

Problem or Stress Information:

What are you experiencing and/or what has happened to cause you to seek counseling?

Have you received previous counseling? Yes ___ No ___ Name of counselor(s) and date(s) _____

General Health Information:

Names of primary care physician/other physician(s) or specialist(s) _____

_____ Date of last physical exam _____

Medications presently taking _____

Known allergies/adverse reactions _____

Dates of surgical/invasive procedures _____

If your insurance company requires me to do the filing, please (1) sign the following authorization statement, (2) provide me with a copy of your insurance card, and (3) call your insurance company and obtain this information: (a) will they pay for you to see me? (b) your copay amount, or (c) your deductible amount, how much of your deductible has been met this benefit year, how much you are required to pay per visit, (d) how many visits are you allowed.

I authorize insurance payment of medical benefits to Jeanine Siler Jones, L.C.S.W., for counseling services. I further authorize the release of medical or other information necessary to process an insurance claim.

Signature _____ Date _____

Please complete the following or we can make a copy of your insurance card.

Name and Address of Insurance Company _____

Policy Holder: Self ___ Spouse ___ Parent ___ Policy # _____ Group # _____

Is there other insurance? Yes ___ No ___ Company _____ Policy # _____

Who will be responsible for the bill? _____ Relationship to the client _____

Any special circumstances you wish to make us aware of? _____

I agree to counseling by Jeanine Siler Jones, LCSW, who is licensed by the state to provide counseling for persons with individual, marital, or family problems. I am aware that Jeanine Siler Jones, LCSW does not provide medical or legal assistance or psychological testing.

I agree to payment of fees at each session by check or cash. **I agree to change or cancel appointments with a twenty-four (24) hour notice, or else pay for the missed appointment.**

I understand that the information shared by either the counselor or the counselee is confidential and cannot be release to anyone without written consent except under the following conditions provided by the law:

- Imminent Danger--the law states that if we judge that you are a danger to yourself or others, we are required to take action to prevent harm from occurring to you or to others.
- Child abuse--we are required, by law, to report all cases of actual or suspected physical, emotional, or sexual abuse or neglect of children to the Department of Social Services.

Signature _____ Date _____