**Please type inside the shaded area or click the select area**

**1733 Wooddale Blvd ▲ Baton Rouge, LA 70806 ▲ 225-924-2800 Phone / Fax ▲** [**info@eclecticcbc.com**](mailto:info@eclecticcbc.com) **▲** [**www.eclecticcbc.com**](http://www.eclecticcbc.com)

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| A logo for a therapy center  Description automatically generated **client information form** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Client ID#:** | | | | |
| **Name:** | | | | | | | | | | | | | | | | | **DOB:** | | | | | | | | | **Age:** | | | **Sex:** | | | | | | **SS#:** | | | | | | | |
| **Address:** | | | | | | | | | | | | | | | | | | | | | **City:** | | | | | | | | | **State:** | | | | | | | | | | **Zip:** | | |
| **Hm Ph #:** | | **Cell Ph#:** | | | | | | | | | | | | **Other #:** | | | | | | | | | | | | | **Email:** | | | | | | | | | | | | | | | |
| **How may we contact you?** | | | | | | | | | | | | | | | **May we leave a message?** | | | | | | | | | | | | | | | | | | **Alternate Contact:** | | | | | | | | | |
| **Marital Status:** | | | | **Living Arrangement:** | | | | | | | | | | | | | | | | | | | | | **Minor’s Parent/Guardian Name:** | | | | | | | | | | | | | | | | | |
| **Occupation:** | | | | | | | | | | | | | **Employer:** | | | | | | | | | | | | | | | | | | | | | | | | **Employer Ph #:** | | | | | |
| **Emergency Contact Name:** | | | | | | | | | | | | | | | | | | | | **Ph #:** | | | | | | | | **Relationship to client:** | | | | | | | | | | | | | | |
| **Are you a  new or  returning client?** | | | | | | | | | | | | | **If returning client, when was your last visit?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Service(s) Requested:** | | | | | | **Referral Sources:** | | | | | | | | | | | | | | | | | **Source Ph #:** | | | | | | | | **Source Email:** | | | | | | | | | | | |
| **insurance information** | | | | | | | | | | | | | | | | | | | | | | | | **OFFIC USE ONLY** | | | | | | | | | | | | | | | | | | |
| **Responsible Party:** | | | | | | | | | | | | | | | | | | | | | | | | **Insurance Provider:** | | | | | | | | | | | | | | | | | | |
| **Subscriber Name:** | | | | | | | | | **DOB:** | | | | | | | | | **Sex:** | | | | | | **Address:** | | | | | | | | | | | | | | | | | | |
| **Address:** | | | | | | | | | | | | | | | | | | | | | | | | **City:** | | | | | | | | | | | | | | | **State:** | | | **Zip:** |
| **City:** | | | | | | | | | | **State:** | | | | | | | | | **Zip:** | | | | | **Ph #:** | | | | | | | | | | **Fax#:** | | | | | | | | |
| **Ph #:** | **Email:** | | | | | | | | | | | | | | | | | | | | | | | **Email:** | | | | | | | | | | | | **Website:** | | | | | | |
| **Subscriber’s ID#:** | | | | | **Client Relationship To Subscriber:** | | | | | | | | | | | | | | | | | | | **Claim Address**: | | | | | | | | | | | | | | | | | | |
| **Subscriber’s Employer:** | | | | | | | | | | | | | | | | | | | | | | | | **Insurance Type:** | | | | | | | | | | | | | | | | | | |
| **Policy/Group Name**: | | | **Group/FECA#:** | | | | | | | | | | | | | | | | | | | | | **In Network:** Yes No | | | | | | | | **Electronic Filing**: Yes No | | | | | | | | | | |
| **Authorization Required: Yes No** | | | | | | | **Author #:** | | | | | | | | | | | | | | | | | **Claim Inquiry Ph#:** | | | | | | | | **Claim Processing:** | | | | | | | | | | |
| **CoPay: $** | | | | | | | **Specialty CoPay: $** | | | | | | | | | | | | | | | | | **Insured’s Effective Date:** | | | | | | | | **Insured’s Terminate Date:** | | | | | | | | | | |
| **Is there another Health Plan: Yes No** | | | | | | | | | | | | | | | | | | | | | | | | **Deductible: $** | | | | | | | | **Deductible Met:** Yes No | | | | | | | | | | |
| **Subscriber Name:** | | | | | | | | | **DOB:** | | | | | | | | | **Sex:** | | | | | | **Limit: $** | | | | | | | | **Amt Satisfied: $** | | | | | | | | | | |
| **Subscriber’s ID#:** | | | | | | **Client Relationship To Subscriber:** | | | | | | | | | | | | | | | | | | **Comments:** | | | | | | | | | | | | | | | | | | |
| **Policy/Group Name**: | | | | | | **Group/FECA#:** | | | | | | | | | | | | | | | | | |
| **Authorization Required: Yes No** | | | | | | | | **Author #:** | | | | | | | | | | | | | | | |
| **CoPay: $** | | | | | | **Specialty CoPay: $** | | | | | | | | | | | | | | | | | |
| **Health Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Primary Care Physician**: | | | | | | | | | | | | | | | | | **Ph#:** | | | | | | | **Specialist:** | | | | | | | | | | | | | | | | | Ph#: | |
| **Medication:** | | | | | | | | | | | **Medication:** | | | | | | | | | | | | | | | | | | **Medication:** | | | | | | | | | | | | | |
| **Describe any serious physical / medical health condition:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Describe any Psychological / Educational Evaluation:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Current concerns / Problems** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Why did you seek counseling services?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **When did the problem begin?** | | | | | | | | | | | | | | | | **How does the problems affect you?** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Have you received treatment before?** No Yes / When | | | | | | | | | | | | | | | | | | | | | | **Is there a Family History of this problem?** No Yes / Who | | | | | | | | | | | | | | | | | | | | |
| **List your counseling / therapy goal(s):** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **behavioral/emotional symptoms**  **Check all of the following symptoms you are currently experiencing.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Loss of interest in work, school, daily activities | | | | | | | | | | | | Hyperactive, Impulsive, out of control | | | | | | | | | | | | | | | | | | Bizarre or Repetitive thoughts/behavior | | | | | | | | | | | | |
| Loss of interest in sex / maintaining arousal | | | | | | | | | | | | Unexplained aches, pains, or muscle tension | | | | | | | | | | | | | | | | | | Difficulty making decisions | | | | | | | | | | | | |
| Loss of interest in hobbies/social activities | | | | | | | | | | | | Hallucinations / hearing voice, seeing things | | | | | | | | | | | | | | | | | | Suspicious/distrust of others | | | | | | | | | | | | |
| Loss / change in appetite | | | | | | | | | | | | Delusions / Incorrect inference | | | | | | | | | | | | | | | | | | Hyperventilation, or trouble breathing | | | | | | | | | | | | |
| Trouble sleeping / Insomnia | | | | | | | | | | | | Detached, disconnected or weird | | | | | | | | | | | | | | | | | | Heart palpitations or chest pain | | | | | | | | | | | | |
| Unintentional weight gain or loss | | | | | | | | | | | | Angry/Hostile | | | | | | | | | | | | | | | | | | Headaches, dizziness, or faintness | | | | | | | | | | | | |
| Feeling sad, helpless, or trapped | | | | | | | | | | | | Mood swings | | | | | | | | | | | | | | | | | | Hot flashes, sweating, or chills | | | | | | | | | | | | |
| Feeling guilt | | | | | | | | | | | | Thoughts of harming self or others | | | | | | | | | | | | | | | | | | Stomach upset, cramps, or nausea | | | | | | | | | | | | |
| Worry, panic or fear | | | | | | | | | | | | Preoccupation with death or dying | | | | | | | | | | | | | | | | | | Frequent urination or diarrhea | | | | | | | | | | | | |
| Restlessness, irritability, nervousness | | | | | | | | | | | | Crying spells for no apparent reason | | | | | | | | | | | | | | | | | | Alcohol or drugs use | | | | | | | | | | | | |
| Loss of energy, fatigued, or weak | | | | | | | | | | | | Trouble concentrating or mind going blank | | | | | | | | | | | | | | | | | | Other: | | | | | | | | | | | | |

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| **Client/Parent/Guardian’s Signature:** | **Date:** |

**08/09/2022**

Logo, company name

Description automatically generated **Consent to Treatment Policy**

**ADULT CLIENT:** I understand that:

* my involvement and cooperation are required and is key to effective treatment; that regular attendance and completion of therapeutic assignments are essential; and that failure to do so may result in termination of services.
* all identifiable, diagnosis and treatment information are confidential and will not be released to any agency or individual without my written consent, except when required by law, and conducting standard health care operations.
* the provision of treatment requires communication of Protected Health Information (PHI) among Eclectic’s administrative staff, and my insurance/third-party payer; and that PHI is collected and stored on an electronic database, and that at all times my privacy and care will be treated with the highest regard.
* Eclectic may consult with other health care providers in order to provide the best treatment possible for me; and that my written consent may not be required when PHI is not released for such purposes. However, should it be necessary to consult with my Primary Care Physician/Specialist about my specific diagnosis and treatment, my written consent is required.
* all consent/authorizationsshall remain in effect until further notice and may be modified or revoked at any time; and that revocation of consent may result in a loss of insurance benefits and services.

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| **MinoR Client**  **Parent/Guardian authorization or consent to treatment children under the age of 19 is required!** | | | | | | | | | |
| Additionally, I understand that:   * parental/guardian participation is required in the treatment of a minor; and that Family Counseling and Consultation is necessary in the treatment of a minor; which may result in additional fees. * my child's regular attendance and completion of therapeutic assignments are essential; and that failure to do so may result in termination of services. I understand that my failure to participate in *Family Sessions* may result in termination of services. * treatment planning may require consultation with others involved with my child’s care in order to provide the best treatment possible. Should it be necessary to consult with my child’s Primary Care Physician/Specialist or Teacher, my written consent is required. * children less than 15 years of age shall be accompanied by an adult entrusted by me (parent/guardian), unless otherwise stated herein. | | | | | | | | | |
| **Father’s Name:** | | | | | **Mother’s Name:** | | | | |
| **Address:** | | | | | **Address:** | | | | |
| **City:** | | | **State:** | **Zip:** | **City:** | | | **State:** | **Zip:** |
| **HmPh#:** | **CelPh#:** | **Email:** | | | **HmPh#:** | **CelPh#:** | **Email:** | | |
| **The child lives with**   Father  Mother  Both/Shared  **Are both parents aware of child’s treatment?** Yes  No | | | | | | | | | |

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| My signature on the *Policy Acknowledgment & Informed Consent* *F****orm*** affirms my receipt of this ***Consent to Treatment Policy***, understanding, and agreement to the conditions set forth therein.  This consent/authorizationshall remain in effect until further notice; and it may be modified or revoked at any time. Revocation of consent may result in a loss of insurance benefits and services. |

**(review otherside for Minors**) **(Revised: 11/2023)**

Logo, company name

Description automatically generated *Policy Acknowledgment & Informed Consent* F**orm**

My signature below affirms my receipt of, understanding, agreement and consent to the conditions set forth by Eclectic’s in the following policies:

* *Financial Policy*
* *Confidentiality / Privileged Communication / Medical Record Policy*
* *Consent to Treatment Policy*
* *Insurance / Third Party Payer Consent to Release PHI Policy*
* *Medical Physician/Specialist Consent to Release PHI*

**Consent to Service Format:** I understand that Eclectic offers three (3) formats of Mental health services, ***Onsite/In-Office Format*** (clinician’s office or an appropriate physical location), ***Telehealth/Teletherapy Format*** (counseling/psychotherapy services using interactive HIPAA secure technology-assisted media via synchronous video/audio conferencing transmission), and a ***Hybrid Format*** (a combination of Onsite/In-Office and Telehealth/Teletherapy Format). I understand that both Onsite/In-Office Format and Telehealth/Teletherapy Format are delivered in accordance with regulatory and ethical standards consistent with HIPAA and Hi-Tech standards of practice. I understand that clients who cannot be diagnosed or treated properly via telehealth/teletherapy services shall be dismissed and treated onsite/in-office, and/or properly terminated with appropriate referrals.

*I hereby consent to receiving mental health services via the following format:*  In-Office/On-Site  Telehealth  Hybrid (Onsite/In-Office & Telehealth)

**Consent to Treatment by PLPC/Counselor Interns**: I understand that *Eclectic* is a training center for Provisional Licensed Professional Counselor (PLPC), and Graduate Counselor Interns. I understand that I may have choice in selecting a PLPC**/**Counselor Intern. I understand that the PLPC/Counselor Intern is supervised by a licensed mental health clinician, and that Protected Health Information (PHI) may be discussed with their respective supervisor. Moreover, I understand that my objection to the use of PLPC**/**Counselor Intern shall in no way jeopardize services with Eclectic.

Yes, I consent  No, I DO NOT consent to receiving mental health services from PLPC**/**Counselor Intern.

**Consent to Video/Audio Recordings.** I understand that as a training center, Eclectic may use video and/or audio recordings for clinical observation and educational presentation to promote quality care, NOT to include marketing. I understand that only authorized staff and trainees will have access to review of video/audio recordings upon receipt of their signed Confidential Agreement. I understand that video/audio recordings shall be the property of *Eclectic, with protection of PHI*. Moreover, I understand that my objection to the use of video/audio recordings shall in no way jeopardize services with Eclectic.

Yes, I consent  No, I DO NOT consent to the use of video/audio recordings.

**Consent to Contact/Communication format.** I understand that telecommunication mediums (phones, text messaging, emails, postal mail, etc.) are not a secure way of preserving confidentiality of patient’s PHI, nor a reliable method of contacting clients or ***Eclectic*** in crisis/non-crisis situations.

I consent to receiving communications as noted on the C*lient Information Form* HmPh CellPh Email Mail Other: 

**with message via:** Voicemail Email Person answering.

**Consent to Release Protected Health Information to Insurance / Third Party Payer:** I understand that patient consent is required to r***elease information to insurance or a third-party payer*** for verification of coverage, benefits, and claims.

Yes, I consent to the following Insurance/Third Party Payer  No, I DO NOT consent to the use of video/audio recordings.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Insurance/Third Party Payer:** | | **Phone#:** | **Fax:** | |
| **Address:** | **City:** | | **State:** | **Zip:** |

**Signature Authorization**

|  |  |  |
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| My signature below affirms my receipt of the forementioned policies; and my understanding, agreement and consent to the conditions set forth by Eclectic’s ***Policies*** as referenced herein.  This consent/authorizationshall remain in effect until further notice. I understand that my consent to all or any policy or condition may be modified and/or revoked at any time; and that revocation of consent may result in a loss of insurance benefits and services. | | |
| **Client's Name (PRINT):** | **Client/Guardian's Name:** | |
| **Client/Parent/Guardian's Signature:** | | **Date:** |

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| **FOR OFFICE USE ONLY**  Written acknowledgment of Consent could not be obtained because:  ❑ Client, Parent/Guardian refused to sign ❑ Emergency situation ❑Communications barriers ❑ Other  **COMMENTS:** |

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| **Revocation of consent TO TREAT** | | |
| **Client's Name (PRINT):** | **Client/Guardian's Name:** | |
| **Client/Parent/Guardian's Signature:** | | **Date:** |

**(Revised: 11/23)**



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| ***Renewing The Mind* ▲ *Transforming Lives*** |
| **1733 Wooddale Blvd ▲ Baton Rouge, LA 70806 ▲ 225-924-2800Phone ▲ 225-924-9280 Fax ▲ info@eclecticcbc.com ▲ www.eclecticcbc.com** |

Medical Physician/Specialist

Consent to release **Protected Health Information (PHI**)

I understand that some symptoms have medical or biological origins that may be comparable to serious mental or physical health conditions warranting consultation with other ***Medical Physician/Specialist (****e. g. primary care, p*sychiatrist, psychologist, *etc.)*; and the review of previous health conditions and/or treatment to provide the best treatment possible; and that my written consent is only required for the release of PHI.

**Medical Physician/Specialist: ** **Phone#:  Fax: **

**Address: ** **City:  State:  Zip: **

I authorize Eclectic Cognitive Behavioral Center, to Disclose/Receive (X) information contained in my record to/from:

|  |  |
| --- | --- |
| **Information RELEASE**  Biopsychosocial History  Diagnosis/Assessment  Eligibility Determination  Treatment Coordination/Planning  Referral  Other: | **Information Requested**  Complete Medical Records  Diagnostic Assessment Report / Results ONLY  Treatment Notes / Plans ONLY  Discharge Summary ONLY  Other (ONLY): |

**Disclosure Method:** Copy of Medical Record Verbal Consultation Written Forms/Report

I understand that my record may contain information (including medications) related to alcohol/drug abuse and/or dependence, mental health, physical health conditions, and/or sexual assault. This information will be disclosed unless I specify that the information is not disclosed by initialing the following:

Alcohol/Drug Use  Mental Health  Sexual Assault  Health Conditions, specify 

The treatment dates covered by this authorization are from  **to** 

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| I understand this release is valid  days or 12 months from the date it was signed. I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient.  I understand authorizing the use or disclosure of the information identified above is voluntary and that I need not sign this form to ensure healthcare treatment.  I understand that I have the right to revoke this authorization at any time except to the extent information has already been released in reliance of this form. To revoke this authorization, I must do so in writing and present it to the Eclectic Cognitive Behavioral Center.  I acknowledge that Eclectic Cognitive Behavioral Center and/or its staff legally liable for the interpretation or use by person(s) to whom information is released.  My signature below affirms my understanding, and consent to the release of records/information to the person(s) noted herein and for the purpose(s) stated above. | | |
| **Client's Name (PRINT):** | **Client/Parent/Guardian's Name:** | |
| **Client/Parent/Guardian's Signature:** | | **Date:** |

**DISCLOSURE**

This information has been disclosed to you from records protected by State and Federal Laws. You are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains. Information related to alcohol/drugs, mental health, sexual assault, and specific health conditions are protected by law and a general authorization for the release of medical or other information is not sufficient for this purpose.

A copy of the Authorization shall be deemed valid as original. This Authorization must be signed and dated.

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| **FOR OFFICE USE ONLY**  **Approved by**:  **Date:**  **Released by:**  **Date:** |

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| **Revocation of consent TO TREAT** | | |
| **Client's Name (PRINT):** | **Client/Parent/Guardian's Name:** | |
| **Client/Parent/Guardian's Signature:** | | **Date:** |

**(Revised: 11/23)**