Brooke & Associates Counseling Company, LLC
7509 NW Tiffany Springs Parkway, Suite 320
Kansas City, MO 64153
(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):

- ☐ Adjustment Issues
- ☐ Adolescent / Teen Issues
- ☐ Anger Management/Aggression
- ☐ Anxiety / Fears / Phobias
- ☐ Bipolar / Mood Problems
- ☐ Children / Parenting / Family
- ☐ Couples / Marital
- ☐ Crisis / Trauma / PTSD
- ☐ Depression
- ☐ EAP Services
- ☐ Grief & Loss
- ☐ Obsessive Compulsive Disorder
- ☐ Psychosis
- ☐ Stress
- ☐ Suicidality / Self-Harm
- ☐ Work / Employment
- ☐ Other: ____________________
- ☐ Other: ____________________

OTHER COMMENTS/INFORMATION (OPTIONAL):

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