Aspen Counseling Services, PLLC
ADULT INTAKE FORM

Date: _____

Client Name: _____ Gender: Male____ Female _____

Address: _____ DOB: ___/ ___/ _____ Age: _____

City/State: _____ Zip Code: _____ Contact Phone: _____

Email Address: _____ Appointment Reminders: Yes or No

Employment Status: Student: ____Employed: ____ Unemployed:____Homemaker:_____ Retired:_____

Employer: _____ SSN: _____

Occupation: _____ Business Ph: _____

Marital Status: (Circle one) Single Married Separated Divorced Widowed Other

Number of children: _____

Spouses Name: _____ DOB:_____ Age: _____

Spouses Employer: _____ SSN: _____

Spouses Occupation: _____ Contact Ph: _____

Insurance Information *(Please fill out)*

Employee Assistance Program (EAP) Yes____No _____ If yes, please list EAP name: _____

Authorization Number: _____ Number of Sessions: _____

Primary Insurance: _____ Member ID: _____ Group #: _____

Insured's Name: _____ DOB: _____ Gender: Male or Female

Secondary Insurance: _____ Member ID: _____ Group #: _____

Insured's Name: _____ DOB: _____ Gender: Male or Female

Number of Siblings: ____ What is your birth order position: _____ Highest Education Completed: _____

Primary Physician: _____ Phone Number: _____

May we contact your primary care Provider? No ____ Yes _____

If YES please sign *Release of Information Sheet*

What is your primary reason for seeking help? _____

_____

_____

_____

Previous Treatments (check all that apply):

Psychiatric: None____Outpatient ____ Inpatient____ Where _____ When _____
within last 12 months ____ One pr or admission _____ 2 or more admissions_____
Counseling: yes ____ No_____ Where:_____ When:_____

Current Symptom Checklist (check once for any symptom present):

Depressed Mood ____	Elevated Mood ____	Dissociative States ___
Decreased Energy ___	Irritable ____	Oppositional ___
Grief ___	Impulsivity ____	Somatic Complaints ___
Hopelessness ____	Hyperactivity ____	Emotional Trauma ____
Worthlessness _____	Disruption of Thought ____	Physical Trauma ____
Guilt ____	Memory problems ____	Sexual Trauma ____
Anxious ____	Delusions ____	Active Substance Abuse ___
Panic Attacks ____	Hallucinations ____	Other ____
Obsessions/Compulsions ____	Paranoia ____	Other ____

Risk Assessment (check all that apply):

Suicidal: Not Present ____ Ideation ____ Plan ____ Means ____ Prior Attempt ____ Date _____

Homicidal : Not Present ____ Ideation ____ Plan ____ Means ____ Prior Attempt ____ Date _____

Current Psychiatric Medications: Current medications and dosages

Family Mental Health History (Please put an X in the column)

	Mother	Father	Sibling	Other (List)
Anxiety				
Depression				
Bipolar Disorder				
Substance Abuse				
Other				

Patient Assessment Forms

NAME: _____ DATE: _____

GAD-7 (Please circle the number in each column)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half the Days	Nearly Every Day
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble Relaxing	0	1	2	3
Becoming so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful may happen	0	1	2	3

_____ + _____ + _____

For office coding: Total Score [ ]

The Patient Health questionnaire PHQ-9 (Please circle the number in each column)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half The Days	Nearly Every Day
Little interest or pleasure in doing things?	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself- or that you've let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or, the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

_____ + _____ + _____

For office coding: Total Score [ ]

ASPEN COUNSELING SERVICES

FINANCIAL AND SERVICE AGREEMENT

This Financial and Service Agreement outlines the terms and conditions for professional counseling services provided by Aspen Counseling Services. By signing below, the client agrees to the following:

1. **PAYMENT FOR SERVICES**
   Counseling services may be fully or partially covered by the Client's insurance plan. If the Client elects not to use insurance, they may request consideration under the Provider's sliding fee scale. Payment is accepted by cash, check, debit card, or credit card.
2. **LATE PAYMENTS**
   If any fees remain unpaid 30 days past the date of service and no payment plan has been established, interest will accrue at a rate of 1.5% per month on the overdue balance.
   If an account remains unpaid for more than 90 days without a payment arrangement, the Provider may submit the account to a collection agency. A collection fee of 25%–47% of the original overdue balance (before late fees and interest) may be added, depending on the standard rates of the collection agency used. In collection proceedings, the Provider will release only the minimum necessary information: the Client's name, the nature of services, and the amount owed.
3. **INSURANCE INFORMATION**
   If the Client wishes to submit claims to insurance, insurance details must be provided before services begin. As a courtesy, the Provider may contact the insurance company to verify benefits; however, all coverage decisions and determinations are made solely by the insurance carrier. The Client is financially responsible for all charges not covered by insurance.
4. **LEGAL PROCEEDINGS**
   Aspen Counseling Services does not conduct custody evaluations and does not provide custody recommendations or reports. Court testimony will not be provided unless legally required by subpoena. If the Client becomes involved in legal proceedings requiring Provider participation, the Client agrees to pay for all professional time, including situations in which the subpoena is issued by another party. A $2,500 retainer is required prior to any legal-related services. Professional time will be billed at $250 per hour for all legal matters, including but not limited to court appearances, consultations, attorney communication, and preparation of documents. Unused retainer funds will be refunded. If legal fees exceed the retainer, an additional retainer will be required.
5. **TREATMENT TERMINATION**
   Upon termination of services, all outstanding balances become immediately due and payable. The Client agrees to review this Agreement carefully and initial all applicable financial sections.
6. **CANCELLATION AND NO-SHOW POLICY**
   Once an appointment is scheduled, the Client will be responsible for the session fee unless cancellation is made at least 24 hours in advance, except in cases of emergency or circumstances beyond the Client's control as determined by the Provider. Insurance companies do not pay for missed or canceled appointments. A $100 fee will be charged directly to the Client for such appointments, and no insurance claim will be submitted.
7. **HIPAA ACKNOWLEDGMENT**
   By signing below, the Client acknowledges receipt of the Aspen Counseling Services HIPAA Notification and affirms understanding of all privacy rights applicable to themselves or their minor child.

_____ _____

SIGNATURE DATE

Aspen Counseling Services

PAYMENT OPTIONS

1. **INSURANCE (OUT-OF-NETWORK)**

If we will be filing with insurance but are not a participating provider in your insurance plan.

If you have insurance coverage and wish to use it, you should contact your insurance representative to obtain coverage information. The insurance contract is between the policy holder and insurance company, not between provider and insurer. We will assist you by submitting claims electronically for each session. The amount varies depending on your individual plan's deductible, co-pay, coinsurance, etc.

2. **INSURANCE (IN-NETWORK)**

If we are a participating provider in your insurance plan.

Fees are reimbursed at the Usual and Customary rate allowed by our contract with your insurance company. You are responsible for the co-payment which is expected at the time of service. Often, the amount is a percentage of the contracted fee. This percentage may change as determined by your insurance. If your deductible is not paid at time of service, we have the right to reschedule your appointment until co-payments are paid in full. Again, your financial responsibility is a contract between you and your insurance company. We do not have the legal authority to waive or reduce rates if you make the decision for us to submit claims to your insurance company.

3. **SLIDING FEE SCALE**

If you are uninsured or choose not to use your insurance. You must complete the sliding fee scale (office manager will provide this to you upon request) and your ongoing rate will be determined based on your total family income.

4. **OUT-OF-POCKET FEE**

If decide to pay cash rate for services. These must be paid at time of service.

***Initial Consultation** = $150.00 per 60 minutes*

***Ongoing individual sessions** = $125.00 per 50-60 minutes*

***School and other off-site meetings/observations** are typically billed at $100.00 per hour and are usually not covered by insurance. Time in excess of standard sessions are prorated.*

***OPTIONAL* CREDIT CARD ON FILE** I would like to have my credit card on file and give permission for Aspen Counseling Services to bill my credit card for co-pays, out of pocket rates, and all other unpaid charges your insurance plan did not reimburse (unmet deductibles and coinsurance). Aspen Counseling will charge your credit card at time of service for co-payments and Out of Pocket rate. Unpaid charges by your insurance company will be charged to your card on file at the end of the month.

Please initial one of these three financial agreements, indicating the appropriate option for you.

_____ Insurance (out-of-network)
_____ Insurance (in-network)
_____ Sliding Fee Scale
_____ Out-of-Pocket Fee
_____ *Optional Selection* I would like my card on file for automatic payment on unpaid charges

By signing below, I acknowledge that I have read and agree to the payment options I selected above.

_____ _____

Signature **Date**

Aspen Counseling Services, PLLC

Acknowledgment of Payment Policy

I give Aspen Counseling Services my permission to charge the card I provided below for co-payments, Sliding Fee Scale charges, and Out-Of-Pocket session rates at time of session. Unpaid charges by which your insurance company does not cover, will be charged to the card provided at the end of each month. This card will be stored securely through our HIPAA-compliant system.

I have read, understand, and agree with the payment policy outlined above. I understand that a card will be kept on file. If my card is declined, I will be notified and will be expected to make other payment arrangements to avoid sessions being rescheduled due to unpaid charges.

Our goal is to help you continue your care without unnecessary interruption.

Client Name: _____ Date:_____

Client or Guardian Signature: _____ Date:_____

Credit/Debit Card Number: _____ Exp Date:_____