The Gentle Shepherd COUNSELING CENTER

1469 SOUTH MAIN ST
NORTH CANTON, OH 44720
330.499.3065 FAX: 330.499.2497

Initial Date of Contact: _____

Counselor: _____

Appointment Date&Time: _____

## ADULT CONFIDENTIAL INFORMATION & CONSENT TO TREATMENT 2022: (PLEASE PRINT)

Name of client: _____ Age: _____ Gender: _____
Last First Middle

Home address: _____
Street City State Zip

Birthdate: _____ Phone: Home _____ Cell : _____

*May we leave a text or voicemail? □ Yes □ No

Occupation: _____

Employer: _____

E-mail: _____ Social Security #: _____ - _____ - _____

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Other

Partner/Spouse's Name: _____ Birthdate: _____

Address (if different from above): _____ Phone: _____

* May we leave a text or voicemail? □ Yes □ No

Employer: _____

Primary Doctor: _____ Practice Name: _____

**Are you willing to sign a form to release information to coordinate treatment with your Primary Care Physician?*

□ Yes □ No

Handicapped Access Required? □ Yes □ No (**Not all facilities have wheelchair accessibility.)*

_____Initials I have been given access to the HIPAA Privacy Practices and have the right to request a paper or electronic copy for my personal use.

_____Initials I consent to allow The Gentle Shepherd Counseling Center to use unsecure email to transmit protected health information (PHI). I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my PHI by unsecured means.

I hereby consent to treatment with The Gentle Shepherd Counseling Center. All information provided above is accurate. I agree to payment of all charges accrued.

Date: _____ Name: _____

Client Name: _____ DOB: _____

Counselor: _____

HOW CAN A COUNSELOR BEST HELP YOU?

_____

_____

_____

PREFERENCES / REQUESTS: *Cannot guarantee all requests (ie. clinician, day or time)

_____

_____

_____

How did you hear about us: _____

☐ Self Pay (Each visit at $150) *Optional sliding fee scale based on qualifications, documentation required

☐ 65+ ☐ College Student (ID required)

Household Annual Salary: _____ Number of Dependents: _____

☐ Insurance (Aetna, Anthem, Aultcare, Cigna, Med Mutual, Mutual Health, The Health Plan, Ohio Health Choice, PHCS, UBH, Optum, UMR, Summa*) ***some plans accepted*** NO MEDICARE/MEDICAID

Insurance Company: _____ Policy Holder: _____

Member ID: _____ Group Number: _____

Person responsible for payment: _____ Phone: _____

Address (if different from above): _____

## Benefits *(for office use only)*

Date: _____ Staff Initials: _____

Insurance Pays: _____ Copay: _____

Deductible: _____ Deductible Met: YES NO

Out of Pocket: _____ Out of Pocket Met: YES NO