_____
CAN WE THANK THEM FOR THE REFERRAL? Y___ N___
NEAREST RELATIVE OTHER THAN SPOUSE:_____
PHONE: _____ RELATIONSHIP TO YOU: _____

PERSON FINANCIALLY RESPONSIBLE: {policy holder}

NAME: _____ RELATIONSHIP TO CLIENT: _____
ADDRESS: _____ZIP: _____
PHONE: {w} _____ {H} _____
SOCIAL SECURITY NUMBER: _____ D.O.B.:_____
EMPLOYER: _____
INSURANCE CARRIER: _____
GROUP: _____ MEMBER or SUBSCRIBER #: _____
PHONE # OF INSURANCE CO.:_____

CONFIDENTIALITY AGREEMENT:
All information shared in session is confidential except in circumstances governed by the laws including the mandatory reporting of alleged harm to self or harm to others, particularly in the case of a child.

GENESIS COUNSELING GROUP.S.C.

CLIENT FEE AGREEMENT & PAYMENT POLICY

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Client Name: _____ Date: _____

Responsible Party: _____ Relationship to Client: _____

FEE PER SESSION

Initial Evaluation/Session	$205.00
Individual	$175.00
Couples	"
Family	"
Group	
Psychological Evaluation/Testing	
Medication management: Initial Psychiatric Evaluation Medication Management	 $225.00 $130.00

{CHECK ALL THAT APPLY}

_____ I have health insurance coverage for services at Genesis Counseling Group, S.C.

_____ I understand that GCG cannot guarantee payment by my insurance carrier and I agree to pay for any unpaid balance including the insurance plans deductible and co-pay portion **at the time of service**.

_____ I do not have health insurance coverage for services at Genesis Counseling Group, S.C. I agree to pay the fee(s) as listed on this agreement at the time of service.

_____ **I understand that I will assume full responsibility to pay my bill if it is not covered by insurance.**

_____ I have read and understand Genesis Counseling Groups' fee agreement and payment policy.

*The Genesis Counseling Group, S.C. reserves the right to charge the full fee for missed appointments or late cancellations. A cancellation within **24 hours** is necessary to avoid late charges except for illness or emergency.

** THE G.C.G. SUGGESTS YOU REVIEW YOUR INSURANCE BENEFITS MANUAL AND CALL YOUR INSURANCE CARRIER TO CLARIFY YOUR COVERAGE WITH G.C.G.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Provider to release any information acquired in the course of treatment to the insurance carrier.

_____

Signature Date

ASSIGNMENT OF BENEFITS: I hereby authorize payment of benefits directly to the undersigned Provider for the services described herein.

_____

Signature Date

_____ _____

Client Signature: Date: Staff Signature: Date:
{parent or guardian if minor}