

# Brooke & Associates Counseling Company, LLC

5545 N. Oak Trafficway, Suite 3  
Kansas City, MO 64118  
(816)500-1355 • Fax (816)569-6797  
BrookeCounselingCompany@gmail.com

## INTAKE INFORMATION:

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Client Name

\_\_\_\_\_  
Client DOB

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Cell Phone Number

May Call    May Leave a Voicemail    May Text

\_\_\_\_\_  
Alternate Phone Number

May Call    May Leave a Voicemail    May Text

\_\_\_\_\_  
Contact Email Address

Email Appointment Reminders: \_\_\_\_ Yes \_\_\_\_ No

\_\_\_\_\_  
Client Marital Status

\_\_\_\_\_  
Client Sex: M / F  
(per insurance record)

\_\_\_\_\_  
Client Employer or School

## INSURANCE INFORMATION:

\_\_\_\_\_  
Insured Name

\_\_\_\_\_  
Insured DOB

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Insured Relationship  
to Client

\_\_\_\_\_  
Insured Sex: M / F  
(per insurance record)

\_\_\_\_\_  
Insured Employer

\_\_\_\_\_  
Insurance Company (with Plan Name, e.g. Blue Select)

\_\_\_\_\_  
Claims/Benefits Phone #

\_\_\_\_\_  
ID#

\_\_\_\_\_  
Group #

For BCBS: Claims sent to local BCBS Plan? (check back of card) \_\_\_\_ Yes \_\_\_\_ No

If No, where should claims be sent? \_\_\_\_\_

**EMERGENCY CONTACT:**

\_\_\_\_\_  
Name of local friend or relative

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Phone Number

*I hereby consent allow Brooke & Associates Counseling Company, LLC to contact the above-named individual in case of emergency.*

\_\_\_\_\_  
Client Signature/Responsible Party

\_\_\_\_\_  
Date

**AUTHORIZATION TO TREAT MINOR CHILD (IF APPLICABLE):**

\_\_\_\_\_  
Name of Child

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Name of Child

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Name of Child

\_\_\_\_\_  
DOB

*I warrant that I am the custodial parent of the above-named child/children. I hereby give permission for him/her to receive counseling. I acknowledge that I am aware of mandated reporting laws in the state of Missouri. I am also aware that I can withdraw the permission to treat my child at any time. I will assume responsibility to notify my child's other parent that counseling has been initiated and will take sole responsibility in arranging for payment for all counseling services for my child.*

\_\_\_\_\_  
Primary Custodian/Guardian Signature      Date

\_\_\_\_\_  
Primary Custodian/Guardian Signature      Date

**TELETHERAPY:**

TeleTherapy, also known as Telehealth, is now offered to provide counseling in a non in-person situation via electronic communication. Teletherapy includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. Teletherapy also involves the communication of your medical/mental information, both orally and visually.

*I hereby consent to teletherapy services, for myself, for my child or the person of whom I am the legal guardian or legal representative.*

\_\_\_\_\_  
Client Signature/Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client Signature/Responsible Party (if participating in couples counseling)

\_\_\_\_\_  
Date

**OUTPATIENT SERVICES CONTRACT:**

Please review our corresponding Outpatient Services Contract for specific information regarding the following areas, and **initial** to indicate you have received and reviewed this information:

- PSYCHOLOGICAL SERVICES
- IN-PERSON & TELETHERAPY SESSIONS
- PROFESSIONAL FEES
- LITIGATION POLICIES
- BILLING & PAYMENTS
- CREDIT CARD ON FILE AGREEMENT
- INSURANCE REIMBURSEMENT
- CONTACTING YOUR THERAPIST
- PROFESSIONAL RECORDS
- POLICY FOR WORKING WITH MINORS
- CLIENT RIGHTS & RESPONSIBILITIES
- CONFIDENTIALITY and NOTICE of PRIVACY PRACTICES

**CONSENT FOR TREATMENT:**

Your signature below indicates that you agree to the information detailed in our OutPatient Services Contract, agree to abide by its terms during our professional relationship, and have received a copy of this document. The signature of a parent or legal guardian is required if the client is unmarried and has not reached his/her 18th birthday, unless adjudicated emancipated.

For clients receiving services from a Provisionally Licensed Professional Counselor, any concerns regarding treatment or provision of services can be addressed by contacting the clinical supervisor, Sherri Brooke, LPC at (816)500-1355.

*I hereby consent to outpatient therapy treatment, including teletherapy services, for myself, for my child or the person of whom I am the legal guardian or legal representative. I hereby acknowledge I have been made aware of and understand the Privacy Practices for Brooke & Associates Counseling Company, LLC.*

*I certify that I, and/or my dependent(s) assign directly to Brooke & Associates Counseling Company, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Brooke & Associates Counseling Company, LLC may use my health care information and may disclose such information to the Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I agree to notify Brooke & Associates Counseling Company, LLC immediately of any changes in address or insurance coverage or I will be responsible for any resulting uncovered services.*

\_\_\_\_\_  
**Client Signature/Responsible Party**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Client Signature/Responsible Party (if participating in couples counseling)**

\_\_\_\_\_  
**Date**

## CREDIT CARD ON FILE AGREEMENT:

We have implemented a new policy which requires all therapy clients to keep a credit card on file for payment purposes. Your credit card information is kept in a confidential and secure, encrypted gateway site, which is completely compliant as required by law. For more information, please visit:

<https://squareup.com/us/en/security>

Payment to your card will be processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

By providing us with your credit card information, you are giving Brooke & Associates Counseling Company, LLC permission to **automatically charge your credit card for the amount due for services rendered**. These amounts match the client's responsibility amounts as determined by your insurance company and are reflected on the explanation of benefits (EOBs) from your insurance company.

**Any canceled or missed appointment without a 4-hour notice will result in the credit card on file being charged the late cancellation/no-show fee of \$50.00.**

If the credit card information we have on file changes for any reason, you must notify Brooke & Associates Counseling Company, LLC as soon as possible. If you have questions about a charge, please notify us within 15 days. After 30 days all charges will be assumed to be correct.

In the rare case an overpayment occurs, your account will be credited, with any amount to be used toward future services. You may request the credit be refunded directly to you, and we will mail you a check for the credit amount within 30 days of your request.

**In the event of a declined charge, you will be asked for a new credit card number and/or payment before continuing therapy sessions.**

### Credit Card Information to be kept on file:

Name on Card:  Exp. Date:  CVV Code:

Card Number:  Billing Zip Code:

*I acknowledge I have been informed and agree to the above financial policy. I understand that payments are due on the date of service. I agree that Brooke & Associates Counseling Company, LLC may bill the credit card on file for any payments which are my responsibility, that have not been paid on the date of service. I hereby consent for Brooke & Associates Counseling Company, LLC to utilize my credit card information for any outstanding balances.*

\_\_\_\_\_  
Signature of Credit Card Holder, Authorizing Payment

\_\_\_\_\_  
Date

## **TELETHERAPY EMERGENCY PLAN:**

While receiving behavioral health services remotely (teletherapy) is convenient, it also has limitations and risks. The therapist's ability to respond to a medical or psychiatric emergency may be impacted, Please complete this form to help inform your therapist's creation of an emergency plan to help reduce some of those risks.

**Your Name:** \_\_\_\_\_

**Address where your teletherapy session occurs:** \_\_\_\_\_

**Telephone number where your teletherapy session occurs:** \_\_\_\_\_

Alternate phone number: \_\_\_\_\_

Telephone Number for Local Emergency Services (not 911): \_\_\_\_\_

Therapist's Location: Brooke & Associates Counseling Company, LLC

Therapists' Telephone Number: 1-816-500-1355

A support person is someone who knows you are receiving therapy and is accessible to you (nearby and willing to help) during your teletherapy session. This support person could help in case of emergency. Sign this form to allow your therapist to contact this person.

**Support Person Name:** \_\_\_\_\_

**Support Person Telephone Number:** \_\_\_\_\_

I give my consent for my therapist to contact my support person. I understand this means my therapist may disclose private and confidential information. (Initial) \_\_\_\_\_

In case of a behavioral/medical emergency, the therapist will attempt to contact emergency services in your local area. Emergencies might include expressing intent to harm yourself or another person, a medical emergency, or any other condition requiring medical or psychiatric attention.

The therapist will try to maintain communication with you while he/she calls for help. This might mean paramedics, mental health professionals, or local police will come to your home to make sure you are safe and well. If appropriate, the therapist will also contact your support person.

In case of a technological videoconferencing failure, the therapist will contact you using the telephone. In case of telephone failure (and without safety concern), the therapist will contact you using email.

**Client (or Legal Guardian) Signature:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**COORDINATION OF CARE (OPTIONAL):**

---

Primary Care Physician	Address	Phone Number
------------------------	---------	--------------

---

Psychiatrist	Address	Phone Number
--------------	---------	--------------

*To coordinate among providers so that I may receive the most complete and accurate care possible, I give permission for my therapist to contact the above-listed physicians.*

---

Client Signature/Responsible Party

---

Date

**PERSONAL HEALTH HISTORY (OPTIONAL):**

Please list any mental or medical problems, hospitalizations and/or previous diagnoses:

---

---

---

Please list all prescriptions or over-the-counter medications you are currently taking:

---

---

**PRIMARY REASON(S) FOR SEEKING SERVICES (OPTIONAL):**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Adjustment Issues             | <input type="checkbox"/> Couples / Marital             | <input type="checkbox"/> Psychosis               |
| <input type="checkbox"/> Adolescent / Teen Issues      | <input type="checkbox"/> Crisis / Trauma / PTSD        | <input type="checkbox"/> Stress                  |
| <input type="checkbox"/> Anger Management/Aggression   | <input type="checkbox"/> Depression                    | <input type="checkbox"/> Suicidality / Self-Harm |
| <input type="checkbox"/> Anxiety / Fears / Phobias     | <input type="checkbox"/> EAP Services                  | <input type="checkbox"/> Work / Employment       |
| <input type="checkbox"/> Bipolar / Mood Problems       | <input type="checkbox"/> Grief & Loss                  | <input type="checkbox"/> Other: _____            |
| <input type="checkbox"/> Children / Parenting / Family | <input type="checkbox"/> Obsessive Compulsive Disorder | <input type="checkbox"/> Other: _____            |

**OTHER COMMENTS/INFORMATION (OPTIONAL):**

---

---

---

---

---