Mending Fences Institute
866 Washington Street Canton, MA 02021

Client _____
Client # _____

Adult Intake

Name: _____Date of Birth: _____

Phone: _____ Email _____

Gender: _____Marital Status: _____ Employment : _____

Home Address: _____

Billing Address if different: _____

In case of Emergency Contact:

Name_____

Relationship to client: _____ Phone/s: _____

Name of Employer: _____

Type of Work: _____

How will you pay for services?

Cash ___ Check ___ Credit Card ___ Bank Transfer ___

Insurance Information Insurance Billing: [ ] Yes [ ]No

Insurance Company:_____

Insurance ID: _____ Group No: _____

Subscriber: _____ Date Of Birth: _____

Social Security #: _____ Relationship to Patient: _____

Some insurance companies require authorization prior to the start of treatment. Please call your insurance company, determine if authorization is needed, and request an Outpatient Mental Health Authorization.

Authorization Number: _____ # Sessions Authorized: ___

Start / End Date of Authorization: _____

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Client _____
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Medical Information:

Primary Doctor: _____ Phone _____

Address: _____

List Allergies: _____

List Medications: _____

List Conditions:_____

Other Medical Issues and Surgeries: _____

_____

Psychopharmacologist _____ Phone _____

Address: _____

Family Constellation

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Treatment History and Concerns

Type of issues:

[ ] Individual [ ] Couples [ ]Divorce [ ] Reunification [ ] Trauma

[ ] Other _____

Briefly describe why you are seeking treatment.

What significant trauma have you experienced?

What have you done in the past to deal with the issues (include therapists and medications).

Describe your relationship with family members.

What are your strengths?

Goals for Treatment

Describe your goals for counseling

What is the most significant challenge to achieving your goals?

Is there anything else you would like me to know?

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Agreement

1. I/we have read the Mending Fences Policies and General Information and agree to the terms.
2. If covered by insurance, I/we authorize Beth H Ross LICSW to bill insurance.
3. I/we will each be responsible for the costs not covered by insurance.
4. Bills not paid in full within 30 days will result in a suspension of treatment.
5. I/we have read the electronic communications authorization, understand the risks and authorize communication electronically with me/us, which will include the transmission of my/our PMI electronically.
6. I/we have read the HIPAA confidentiality agreement and understand my rights.
7. I/we give Beth H. Ross LICSW permission to talk with other family members with my/our consent.
8. The above information is true and I/we agree to the consents

Signature: _____ Date _____

Signature: _____ Date _____

Signature: _____ Date _____