The Soar Firm, LLC
Coaching | Counseling | Consulting

CLIENT INTAKE FORM

Please provide the following information and answer the questions below. Please note that information you provide here is protected as confidential information.

DEMOGRAPHIC INFORMATION

Name (Last, First, Middle):
Name of parent/guardian (if under 16 years):
Birth Date: / / Age: Gender: □ Male □ Female □ Non-Binary □ Other:
Marital Status: □ Never □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed
Race/Ethnicity: □ American Indian or Alaska Native □ Asian □ Black or African American □ Hispanic or Latino □ White □ Other
Address:
Home Phone:
Cell/Other Phone:
E-mail:
Emergency Contact & Phone Number:
How did you hear about us?

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

Briefly describe what has prompted you to seek therapy. Include any symptoms you are experiencing, current stressors, recent life changes, traumatic experiences, etc.

Are you currently employed? □ Yes □ No
Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ Yes - Previous therapist/practitioner: □ No
List any medications you are currently taking, if applicable.
How would you rate your current physical health? (please check) □ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good
List any specific health problems you are currently experiencing, if applicable.
How often do you consume alcohol? □ Daily □ Weekly □ Monthly □ Infrequently □ Never
How often do you use non-prescriptive drugs (i.e. tobacco, cannabis, etc)? □ Daily □ Weekly □ Monthly □ Infrequently □ Never
Describe your religious/spiritual beliefs.
What are some personal traits that you like most about yourself?
What do you hope to accomplish in therapy?

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POLICIES AND INFORMED CONSENT

Your therapist can be reached via phone and email between 9:00 am to 4:00 pm Monday through Friday. Your therapist will check voicemails/emails throughout the day and will make every effort to return your call/email within 1 business day. If you are having an emergency, you may always call the Mental Health America of Greenville County CRISISLINE at 864-271-888 for immediate assistance.

FEES: The fee for a standard hour appointment for an individual is **$125** and **$150** for couples. A 30-minute session is **$65**. As an out-of-network provider, we do not bill insurance. For clients who would like to utilize their out of network insurance benefits, a statement can be provided to you to submit to your insurance company for potential reimbursement.

NO SURPRISES ACT: Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to inform individuals both orally and in writing of their right to receive a "Good Faith Estimate" of expected charges upon request or at the time of scheduling their health care services. This act applies to individuals who do not have health insurance and those who choose not to utilize their health insurance.

PAYMENT: Full payment is due at the end of each session. A credit card is required to be on file. Cash, HSA/FSA cards, and major credit cards, including Discover, Visa, American Express and MasterCard are accepted.

CANCELLATION/MISSED APPOINTMENTS: If you need to reschedule or cancel an appointment, please notify your therapist within 24 hours of the appointment time. Failure to do so will result in a **$50** fee for appointments cancelled less than 24 hours and for missed/cancelled appointments. This fee must be paid prior to your next appointment.

CONFIDENTIALITY: I abide by the laws and ethical principles that govern privilege and confidentiality. I will not disclose to anyone anything you tell me nor even the fact that I have seen you without your written permission by way of a signed release of information form. However, there are few exceptions to these standards (*see Notice of Privacy Practices*).

SOCIAL MEDIA POLICY: Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any of my *personal* social networking sites (Facebook, Instagram, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. However, clients are welcome to follow the *The Soar Firm's* business pages on social media platforms.

SOBRIETY POLICY: Your therapist is ethically required to terminate any session in which he/she believes a client is under the influence of, or has within the past 24 hours, used substances that impair his/her ability to participate in care. With a client currently under the influence, the therapist will require that he/she not drive and make alternative arrangements to get home.

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INFORMED CONSENT TO TREATMENT: Care is voluntary; therefore, you have the right to terminate therapy at any time. Your therapist also has the right to terminate therapy if he/she believes the therapy being provided is no longer beneficial and that you will be better served by another professional; You are seeing another therapist; Your therapist reasonably perceives you as posing a threat to his/her physical well-being; You have failed to show up for your last 3 therapy sessions without providing 24-hour notice; You have a balance that is significantly past due.

CONSENT FOR TREATMENT

Signature(s) below indicate that I /we have read and understand the above consent to treatment under the conditions specified above. In the event that treatment is for a minor child, I hereby give my consent to treatment and affirm that I am their legal guardian with authority to authorize mental health treatment.

I also assume financial responsibility for any balance on the account. I will make payments owed at the time of each session unless alternative arrangements have been made. I understand and agree to pay a $50 fee for an appointment canceled less than 24 hours or for missed appointments.

Client Name: Date:

Client Signature (Parent/Guardian if client is under 16 years old): Date:

RECEIPT OF PRIVACY PRACTICES NOTICE

Please sign below to indicate that you have received a copy of the Notice of Privacy Practices:

I confirm that I have received a copy of the Notice of Privacy Practices from The Soar Firm, LLC. I acknowledge that I understand the information in this disclosure and that I am entering into therapy in agreement with this policy.

Client Name: Date:

Client Signature (Parent/Guardian if client is under 16 years old): Date:

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CREDIT CARD AUTHORIZATION FORM

The Soar Firm, LLC requires you to provide your credit/debit card information on file with us so we can automatically charge payments, collect balances and any other professional service charges such as late cancelation or missed appointment charges. It is the client's responsibility to keep cards accurate and up to date. We store financial information and other protected health information in an encrypted, HIPAA compliant site. Your information is never shared with anyone.

Payment is required at the time of service and you may pay your balance in session with your therapist. If a balance accrues and no payment is received, we reserve the right to seek payment, including using the credit/debit information we have on file and contacting the client for payment. If the client's balance remains unpaid, we reserve the right to suspend services until the balance is paid in part or in full.

Cardholder Name:	
Card Number:	
Card Type:	□ Visa □ Mastercard □ AMEX □ Discover
Expiration Date:	
CVC Number:	
Billing Address:	
Zip Code:	
Signature:	
Date:	