PCS READMISSION
CLIENT INFORMATION FORM

CLIENT INFORMATION

NAME:	DATE:
STREET ADDRESS (Required):	D/O/B:
P. O. BOX (if applicable): APT. # (if applicable):	SEX: ○ M ○ F
CITY: STATE: ZIP:	SSN:
PHONE: OK to leave a message? Home: _____ Yes ○ No ○ Work: _____ Yes ○ No ○ Cell: _____ Yes ○ No ○ EMAIL ADDRESS: _____	ETHNIC BACKGROUND ○ Native American / Alaskan Native ○ Asian/Pacific Islander ○ Hispanic ○ Black/African-American ○ White/Caucasian ○ Other

REASONS FOR SEEKING COUNSELING: _____

COUNSELING HISTORY: IF NO PRIOR TREATMENT, CHECK HERE AND OMIT FOLLOWING SECTION: ( )

PREVIOUS THERAPIST	DATES OF TREATMENT	REASON FOR SEEKING COUNSELING	REASON FOR TERMINATION

SYMPTOMS & CHANGES IN FUNCTIONAL IMPAIRMENT: IF PRESENT, PLEASE CHECK TO WHAT DEGREE

	Mild	Mod.	Severe
Anxiety	○	○	○
Panic Attacks	○	○	○
Decreased Energy	○	○	○
Depressed Mood	○	○	○
Delusions	○	○	○
Hallucinations	○	○	○
Hyperactivity	○	○	○
Sleep Disturbance	○	○	○
Physical Health	○	○	○
Work/School	○	○	○

	Mild	Mod.	Severe
Hopelessness	○	○	○
Activities of daily living	○	○	○
Family/Relationships	○	○	○
Inattention	○	○	○
Irritability/Mood instability	○	○	○
Impulsivity	○	○	○
Obsessions/Compulsions	○	○	○
Significant weight change	○	○	○
Suicidal thoughts	○	○	○
Homicidal thoughts	○	○	○

HISTORY OF ABUSE: (PHYSICAL, EMOTIONAL, VERBAL, SEXUAL, RELIGIOUS) ○ **Yes** ○ **No**

INSURANCE INFORMATION

PRIMARY Insurance Information

Relationship to Insured: ○ Self ○ Spouse/Partner ○ Child ○ Other

Insurance Co.: _____ Insurance Co. Phone: _____

Policy Holder: _____ Date of Birth: _____

ID/Policy #: _____ Group #: _____ Group Name: _____

SECONDARY Insurance Information

Relationship to Insured: ○ Self ○ Spouse/Partner ○ Child ○ Other

Insurance Co.: _____ Insurance Co. Phone: _____

Policy Holder: _____ Date of Birth: _____

ID/Policy #: _____ Group #: _____ Group Name: _____

PLEASE PROVIDE INSURANCE CARD(S) FOR US TO COPY

METHOD OF PAYMENT

○	I will pay the full fee for each session at time of service.
○	Bill my insurance company for what I owe. I will pay each session, any deductible and/or co-payment, as well as any amount in excess of my insurance coverage limits.
○	I will provide new and/or updated insurance information as it becomes available.

We accept cash, checks, made payable to **"PCS"** or
VISA, MASTERCARD, DISCOVER and AMERICAN EXPRESS.

To the best of my knowledge, the above information is true and complete. I understand that I am responsible to pay for all services rendered to me, and that I am willing to make specific arrangements to pay whatever part is not covered by insurance on a timely basis. I authorize the release of any information necessary to process this claim. I authorize payment to be made directly to the healthcare provider(s) submitting my claims.

_____ _____
Insured's or Authorized Person's signature Date

PCS READMISSION
CLIENT INFORMATION FORM

Counseling • Education • Consultation
2013 Elm Street • Manning House • Manchester, NH 03104-2528
Phone (603) 627-2702 • Fax (603) 627-3643 • Website pcs-nh.org
Satellite Offices in Bedford, Nashua & Exeter

AGREEMENT TO TREATMENT

I have received and reviewed with my therapist the following information:

- ☐ Confidentiality
- ☐ Professional Ethics and Complaints
- ☐ Emergency Coverage
- ☐ Cancellation Policy
- ☐ Termination of Psychotherapy
- ☐ Fees and Insurance Coverage

CANCELLATION POLICY

PCS requires a **24-hour notice** if you need to cancel an appointment. We cannot bill an insurance company for a missed appointment. The policy of the center is that the client will be charged for a missed appointment or late cancellation at the contracted rate allowed by your insurance company, up to a maximum of $75.

There are many unanticipated reasons why someone might have to cancel without adequate notice (for example, illness, transportation problems, and work demands). The only consistent exception to this policy however is when inclement weather poses a safety risk. Please talk to your therapist if you have any questions about this policy.

Client: _____ Date: _____

Therapist: _____ Date: _____

PCS
Pastoral Counseling Services

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NOTICE OF H.I.P.A.A. PRIVACY PRACTICES

Acknowledgment:

I hereby acknowledge that I received this Notice of H.I.P.A.A. Privacy Practices on _____ , 20 _____

Signed: _____
Client or Responsible Party

Please Print: _____

Please Print: _____
Responsible Party (if applicable)

PERSON TO CONTACT IN EVENT OF AN EMERGENCY:

Name: _____

Relationship _____ **Phone#:** _____

REFERRED TO PCS BY: _____

RELATIONSHIP TO THIS REFERRAL: _____

MAY WE THANK THE PERSON WHO REFERRED YOU? ○ Yes ○ No

ADDRESS: _____

_____