**Confidential Client Intake Information**

**Megan Stoneberg, LCSW**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_**

**Primary Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Secondary Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Leave Message: Yes / No Leave Message: Yes / No**

**Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Best time/day to contact you:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Birth Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Single, Married, Widowed, Divorced, Separated)**

**Education Level: \_\_\_High School \_\_\_Some College \_\_\_Associates \_\_\_Bachelors \_\_\_Masters \_\_\_Doctorate**

**Have you been in counseling/therapy before? Yes / No If yes, when: \_\_\_\_\_\_\_\_\_\_\_Did it help? Yes / No / Some**

**Reason for therapy?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you or a family member ever attempted suicide?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list all medications you take:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Psychiatrist’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have any physical disabilities or chronic illnesses: (please list):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- |
| **Please circle any of the following that are currently troubling you:**  Alcohol/Drug Use Eating Problems Physical Abuse Communication with partner Motivation  Self-Esteem Sexuality Verbal Abuse Sexual Harassment School/Education  Assertiveness Stress Sexual Abuse Suicidal Thoughts Dating  Addiction Career Marriage/Spouse/Partner Spiritual/Religious Appearance/Weight  Lonliness Work Stress Depressive/Sadness Perfectionist Time Management  Expressing Feelings Anxiety/Panic Money/Financial Issues Hopelessness Grief/Loss  Worry/Fear Shyness Childhood issues Divorcing/Breakup Anger/Rage  Sleep PTSD Parenting Meeting People/Friends Guilt  Helplessness Boredom Traumatic Event Homesickness Stalking  Trust Relationship Issues Family  **Please describe briefly your reason for seeking counseling:** |
| **Please describe how you will know counseling is working:** |

1. Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

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| **Insurance Company Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insured’s Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Policy Holder Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Member ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Group Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient (Self/Spouse/Child/Other)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Billing Contact** (Complete only if patient is under 18 years of age)  **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **I authorize the release of information necessary to process my insurance claims. I also authorize payment of benefits from my insurance company to Megan Stoneberg, LCSW/Stoneberg Counseling, LLC for services provided.**  **Client/Guarantor Signiture\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**All payment is expected at the time of service.**

I am an in network provider for most major insurance companies with the exception of Medicaid and Medicare. At your request, my practice will bill your insurance company as a courtesy to you provided you provide complete and accurate insurance information, you give written consent, and your coverage is verified before services are provided. Payment or co-payments for services are an insurance requirement and cannot be billed to you. If payment from your insurance company is not received within 45 days of the date of service, you will be expected to pay the balance in full. You are responsible- for all charges. If you have questions regarding billing your insurance, please feel free to contact Megan Stoneberg, LCSW at 208-949-8570.

If appointments are broken without 24-hour notice, the responsible party will be charged for the full amount of the appointment. No-shows will result in removal of recurring or ‘standing’ scheduled appointment.

I have read and understand the Financial Policy. I agree to assign insurance benefits to Megan Stoneberg, LCSW, whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I will be responsible for the fee charged by the collection agency for the cost of collection.

Client Signiture\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_