Intake Form

First Name: ____ MI: ____ Last Name: ____

Address: ____ Soc.Sec.#: - -

City: ____ State: ____ Zip+4: ____ Birth Date: / / Age: ____

Home Phone: ( ) - Work Phone: ( ) - Sex: ☐ Male ☐ Female

Mobile Phone: ( ) - E-mail: ____

Marital Status		Ethnic Origin		Employment Status
☐ Single	☐ Separated	☐ Euro-American	☐ Asian-American	☐ Employed
☐ Married	☐ Divorced	☐ African-American	☐ Native American	☐ Full-time Student
☐ Domestic Partner	☐ Widowed	☐ Hispanic-American	☐ ____	☐ Part-time Student

Occupation: ____ Referral Source: ____

Emergency Contact | Phone # | Relationship: | |

Primary Care Physician | City | Phone #: | |

Allergies: ____ Presenting Problem: ____

Insurance Company / EAP Information (if applicable)

Insurance / Managed Care / EAP Name: ____

Address: ____ ID/Policy#: ____

City: ____ State: ____ Zip: ____ Group#: ____

Policy Holder's Employer: ____

Insurance Plan Name: ____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____

Policy Holder (if not self)

First Name: ____ MI: ____ Last Name: ____

Address: ____ Soc.Sec.#: - -

City: ____ State: Zip+4: ____ Birth Date: ____

Home Phone: ( ) - Work Phone: ( ) - Sex: ☐ Male ☐ Female

For Office Use Only

Pgm Name: ____

Intake Dt: ____ S: ____ Acct#: ____

N/R: ____ S/N: ____ Serv: ____ Clinic: ____

F: ____ ____ ____ ____

Dx:

- MED:
- SA:
- PSYCH:
- PSYCH:
- FOCUS:

TY (Y/N): ____

PCP LTR (Y/N): ____

A1 ☐ CC ☐
LOG ☐ A2 ☐
FOLD ☐ TH ☐
WORD ☐ Auth ☐

INS: scan copy
ID: scan copy

Goog ____
Outl ____
Post ____

AUTH
#SESS:
DATES:
AUTH#:

Next Appt: / /

Personal Growth Concepts, Inc.

COUNSELING & RELATED SERVICES

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, ________________ and Personal Growth Concepts, Inc. and its staff. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here: ________________.

When we evaluate, 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 here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you, including your primary care physician so that we can coordinate services. We also provide information as needed to insurance & managed care companies in order to arrange payment for your treatment.

By signing this form you are agreeing to let us use your information here and send it to others only as outlined above. The Notice of Privacy Practices (NPP) explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form. **If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices (NPP), we can not treat you.**

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from our Web Site, www.personalgrowthconcepts.com or by calling us at 203-375-5782, or from our privacy officer.

If you are concerned about some of your information, you have the right to ask us not to use or share some of your information 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 agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information and can not change that.

PLEASE CIRCLE ONE: I AGREE TO HAVE INFORMATION RELEASED TO MY PRIMARY CARE PHYSICIAN: YES NO

________________________________ ________________
Signature of client or his or her personal representative Date

________________________________ ________________
Printed name of client or personal representative Relationship to the client

Date of NPP: 4/14/2003; consent rev 7/07
rev 05/11

☐ Copy offered/given to the client/parent/personal representative

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