Northshore Clinic and Consultants

Adult Intake Form

Welcome to Northshore Clinic and Consultants

Thank you for choosing us for your mental health care. Please complete this form in its entirety before your first appointment. All information provided is confidential and protected by HIPAA regulations.

---

1. Patient Information

- **Full Name:** _____
- **Date of Birth (MM/DD/YYYY):** _____
- **Gender:** ☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to answer ☐ Other: _____
- **Preferred Pronouns:** _____
- **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____
- **Address:** _____
- **City:** _____
- **State:** _____
- **ZIP Code:** _____
- **Email Address:** _____
- **Phone Number:** (_____) _____ - _____
- **Preferred Method of Contact:** ☐ Phone ☐ Email ☐ Text
- **Emergency Contact Name:** _____
- **Emergency Contact Relationship:** _____
- **Emergency Contact Phone Number:** (_____) _____ - _____

2. Insurance Information

- **Insurance Provider: _____**
- **Policy Number: _____**
- **Group Number: _____**
- **Policy Holder Name (if different): _____**

3. Primary Care Provider Information

- **Primary Care Provider Name: _____**
- **Phone Number:** (_____) _____ - _____
- **Address: _____**

4. Reason for Seeking Treatment

- **Please briefly describe the issues that led you to seek therapy:**

  _____

  _____

  _____

- **How long have you been experiencing these issues?**

  _____

- **Have you sought therapy for this issue before?** ☐ Yes ☐ No
  - If yes, when? _____
  - Was it helpful? _____
- **Are you currently experiencing any suicidal thoughts or feelings?** ☐ Yes ☐ No
  - If yes, please describe: _____

5. Mental Health History

- **Have you been diagnosed with any mental health conditions in the past?** ☐ Yes ☐ No
  - If yes, please list: _____
- **Are you currently taking any medications?** ☐ Yes ☐ No
  - If yes, please list: _____
- **Have you ever been hospitalized for mental health concerns?** ☐ Yes ☐ No
  - If yes, when and why? _____
- **Do you have a history of substance use (drugs, alcohol, etc.)?** ☐ Yes ☐ No
  - If yes, please describe: _____

6. Family and Social History

- **Do you have a family history of mental health issues?** ☐ Yes ☐ No
    - If yes, please describe: _____
- **What is your current support system like (family, friends, etc.)?**

  _____
- **Are there any cultural or religious factors that you would like your therapist to consider?**

  _____

7. Current Life Stressors

- **Please indicate any current stressors or life changes (e.g., job loss, relationship changes, financial stress):**

  _____

8. Goals for Therapy

- **What are your goals for therapy?**

  _____

  _____

  _____

9. Consent for Treatment and HIPAA Agreement

By signing below, I acknowledge that I understand the purpose of this form and that the information provided will be kept confidential in accordance with HIPAA guidelines. I consent to participate in therapy and understand that I can withdraw consent at any time. I have been provided with the clinic's privacy policy and HIPAA notice.

- **Patient Signature: _____**
- **Date: _____**

10. Electronic Signature Authorization Form

By signing this form, I agree that my electronic signature, in any font or format, is the legally binding equivalent of my traditional handwritten signature. I understand that this electronic signature may be used on all applicable documents related to my care at Northshore Clinic and Consultants, including, but not limited to:

- Initial Assessments
- Diagnostic forms
- Treatment Plans
- Progress Notes

I give consent for my Clinician/Therapist to use my electronic signature in conjunction with these forms and any other clinical or administrative documents required during the course of my treatment.

- **Patient Name (Printed): _____**
- **Date of Birth: _____**
- **Patient Signature: _____**
- **Date: _____**

11. Informed Consent for Counselor Intern Services

I understand that I may receive services from a Counselor Intern who is in the process of completing their training under the supervision of a licensed clinician. The licensed supervisor will have access to my records and may review session notes or recordings for supervision purposes. I understand that I can request to work with a licensed clinician at any time.

By signing below, I consent to receive services from a Counselor Intern.

- **Patient Name (Printed): _____**
- **Date of Birth: _____**
- **Patient Signature: _____**
- **Date: _____**

12. Telehealth Consent Form

Telehealth involves the use of electronic communications to enable clinicians to connect with patients for remote healthcare services. By signing below, I agree to receive telehealth services from Northshore Clinic and Consultants.

- **I understand that I have the right to withhold or withdraw consent to telehealth at any time without affecting my right to future care or treatment.**
- **I understand that telehealth may involve risks such as technology failures or unauthorized access to data.**
- **I agree that telehealth is not appropriate for emergencies and that I will contact 911 or go to the nearest emergency room in such cases.**
- **I understand that I may be responsible for co-pays or fees associated with telehealth services.**

By signing below, I consent to participate in telehealth services.

- **Patient Name (Printed): _____**
- **Date of Birth: _____**
- **Patient Signature: _____**
- **Date: _____**

13. Email and Texting Consent Form

By signing below, I consent to receive non-urgent communications from Northshore Clinic and Consultants via email and/or text. I understand the potential risks of email and texting, including the possibility of unauthorized access. I agree to safeguard any communications I receive.

- **Patient Name (Printed): _____**
- **Date of Birth: _____**
- **Email Address: _____**
- **Phone Number for Texting:** (_____) _____ - _____
- **Patient Signature : _____**
- **Date: _____**

I do not consent to electronic communication: ☐

14. Informed Consent for Counselor Intern Services

I understand that I may receive services from a Counselor Intern who is in the process of completing their training under the supervision of a licensed clinician. The licensed supervisor will have access to my records and may review session notes or recordings for supervision purposes. I understand that I can request to work with a licensed clinician at any time.

By signing below, I consent to receive services from a Counselor Intern.

- **Patient Name (Printed): _____**
- **Date of Birth: _____**
- **Patient Signature: _____**
- **Date: _____**

15. Financial Policy

Payment and Insurance

- **Payment is due at the time of service unless prior arrangements have been made.** We accept cash, checks, and major credit cards.
- **Insurance:** We accept many insurance plans and will submit claims to your insurance company on your behalf. However, it is your responsibility to:
    - Verify your insurance coverage prior to your first appointment.
    - Pay any co-pays, deductibles, or co-insurance as required by your insurance plan.
    - Understand that any amount not covered by your insurance is your responsibility.
- **Self-Pay Clients:** For those without insurance or those who prefer not to use insurance, payment is due in full at the time of service. We offer a sliding fee scale in certain cases—please discuss this with our office.

Cancellation and Missed Appointment Policy

- **Cancellations:** If you need to cancel or reschedule an appointment, please notify us at least **24 hours** in advance. Failure to do so may result in a cancellation fee of **$50**.
- **Missed Appointments:** Appointments that are missed without notification ("no-shows") will be charged a fee of **$75**. This fee is your responsibility and will not be billed to your insurance company.

Late Payment and Returned Check Policy

- **Late Payments:** Payments not made within 30 days of receiving a bill will be considered past due. If your account becomes delinquent, we reserve the right to suspend or terminate services until the balance is paid.
- **Returned Checks:** A fee of **$35** will be charged for any returned checks due to insufficient funds.

Credit Card on File

For your convenience, we require a credit card on file to cover co-pays, fees, and any outstanding balances. Your card will only be charged if:

- You fail to pay your balance by the agreed-upon due date.
- A cancellation fee or missed appointment fee is incurred.

By signing below, I acknowledge that I have read and understand Northshore Clinic and Consultants' Financial Policy. I agree to the terms and understand that I am financially responsible for all charges incurred, whether or not paid by insurance.

- **Patient Name (Printed): _____**
- **Date of Birth: _____**
- **Patient Signature: _____**
- **Date: _____**
- **Credit Card: _____**
    - **Card Type: _____**
    - **Ex. Date: _____**
    - **Sec.Code**: **_____**

*Full Financial Policy and Fee Schedule Provided at time of first appointment or available online.