THE BINDU INSTITUTE
COUNSELING • COACHING • CONSULTING

Adult Counseling Initial Intake

Client Name: *Last* _____ , *First* _____ ***Client ID:*** _____
Today's Date: *(mm/dd/yyyy)* _____

Chief Concern; *Please describe the main difficulty or issue that has brought you to here:* _____
_____
_____
_____

Treatment History; *Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?* No ☐ Yes ☐ *If yes, please indicate:*

When?	*From whom?*	*For what?*	*With what result?*

Have you ever taken medications for psychiatric or emotional problems? No ☐ Yes ☐ *If yes, please indicate:*

When?	*From whom?*	*Which medication?*	*For what?*	*With what result?*

1. *Do you have any history of suicidal/homicidal ideations or thoughts?* No ☐ Yes ☐ *If yes, please describe when and the circumstances:*

_____
_____
_____

2. *Do your currently have any suicidal/homicidal ideations or thoughts?* No ☐ Yes ☐ *If yes, please describe:*

_____
_____
_____

Relationships in your family of origin; *Please describe the following:*

1. *Your parents' relationship with each other:* _____

   _____

   _____

2. *Your relationship with each parent and with any other adults present:* _____

   _____

   _____

3. *Your parents' physical health problems, drug or alcohol use, and mental or emotional difficulties:*

   _____

   _____

4. *Your relationship with your brothers and sisters, in the past and present:* _____

   _____

   _____

   _____

Abuse History: ☐I was not abused in any way. ☐I was abused. *If you were abused, please indicate the following. For type of abuse, use these letters:* P = Physical, such as beatings, S = Sexual, such as touching/molesting, fondling or intercourse, N = Neglect, such as failure to feed, shelter, or protect, E = Emotional, such as humiliation, etc. *If more than one kind of abuse applies, use multiple letters.*

Your age at the time	***Type of abuse***	***By whom?***

Present relationships:

1. *Describe your relationship with your present spouse or partner?* _____

   _____

   _____

   _____

   _____

   _____

2. *Biological children and their ages:*
    1. *Name:_____ Age:_____* ☐ *Check if living in your home*
    2. *Name:_____ Age:_____* ☐ *Check if living in your home*
    3. *Name:_____ Age:_____* ☐ *Check if living in your home*
3. *Step children and their ages:*
    1. *Name:_____ Age:_____* ☐ *Check if living in your home*
    2. *Name:_____ Age:_____* ☐ *Check if living in your home*
    3. *Name:_____ Age:_____* ☐ *Check if living in your home*

Your important friends, past and present:

Names	***Good aspects of the relationship***	***Negative aspects of the relationship***

Other History:

1. ***Education:*** High School ☐ Some College ☐ AA Degree ☐
   Four-Year Degree ☐ Advanced Degree (Masters, PhD, MD) ☐
2. ***Have you had any major losses in your life?*** No ☐ Yes ☐ *If yes, please describe:*

_____

_____

_____

_____

3. ***Describe your supportive resources:***

_____

_____

_____

_____

4. Have you served in the military? If yes, please describe:

1. *List Branch, where stationed, number of years in service, rank:*

   _____

2. *Nature of primary duties:*

   _____

3. *Describe any combat experience:*

   _____

   _____

4. *Describe your feelings about your military service:*

   _____

   _____

5. What is your religious affiliation? _____

6. Describe your strengths and abilities:

_____
_____
_____

Chemical Use:

1. *How many cups of regular (caffeinated) coffee do your drink each day? _____ How many cups of (caffeinated) tea? _____ How many sodas with caffeine (Coke, Pepsi, Mountain Dew, Dr. Pepper, Orange Crush, etc.)? _____ How many "energy drinks?" _____ How often do you use NoDoz or similar pills? _____*
2. *How much tobacco do you smoke or chew each week? _____*
3. *How much beer, wine or hard liquor do you consume each week on the average? _____*
4. *Have you ever used inhalants ("huffing") such as glue, gasoline, or paint thinner?* No ☐ Yes ☐

   If yes, which and when? _____
5. *Which drugs (not medications prescribed for you) have you used in the last 10 years? _____*

   _____

   _____

   _____

   Please provide details about your use of these drugs or other chemical, such as amounts, how often you used them, their effects, and so forth: _____

   _____

   _____

6. *Does anyone in your home use drugs or alcohol?* No ☐ Yes ☐ *If yes, please describe:*
    1. *Name: ____________________________ Substance(s) used: ________________________*
    2. *Name: ____________________________ Substance(s) used: ________________________*

Legal History:

1. *List all the contacts with the police, courts, and jails/prisons you have had. Include all open charges and pending ones. Under "Jurisdiction" wrote in a letter: F = Federal, S = State, Co = County, Ci = City. Under "sentence" write in the time and the type of sentence you served or are facing: (AR = accelerated or alternative resolution, CS – community service, F = fine, I – incarceration, Pr = probation, Po = parole, O = other, R = restitution).*

Date	***Charge***	***Jurisdiction***	***Sentence***	***Probation/Parole Officer's Name***	***Your attorney's name***

1. *Do you have any other legal issues?* ____

    ____

Other: *Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it.*

____

____

Signature: *In signing below, I attest that I have answered all questions honestly, fully and accurately to the best of my ability*

Client: ____ ***Date:*** ____/____/_______
mm/dd/yyyy

Please do not write below this line, Office use only.

- -

Clinician: ____________________ **Assigned Client ID:** ______

Payment Code: ____________ ***Referral Code:*** _____________ ***Discharge Code:*** ____________

This is a strictly confidential patient medical record. Disclosure or transfer is expressly prohibited by law.

THE BINDU INSTITUTE
COUNSELING • COACHING • CONSULTING

Adult Counseling Registration

Client Name: *Last* _____ , *First* _____ ***Today's Date:*** *(mm/dd/yyyy)* _____

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

Daytime Phone: (___) _____ - _____ ***Alternate Phone:*** (___) _____ - _____ ***Gender:*** *Male* ☐ *Female* ☐

Sexual Orientation: *Heterosexual* ☐ *Homosexual* ☐ *Bisexual* ☐ *Other* ☐ _____

Email: _____ **Date of Birth:** ____/____/_____

Referred by: _____ *OK to thank referrer?* ☐

Chief Concern; *Please describe the main difficulty or issue that has brought you to here:* _____

_____

_____

1. ***Marital Status:***
   ☐*Married* ☐*Single* ☐*Divorced* ☐*Separated*
   ☐*Widowed* ☐*Dating* ☐*Living with someone*
2. ***If you are in a relationship currently, How long have you been together****?* _____
3. ***Current employment status/past employment:***
   Employer: _____ *Job Title:* _____ *From* _____ *to* _____
   mm/yyyy *mm/yyyy*
   Employer: _____ *Job Title:* _____ *From* _____ *to* _____
   mm/yyyy *mm/yyyy*
   Employer: _____ *Job Title:* _____ *From* _____ *to* _____
   mm/yyyy *mm/yyyy*
   Employer: _____ *Job Title:* _____ *From* _____ *to* _____
   mm/yyyy *mm/yyyy*

Signature: *In signing below, I attest that I have answered all questions honestly, fully and accurately to the best of my ability.*

Client: _____ ***Date:*** ____/____/_____
mm/dd/yyyy

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Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

If this questionnaire is completed by an informant, **what is your relationship with the individual? _____**
In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

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1913 Highway 87, Navarre, FL 32566
www.TheBinduInstitute.com

LEVEL 2—Anxiety—Adult*

*PROMIS Emotional Distress—Anxiety—Short Form

Name:
Age:
Sex: ❑ Male ❑ Female Date:

If the measure is being completed by an informant, what is your relationship with the individual?

In a typical week, approximately how much time do you spend with the individual? hours/week

Instructions to patient: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* you (individual receiving care) have been bothered by "feeling nervous, anxious, frightened, worried, or on edge", "feeling panic or being frightened", and/or "avoiding situations that make you anxious" at a mild or greater level of severity. The questions below ask about these feelings in more detail and especially how often you (individual receiving care) have been bothered by a list of symptoms **during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
In the past SEVEN (7) DAYS....							**Item Score**
		Never	**Rarely**	**Sometimes**	**Often**	**Always**	
1.	I felt fearful.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
2.	I felt anxious.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
3.	I felt worried.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
4.	I found it hard to focus on anything other than my anxiety.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
5.	I felt nervous.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
6.	I felt uneasy.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
7.	I felt tense.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	

Total/Partial Raw Score:	
Prorated Total Raw Score:	
T-Score:	

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LEVEL 2—Depression—Adult

PROMIS Emotional Distress—Depression—Short Form

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date: _____

If the measure is being completed by an informant, what is your relationship with the individual receiving care? _____

In a typical week, approximately how much time do you spend with the individual receiving care? _____ hours/week

Instructions: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* you (the individual receiving care) have been bothered by "no interest or pleasure in doing things" and/or "feeling down, depressed, or hopeless" at a mild or greater level of severity. The questions below ask about these feelings in more detail and especially how often you (the individual receiving care) have been bothered by a list of symptoms **during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
In the past SEVEN (7) DAYS....							**Item Score**
		Never	**Rarely**	**Sometimes**	**Often**	**Always**	
1.	I felt worthless.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
2.	I felt that I had nothing to look forward to.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
3.	I felt helpless.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
4.	I felt sad.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
5.	I felt like a failure.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
6.	I felt depressed.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
7.	I felt unhappy.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
8.	I felt hopeless.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
						Total/Partial Raw Score:	
						Prorated Total Raw Score:	
						T-Score:	

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LEVEL 2—Substance Use—Adult

Adapted from the NIDA-Modified ASSIST

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:** _____

If the measure is being completed by an informant, what is your relationship with the individual receiving care?

_____

In a typical week, approximately how much time do you spend with the individual receiving care? _____ hours/week

Instructions: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* you (the individual receiving care) have been bothered by "using medicines on your own without a doctor's prescription, or in greater amounts or longer than prescribed, and/or using drugs like marijuana, cocaine or crack, and/or other drugs" at a slight or greater level of severity. The questions below ask how often you (the individual receiving care) have used these medicines and/or substances **during the past 2 weeks.** **Please respond to each item by marking (√ or x) one box per row.**

During the past **TWO (2) WEEKS**, about how often did you use any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed?							**Clinician Use**
		Not at all	**One or two days**	**Several days**	**More than half the days**	**Nearly every day**	**Item Score**
a.	Painkillers (like Vicodin)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
b.	Stimulants (like Ritalin, Adderall)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
c.	Sedatives or tranquilizers (like sleeping pills or Valium)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
Or drugs like:							
d.	Marijuana	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
e.	Cocaine or crack	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
f.	Club drugs (like ecstasy)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
g.	Hallucinogens (like LSD)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
h.	Heroin	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
i.	Inhalants or solvents (like glue)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
j.	Methamphetamine (like speed)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
						Total Score:	

LEVEL 2—Anger—Adult*

*PROMIS Emotional Distress—Anger—Short Form

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

If the measure is being completed by an informant, what is your relationship with the individual receiving care? _____

In a typical week, approximately how much time do you spend with the individual receiving care? _____ hours/week

Instructions: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* you (the individual receiving care) have been bothered by "feeling irritated, grouchy, or angry" at a mild or greater level of severity. The questions below ask about these feelings in more detail and especially how often you (the individual receiving care) have been bothered by a list of symptoms **during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
In the past SEVEN (7) DAYS....							**Item Score**
		Never	**Rarely**	**Sometimes**	**Often**	**Always**	
1.	I was irritated more than people knew.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
2.	I felt angry.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
3.	I felt like I was ready to explode.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
4.	I was grouchy.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
5.	I felt annoyed.	❑ 1	❑ 2	❑ 3	❑ 4	❑ 5	
						Total/Partial Raw Score:	
						Prorated Total Raw Score:	
						T-Score:	

THE BINDU INSTITUTE
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1913 Highway 87
Navarre, FL 32566
(850) 692-9824

The Bindu Institute Consent to Use and Disclose Your Health Information

This form is an agreement between you, and The Bindu Institute, When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here:

.

_____

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy from our website, www.thebinduinstitute.com, or by calling us at (850) 692-9824. Please ask to speak to our privacy officer.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to our privacy officer. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

_____ _____

Signature of client or his or her personal representative | Date

_____ _____

Printed name of client or personal representative | Relationship to the client

_____ _____

Description of personal representative's authority | Signature of authorized representative of this office or practice

Date of NPP: _____ ❑ Copy given to the client/parent/personal representative

The Bindu Institute Notice of Privacy Practices (Brief Version)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This is a shorter version of the attached, full, legally required notice of privacy practices. Please talk to our privacy officer (see the end of this form) about any questions or problems.

How we use and disclose your protected health information with your consent

We will use the information we collect about you mainly to provide you with **treatment**, to arrange **payment** for our services, and for some other business activities that are called, in the law, **health care operations.** After you have read this notice we will ask you to sign a **consent form** to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your health information without your consent

There are some times when the laws require us to use or share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
2. When we are required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For workers' compensation and similar benefit programs.

There are some other rare situations. They are described in the longer version of our notice of privacy practices.

Your rights regarding your health information

1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask. We can also offer Telehealth services on an as needed bases.

2. You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.

3. You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you for it. Contact our privacy officer to arrange how to see your records. See below.

4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our privacy officer. You must also tell us the reasons you want to make the changes.

5. You have the right to a copy of this notice. If we change this notice, we will post the new version in our waiting

area, and you can always get a copy of it from the privacy officer.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our privacy officer and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise. If you have any questions regarding this notice or our health information privacy policies, please contact our privacy officer, who is Alice Malcolm and can be reached by phone at or by e-mail at alice@TheBinduInstitute.com

The effective date of this notice is May 31, 2019.

THE BINDU INSTITUTE
COUNSELING • COACHING • CONSULTING

1913 Highway 87
Navarre, FL 32566
850.692.9824

Request/Authorization to Release Confidential Records and Information

I hereby authorize:
Person or facility: The Bindu Institute

Address: 1913 Highway 87, Navarre, FL 32566 Phone: 850-692-9824 Fax: 844.201-8559

to release information from records about _____, born on _____,

and whose Social Security number is _____,

to_____

Address: _____ Phone: _____ Fax: _____

for the following purpose(s):

❑ Further mental health evaluation, treatment, or care ❑ Treatment planning ❑ Substance Assessment
❑ Other: _____

These records concern the time between _____ and _____.
In the boxes below, the information to be disclosed is marked by an X, the items not to be released have a line drawn through them.

❑ Intake and discharge summaries ❑ Medical history and evaluation(s) ❑ Educational records
❑ Mental health evaluations ❑ Developmental and/or social history ❑ Psychosocial Assessment
❑ Progress notes, and treatment or closing summary ❑ Assessment (indicate type) _____
❑ Other: _____

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: ❑ Do not release HIV-related information ❑ Do not release drug and alcohol information.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

_____	_____	_____
Signature of client	Printed name	Date

_____	_____	_____	_____
Signature of parent/guardian/representative	Printed name	Relationship	Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

_____	_____	_____
Signature of witness	Printed name	Date

❑ Copy for patient or parent/guardian ❑ Copy for source of records ❑ Copy for recipient of records

Financial Information and Policy - Mental Health Counseling Services

We truly appreciate your choosing The Bindu Institute. As part of providing high-quality services, we need have accurate insurance information and be clear about our financial arrangements.

A. Client Information

Client's name: _____ Date of Birth: _____Soc. Sec. #: _____ Home Address: _____Contact phone: _____ (If the client is a minor we will need the name, birth date, and Soc. Sec. # of parent/guardian:
Full name of parent/guardian: _____ Date of Birth: _____ Soc. Sec. #: _____

B. Insurance Information

If you have insurance you would like us to use/file, please fill in the information in this Section.

Full name of policy holder/subscriber (if not the patient):_____

Insurance Company: _____ Policy Number: _____

If you have other (secondary) insurance, complete below:
Full name of policy holder/subscriber (if not the patient):_____
Insurance Company: _____ Policy Number: _____

C. Payment Method: If you do not have insurance how will you pay for services from this office?

___ Cash ___ Check ___ Debit/Credit Type of Card: ___ Visa ___ M/C ___Discover ___Other

Card Number (16 digit): _____ Exp. Date: _____ Security Code: _____

D. Returned Checks

There will be a $25.00 charge for returned checks.

E. Release of Information to Insurance Company

I give this office permission to release any information obtained during examinations or treatment of this client that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself.

F. Billing

I understand that I am responsible for all charges, regardless of insurance coverage. Payment for all client statements is due in full upon receipt. Payment arrangements can be made in advance for some accounts. A divorce decree cannot assign responsibility for an adult's or child's account. Failure to pay your bill will result in your account being turned over to a collection agency. Only your account status will be discussed with the collection agency.

G. Appointment Cancellation Policy

Our staff at The Bindu Institute is committed to our clients and we continue to accept new clients. A missed appointment means that other clients were not able to make use of the appointment time missed. Therefore, we require a credit card number in order to hold your appointment time. If for any reason you are unable to keep you're appointment, please call at least one business day in advance to allow us to schedule that time for another client. If you fail to notify us prior to one business day before your schedule appointment, a $60.00 fee will be charged. If more than two sessions are missed without proper notification, continued services will be re-evaluated. We appreciate your assistance in helping us serve you better by keeping scheduled appointments.

H. Assignment of benefits

I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to The Bindu Institute. A photocopy of this assignment is to be considered as good as the original.

My signature below acknowledges that I have read, fully understand, and agree to all parts of the financial policy of The Bindu Institute.

_____ Date: _____
Client's (or parent/guardian's) signature, indicating agreement to the Financial Policy

_____
Printed name