Amber Creek Counseling & Recovery Services, PLLC

Intake Information

Name:____Gender: Male Female
(Last) (First) (Middle Initial)

Address____
(City) (State) (Zip Code)

Home Phone: _______________Cell Phone: _________________Work:_________________
May we leave messages? Yes No
Date of Birth: _____/_____/_____ Age: __________ SSN:_________________________
Email:____

Name of parent/guardian (***if client under 18 years of age***):

____
(Last) (First) (Middle Initial)

If you are having your children seen, do you have: Joint Physical/Legal Custody
Sole Custody Primary Physical Custody

Have you previously attended therapy? _____________If yes, with whom?____________

Reason: ____

Whom may we thank for referring you?____

Current reason for seeking therapy?____

Marital Status: Single Married Domestic Partnership Separated
Divorced Widowed

Family Members (spouse/significant other, children, with date of birth)

_______________ _______________ _______________ _______________

Laura L. Bage, MSC, MFT • Lisa F. Almada, MSC, MFT
4894 Sparks Blvd •Sparks, NV 89436 • 415 Highway 95A Building G-701• Fernley, NV 89408
Phone: 775-284-9888 Phone: 775-575-2144

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Employment Information: Company

Name:____
Address:____Phone:__________________

Responsible Party for Patient Liability

Employer:____
Address:____
Phone:___________________________
Spouse's SSN______________________________________DOB:_____________

Primary Insurance

Company:____
Address:____
PrimaryInsured:____________________________ DOB________________
SSN_________________ Employer:____
Policy #____________________________________ Group #______________________

Emergency Contact:_______________Phone:______________ Relationship__________

Informed Consent

Billing Policies-Please initial next to each statement that you have read and understand our policies.

______ 1. AmberCreek Counseling & Recovery Services requires payment of either a session fee, co-pay or co-insurance if insurance is to be billed at the time of service. All fees, co-pays or co-insurance are due at the ***beginning*** of each session. The client is always responsible for the payment of costs incurred for services, regardless of benefits. This means that if for whatever reason a claim from this office is denied, you are responsible for the remaining balance of the bill. Some insurance companies require prior authorizations. Please make sure you have obtained these prior to your appointment.

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_______ 2. Your appointment time has been set aside specifically for you. If you are unable to attend your appointment, you MUST cancel at least 24 hours in advance. If you do not cancel more than 24-hours in advance or miss a session without canceling, you will be responsible to pay $50.00.

_______ 3. All telephone consultations over 10 minutes in duration are billed at a rate of $30.00 per 15-minute interval. If you request us to write reports for attorneys, doctors, courts, Child Protective Services, etc., you will be charged for the time it takes to write the report at a rate of $30.00 per 15-minute interval.

_______ 4. If a check is returned for insufficient funds, a $25.00 fee will be assessed in addition to the session fee.

_______ 5. I agree to pay $_____________/session and I understand that I am responsible for the total amount should my insurance company refuse to pay for my session.

_______ 6. Court ordered evaluations & reports will not be released until balance is paid in full.

_______ 7. AmberCreek offers a sliding fee scale. Please inquire prior to your session so we can take care of all business before your session.

________ 8. I understand that my therapist will NOT (at the request of the client) testify in court as an expert witness, including: divorce, child custody, or criminal cases. I understand that my personal patient file belongs to my therapist.

________ 9. If my therapist is subpoenaed by the Court, I understand that court testimony on my behalf is charged at a higher rate of $250.00 per hour including: testimony related matters like case research, report writing, travel, depositions, actual testimony, cross examination and courtroom waiting time. Payment for court services is due prior to appearance with a three (3) hour minimum. Signing this disclosure statement gives permission for me to release confidential information in courtroom testimony and written reports to the Court if legally requested by the Court.

Benefit Assignment & Records Release:

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This signature authorizes AmberCreek Counseling & Recovery Services to release any information regarding my medical/psychological treatment to my insurance company for the purpose of insurance collection. This signature also authorizes payment of medical benefits to be paid directly to AmberCreek Counseling & Recovery Services and/or the individual therapist as appropriate.

____________________________________ ____________
Patient Signature or Legal Guardian Date

Confidentiality and Limitations:

A. The confidentiality of counseling is protected by law except for the following exceptions

1. Any accounts of child abuse/neglect, past or present of a child less than 18 years of age.
2. Any situation in which someone is threatening themselves or others with physical harm. This would be reported to the police or to a relative.
3. Any account of abuse, neglect, or exploitation of senior citizens, past or present.
4. When client information is court ordered to be released.

B. For any of the above exceptions, AmberCreek Counseling & Recovery Services will only reveal the information necessary to protect you or the person in danger, or to meet legal requirements.

I have read the policies and procedures, asked any necessary questions, and understand the terms of this consent. I understand my rights and responsibilities as a client and my therapists' responsibilities to me. I agree to these conditions and consent to treatment.

__________________ _______ __________________ _______
Signature Date Signature Date

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