Vasa Parsons, MSW, LCSW
610 N California, Missoula, MT 59802

Medicaid_____
Ins. _____
Co pay _____

Initial Intake Information

Date: _____ DX: _____

Client Name: _____ DOB: _____ Age: _____
Gender/How do you identify _____
Address _____ City/State/Zip: _____
SS No.: _____/_____/_____ Home Phone: _____ Work Phone: _____ Cell _____
Employer Name & Address_____
Years of School Completed: _____ If student, school/grade/curriculum: _____

Do we have your permission to call your phone and leave a message? Yes_____ No_____

Client's Counseling Agreement

- I understand I am responsible for this bill and the typical fee for individual service is $125.00 per session usually lasting 50 minutes. The first session (diagnostic assessment) is charged at $160.00.
- 24 hour advance cancellation notice is required or a $125.00 missed appointment fee may be charged.
- Co-payment at the time of service is expected.
- All patients will be accepted as private pay patients. Insurance will be billed as a courtesy and any unpaid balance will be your responsibility. Please check with your insurance company about preauthorization requirements otherwise services may not be covered.
- A record is kept of the services provided to you. These records are in a locked file and will not be disclosed to others unless directed by you or unless the law authorizes or compels my office to do so.
- By signing, I affirm I have received a copy of the HIPAA privacy practices of this office and consent to the terms of this agreement.

Primary Insurance Information and Insurance Release

I agree to release basic information deemed necessary to process the insurance claims. I also authorize my insurance benefits to be paid directly to Blue Mountain Clinic.

Responsible Party or Custodial Parent: _____
Relationship to Client: _____
Insured: _____ Insured's DOB: _____/_____/_____
Insurance Carrier: _____ Ins. Co. Phone#: _____
Ins. Co. Address: _____ Policyholder's Soc. Sec. #: _____/_____/_____
_____ Group #: _____
Insured's Employer: _____

Do you have other insurance? Yes No
SECONDARY INSURANCE:
Insured: _____ Policyholder's DOB: _____/_____/_____
Insurance Carrier: _____ Ins. Co. Phone#: _____
Ins. Co. Address: _____ Policyholder's Soc. Sec. #: _____/_____/_____
_____ Group #: _____

Signed: _____ Date: _____
(A photocopy of this signature is valid as the original)

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Please list the names and ages of those persons currently living in the same household:
_____
_____

Have you ever been in counseling before? Yes No Was it helpful? Yes No
With whom? _____

Briefly describe what brings you to therapy:
_____
_____
_____

List any medications you are currently taking and dosages:
_____
_____
_____

Additional information you think might be helpful:
_____
_____
_____

How were you referred to me? _____

Limits of Confidentiality

Information discussed during this appointment is held confidential and will not be shared without written permission except under the following conditions:

1. The client threatens suicide.
2. The client threatens to harm another person(s), including murder, assault or other physical harm.
3. The client is a minor (under 18) and reports suspected child abuse, including but not limited to, physical beatings and sexual abuse/statutory rape.
4. The client reports abuse of the elderly.
5. The client reports sexual exploitation by a therapist.

State law mandates that health professionals may need to report these situations to the appropriate persons and/or agencies.

Communications between the clinician and client will otherwise be deemed confidential as stated under the laws of the state.

Having read and understood above, I agree to these limits of liability.

_____ _____

Name of Client or Guardian **Date**

_____ _____

Signature of Client or Guardian **Date**