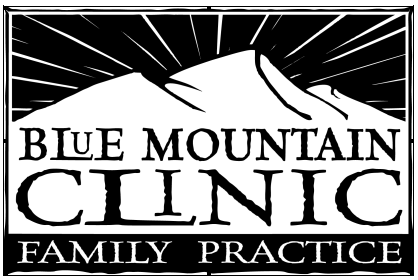

Bernadette (Bernie) Kneefe, MSW, LCSW
610 N California Missoula, MT 59802

Medicaid _____
Ins. _____
Co pay_____

Initial Intake Information

Date: _____ DX:_____

Client Name:_____ DOB: _____Age_____
Gender-How do you identify: 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)

Bernie Kneefe, MSW, 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 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 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