GROUP INTAKE FORM | ichoosechange

GROUP PARTICIPANT'S INFORMATION:

OFFICE USE ONLY:
CSLR: ___________
DX: ___________
FEE: ___________

Today's Date: ____________________ **Participant's Name:** ____________________
Legal Guardian(s) if under 17 years: ____________________
Address: ____________________
City / State / Zip: ____________________
Ok to send correspondence to this address? Yes / No
Phone: ____________________ Ok to leave a message here? Yes / No
Alternate Phone: ____________________ Ok to leave a message here? Yes / No
Email: ____________________ Ok to send email here? Yes / No
Birth Date: ___ / ____ / ____

How did you hear about this group?
(Check all that apply)

- ☐ Magazine
- ☐ Internet Search
- ☐ Physician: _____________
- ☐ Relative
- ☐ Community Paper
- ☐ Counselor: _________________
- ☐ Friend
- ☐ Other: _________________

Would you like to receive emailed blog articles or information on upcoming events? Yes / No

PAYMENT INFORMATION:

$55 per month (billed on the 1st of every month unless given verbal and/or written notice)

Payment Type (circle one):
Cash - Check - Visa - MasterCard - AMEX - Flexible Spending Card

If paying by credit card, please fill out the following:
Name on card: ____________________
Card number: ____________________
Card Expiration: ____________________

______________________ ______________________
Participant's Name Authorized Signature

HIPAA COMPLIANCE

The HIPAA notice describes how mental health information about you may be used and disclosed and how you can get access to this information. This Privacy Notice tells you about your rights about your mental health care records. You can look at this copy anytime to see what use is made of your health care records and who gets to see them. A new government rule requires that we give you this Privacy Notice to sign.

The HIPAA Compliance notice is posted in the I Choose Change waiting room and on the website. If you would like a hard copy of the HIPAA Compliance information, please let your counselor know and a copy will be provided for you. Please review it carefully.

Our policy has always been to keep your records safe. Your records are usually kept in a folder of papers with your name on it. Your records can also be stored in a computer. Your records tell what analysis and treatments you have had, and what decisions the counselor has made.

By signing below, you attest that you have read and have been made aware of your rights of confidentiality as a mental health consumer.

______________________________ ______________________________

Guardian Printed Name Relationship to Patient