



614 South Ave
Springfield, MO 65806
Office: 417-869-9011
Crisis: 417-862-6555

Welcome to Betty & Bobby Allison Ozarks Counseling Center, we look forward to working with you. **Please read the following information carefully.** Feel free to ask any questions you may have at the initial intake. You are welcome to show this information to others in your family or to other professionals you trust.

TIME OF APPOINTMENTS: Each of our appointments is scheduled to last about 50 minutes. It is our policy to charge for a missed appointment without 24 hour notice, unless it was an emergency situation. If you consistently fail to keep your appointments we will refer you elsewhere for counseling. If you are set up with a standing appointment and fail to keep an appointment without notifying our office we will cancel any future appointments. You can still schedule with us, but may lose your standing appointment time.

SEE YOUR DOCTOR: If possible, we strongly recommend that you get a physical examination from your personal physician as soon as possible. This is important to make sure that none of the problems to be discussed are the result of physical health difficulties. Because we are not physicians, we cannot know if you have physical conditions that might be related to your situation.

EMERGENCY SITUATIONS: We will try to be available to you as much as possible. We are open Monday-Thursday 9:00-8:00, Friday 9:00-4:00, and Saturday 9:00-1:00. The telephone numbers on the front of this form are to the BBAOCC and the area 24 hour crisis line.

COST: It is our mission to make the counseling you need affordable. Your fee is discounted according to your household income and the number in the household. If your fee on the sliding scale is still not affordable you can request a grant form which may reduce your fee based on your expenses. Our basic rate is \$80 per counseling hour before adjustment for income. Our sliding scale is made possible in part by United Way of the Ozarks funding as well as our use of Counselors-In-Training and graduate level interns, all of whom are supervised by our licensed staff members.

INSURANCE: Your health insurance *may* cover this service. Please provide your insurance card to the front desk at initial session. If we bill insurance for you we charge the \$80.00 flat rate fee. Your fee if self pay is based on the sliding scale fee and you are responsible for the fee if your insurance does not pay. Medicaid/MC+ will pay for counseling if the client is under age 21. Medicare may also cover our counseling services, but we will need to verify coverage.

CONFIDENTIALITY: As a client, you have rights to confidentiality. Therapists are bound by ethical codes of their profession and under the privacy act laws of Missouri. Information shared with a therapist will be given to others only upon your request and with your written permission. Some limits on maintaining confidentiality are:

- *Subpoena of records by a court of law.
- *Laws mandating reporting of child or vulnerable adult abuse.
- *Duty to warn the proper authorities regarding homicidal or suicidal concerns.
- *Your diagnosis which is required on all health insurance forms.
- *Special rules for Minors: under MO Law (431.061.4) Both parents have access to the minor's health (including mental health) records.

Adult Intake Basic Information

Name: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____ Birthdate: _____

Cell Phone: _____ Alt Phone: _____ Email: _____

I would like to receive appointment reminders by (circle all that apply): Email Text None

It is ok to leave messages with the person answering the phone, answering machine, and/or voicemail: Yes No

Age: _____ Gender: _____ Race: _____

Highest Education Completed: _____ Marital Status: _____

Emergency Contact Person: _____ Phone: _____

List the persons you are now living with, ages, and relationship to you: _____

Employer: _____ Occupation: _____

Annual Gross Income for Household (includes child support, disability, retirement, etc.): _____

How did you find out about us? _____

Insurance/Healthcare (optional)

Do you have (please circle): Medicaid, Medicare, Private Insurance *please present cards to front desk*

Clinic or physicians name: _____

Last Visit: _____ Reason: _____

Current Health Problems: _____

Medications: _____

Previous Hospitalizations (reason/date): _____

Previous Counseling: _____

Your Concerns

Briefly describe your reason for coming to counseling: _____

Do you use alcohol? _____ How often? _____ Typical # drinks: _____

Do you use drugs? _____ Frequency of use: _____

Substances Used: _____

Have you ever had thoughts of suicide? _____ Have you ever attempted? _____

Please check all areas that you are currently concerned about. Circle areas most important to you now.

- | | | |
|---|---|--|
| <input type="checkbox"/> marriage | <input type="checkbox"/> drugs (self) | <input type="checkbox"/> divorce preparation |
| <input type="checkbox"/> parenting | <input type="checkbox"/> drugs (other) | <input type="checkbox"/> divorce adjustment |
| <input type="checkbox"/> anger | <input type="checkbox"/> death | <input type="checkbox"/> relationship problems |
| <input type="checkbox"/> depression | <input type="checkbox"/> weight problems | <input type="checkbox"/> guilt |
| <input type="checkbox"/> alcohol (self) | <input type="checkbox"/> eating disorders | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> alcohol (others) | <input type="checkbox"/> sexual abuse | <input type="checkbox"/> suicide |
| <input type="checkbox"/> physical abuse | <input type="checkbox"/> legal problems | <input type="checkbox"/> hallucinations (audio/visual) |
| <input type="checkbox"/> school | <input type="checkbox"/> step-family issues | <input type="checkbox"/> family |
| <input type="checkbox"/> job/career | <input type="checkbox"/> sleep problems | <input type="checkbox"/> problems with parents |
| <input type="checkbox"/> phobia/fears | <input type="checkbox"/> grief/mourning | <input type="checkbox"/> obsessive thoughts |
| <input type="checkbox"/> assertiveness | <input type="checkbox"/> health | <input type="checkbox"/> trauma victim |
| <input type="checkbox"/> seizures, black-outs | <input type="checkbox"/> sexuality or LGBTQ | <input type="checkbox"/> financial |
| <input type="checkbox"/> panic attacks | <input type="checkbox"/> marriage preparation | <input type="checkbox"/> head injuries |
| <input type="checkbox"/> other: _____ | | |

Consent for Treatment

I hereby consent to assessment, treatment, counseling, and/or family therapy for myself as deemed appropriate by the staff of the Ozarks Counseling Center. My signature indicates that I understand the information as provided to me on the information sheet I received with this consent form.

I give permission for this agency to release information necessary to bill Medicaid, Medicare or private insurance for services rendered by Ozarks Counseling Center.

*Signature