Andrea Strizich, LCSW
610 N California Missoula, MT 59802
Ins. _____

Medicaid _____

Co pay_____

Initial Intake Information

Date: _____ DX:_____

Client Name:_____ DOB: _____Age_____
Gender-How do you identify: M ___ F___ Transgender__FTM___MTF____
Address: _____
City/State/Zip:_____
SS No. _____ Home Phone:_____ Work Phone:_____ Cell_____
Employer Name & Address: _____
Years of School completed:_____If student, school/grade/curriculum:_____

Client's Counseling Agreement

- I understand that 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 below, I affirm that I have received a copy of the HIPPA 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 #: _____

Address:_____ Policyholder's Soc. Sec. #_____

_____ Group # _____

Signed: _____ Date: _____

(A photocopy of this signature is as valid as the original)

Andrea Strizich, LCSW

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

_____

_____

Have you ever been in counseling before? YES NO

With whom?_____How long?_____

Do you feel safe?_____

Briefly describe what brings you to therapy:

_____

_____

_____

_____

_____

List any medications you are currently taking and dosages:

_____

_____

Additional information that 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 the above, I agree to these limits of liability.

_____	_____
Name of Client or Guardian	Date
_____	_____
Signature of Client or Guardian	Date