Serenity Coaching and Counseling LLC

Welcome! Please fill out the form below. Information you provide is confidential & will help you & your provider when you meet for the first time. Please feel free to ask questions. (Use back of page for extra space).

Name _____ Date of Birth _____/_____/_____

Partner's Name _____ Date of Birth _____/_____/_____

Address _____
Street City State Zip

Is it appropriate to send correspondence to this address? (please circle) Yes No

Phone (primary) _____ Can we leave you messages? (please circle) Yes No

(Partner's Phone) _____ Contact E-mail _____

Would you like appointment reminders? If so, please circle: Text Email Text and Email Decline All

Do you agree with e-mail correspondence for scheduling purposes or for general questions? Yes No

Emergency Contact: **(Name/Contact)**_____

Primary Care: (Name/Contact)_____
Are you willing to sign written consent for us to contact your Primary Care Provider? **Yes** **No**

Do you/partner have any medical or physical health issues that we would need to know about?

_____

Are you/partner on any medications that we should know about ? Who prescribes them (ie Psychiatrist)?

_____

Do you/partner have other **Supports or Legal** issues we should know about? (self-help, psychiatry, groups, probation, etc)

_____

Have you ever been to therapy before or been **hospitalized** for a mental health, emotional, or a substance use disorder?
Please explain:

_____

Family Status (circle): Single Married Separated Divorced Widowed Other___ Children in Home? _____

Education: (Self):_____(Partner): _____ Occupations: _____

Is there anything about you both (spirituality, cultural beliefs, identity, etc) that we should know about?

How did you hear about us? _____

Serenity Coaching and Counseling LLC

42 Lake Ave Worcester, MA 01604 www.SerenityMA.com Group NPI: 1992159867 EIN: 812268223
Main #: 508.556.0745 Fax #: 508.519.6539 Intake: 508.868.8070 or intake@SerenityMA.com

Consent for Treatment:

* During my intake, I have received and agree to the following information:

- ✓ Privacy Notice (HIPAA)
- ✓ Notification of clients' rights
- ✓ Agency policies and procedures
- ✓ Notice of AI Use
- ✓ Grievance Procedure
- ✓ Copy of the Orientation to Treatment and Client Policies Pamphlet
- ✓ Telehealth Consent

* I understand that it is my responsibility to attend all scheduled appointments. If I need to reschedule an appointment, I will call with at least eight (8) hours notice. I understand that there will be a $25.00 fee for any appointments that I do not attend and do not cancel (no shows). I understand that I am responsible for this fee. I understand that if I "no show" two appointments, or if I cancel two appointments within a 30 day period, my case will be closed.

_____ _____

Client Name (Please Print) **Date of Birth**

_____ _____

Client Signature **Date**

Consent to Release Information & Authorization of Benefits (Insurance)

Please provide a copy of your insurance card or information to your Serenity Provider

Client: _____ DOB: _____ Are you the subscriber? Yes No

If not subscriber, who is? _____ DOB: _____ Relationship to Client: _____

Subscriber Address/Phone: Same as address listed or: _____

Insurance Company: _____Insurance ID#: _____ Copay: $_____

*I authorize the release of information as may be required by my insurance company, their reimbursing agency, or as may be otherwise necessary for payment of claims resulting from my mental health treatment. *I understand information will be disclosed for processing claims for treatment I have received, quality review & continuity of care purposes. This may include information contained in my records that concerns medical illness, mental illness or substance abuse, and/or domestic violence. *I authorize payment directly to Serenity Coaching and Counseling, LLC of benefit otherwise payable to me. *I understand that I am financially responsible for any deductible, co-insurance, non-covered charges, or charges resulting from my failure to follow my insurers' referral guidelines. *I understand that I may revoke release at any time, but I must notify Serenity Coaching and Counseling, LLC of revocation in writing.

Having read & understanding the provisions, I consent to these statements & authorize Serenity Coaching & Counseling, LLC to act in accordance with these provisions.

_____ _____

Client Name (Please Print) **Date of Birth**

_____ _____

Client Signature **Date**

Witness: _____ _____ _____

Name (Please Print) Signature Date