Flourish Counseling Group

6202 Constitution Dr. Suite B

Fort Wayne, IN 46804

(260) 627-9794

Dear Future Client,

,

Thank you for choosing to consult with Flourish Counseling, Group. I am looking forward to meeting with you.

Your appointment date is _____.
Please complete the enclosed forms and bring them with you to your appointment.

What to expect when you come for your session:

1. Please have a seat in the waiting room and be assured that I will be with you shortly.
2. During our initial meeting, we will discuss information to help me understand your needs. This is also your time to ask questions and determine if this is a fit for you.
3. Phone calls are answered by the voice mail system. Please feel free to leave a message.

Again, I am looking forward to meeting. However, if questions arise prior to our first meeting, please contact me at (260) 627-9794.

Sincerely,

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CLIENT INFORMATION

Name _____ DOB _____

Address _____ _____ City _____ State _____ Zip _____

Phone Number _____ Alt. Number _____

Employer/School _____

If Child, Father's Name _____Mother's Name _____
Non-custodial parent and address, if applicable _____
_____

Family Physician _____ Telephone Number _____

Medications
_____
_____

Emergency Contact _____ Telephone Number _____

Concerns _____

INSURANCE INFORMATION

Insured's Name _____ DOB _____ Relationship to Client_____

Address _____ City _____ State ____ Zip _____

Telephone _____ Employer Name _____

Name of Insurance Company _____ Ins. Telephone _____

ID Number/SS Number _____ Group Number _____

Please read, sign, and date. This will allow our office to submit insurance claims without your signature on every form.

_____ _____

Signature of client/authorized person **Date**

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PAYMENT INFORMATION

Name of Cardholder _____ Credit Card Type _____ Zip Code _____
Credit Card Number _____ Expiration Date _____ 3 Digit Code ____

I hereby give permission to Flourish Counseling LLC to use the following credit card to make payments on my account for the duration of my counseling.

I understand that if using insurance for payment of services, I am subject to the provisions of the insurance and agree to pay any required co-insurance, co-pay, or deductible.

I understand that by giving permission for the use of my credit card, a fee of $125 will be charged to my card if 24 hour notification to change or cancel an appointment is not made. This fee is NOT REIMBURSABLE by insurance and I am held responsible for the payment in full.

This authorization may be canceled, in writing, at any time.

_____ _____

Signature of Cardholder **Date**

RESPONSIBILITY INFORMATION

I understand that the above information is considered confidential and will not be shared with any outside entities or persons, except for the making of a payment on my account or insurance claims. This information will remain on file through the duration of counseling.

I understand I am responsible to keep this information current and to monitor my insurance and credit card charges.

I am responsible for all financial obligations of mental health services, including failed appointments, for myself or the above minor child and for reimbursement and payment of claims from my insurance company. If, for any reason, the account should become delinquent, I agree to pay for all the re-billing charges, collection costs, court costs, and reasonable legal fees.

_____ _____

Signature of Client or Responsible party **Date**

I authorize Flourish Counseling Staff to administer evaluation and/or subsequent counseling treatment for myself and/or child, for whom I am legally responsible.

_____ _____

Signature of client or Responsibly Party **Date**

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Appointments

Each session is 53-55 minutes in length. Charges for longer sessions will be prorated.

Confidentiality

All communication between the client and therapist will be held in complete confidence in accordance with legal and ethical standards.
Release of Information will be necessary to authorize any information to be shared with another person or entity, outside legally subpoenaed information.

Fees

Payment is expected at TIME OF SERVICE and is the responsibility of the client. Insurance is filed as a COURTSEY and it is the client's responsibility to know the amount you are responsible for paying. FULL PAYMENT will be expect on first appointment unless client supplies paperwork with details of insurance payments.
Initial Intake - $185
Additional Sessions - $135
5 Session Package - $550
Paperwork - $30/hour
Court Appearances - $200 minimum (for 2 hours)
$100/hour for each additional hour
Outside Session Coordination - $100/hour

Payment

Payment required at the time of each session.

Outstanding Balances

Past due accounts will be charged to the credit card on file. If the card is not active or has been terminated, the account will be forwarded to collection services.

Cancellation/Rescheduling Appointments

If you are unable to keep a scheduled appointment, a notice of 24 hours is required.
If you do not show for an appointment, or cancel in less than 24 hours, $125 charge will be placed on your account. This charge must be paid BEFORE rescheduling of your appointment will take place.

Psychiatric, Medical, or Psychological Testing Consultation

In some cases, the therapist may request that you or your child receive a psychiatric/medical consultation or psychological testing. These procedures are not included in the therapy fee and take place OUTSIDE the therapy office.

Telephone Messages

The phones are answered with confidential voice mail system. Please leave your message.

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SYMPTOM CHECKLIST

Please check any symptom that you have been experiencing in the last 30 days.

Cognitive Symptoms:

___ Memory problems
___ Inability to concentrate
___ Poor judgment
___ Seeing only the negative
___ Anxious or racing thoughts
___ Constant worrying

Emotional Symptoms:

___ Moodiness
___ Irritability or short temper
___ Agitation, inability to relax
___ Feeling overwhelmed
___ Sense of loneliness and isolation
___ Depression or general unhappiness

Physical Symptoms:

___ Aches and pains
___ Diarrhea or constipation
___ Nausea, dizziness
___ Chest pain, rapid heartbeat
___ Loss of sex drive
___ Frequent colds

Behavioral Symptoms:

___ Eating more or less
___ Sleeping too much or too little
___ Isolating yourself from others
___ Procrastinating (neglecting responsibility)
___ Using alcohol, cigarettes or drugs to relax
___ Nervous habits (nail biting, pacing)

Use the space below to explain issues surrounding any of the symptoms checked above or if they were conditions you have been experiencing longer than 30 days.

_____
_____
_____
_____
_____
_____
_____

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GOALS

Please fill in the goals that you are wanting to work on in your therapy sessions.

1. **GOAL** _____
2. **GOAL** _____
3. **GOAL** _____