

# Myers Counseling Group Intake Form

Date: \_\_\_\_\_

C L I E N T  I N F O R M A T I O N	Name		Social Security Number		
	Street Address		Home Telephone Number		
			Cell Phone Number		
	City	State	Zip	Email Address	
	Birthdate ____/____/____		Age	Can we email if needed? Y                      N	
	(Please Circle One) Single    Married    Divorced    Widowed		(Please Circle) Male                      Female		
	Client Employment/School		Occupation		
	Business Address		Business Telephone		
In case of emergency who should we notify?		Relationship to Client			
P R I M A R Y  I N S U R A N C E	Person responsible for Account		Relationship to Client		
	Birthdate for Policy Holder		Social Security Number (Policy Holder)		
	Address (if different from client)		Telephone Number		
	City	State	Zip	Person responsible employed by:	
	Occupation		Business Address and telephone		
	Insurance Company		Policy number		
	Group number:		Certification or Authorization number		
	Insurance Telephone Number		Number of sessions authorized		

### (For Office Use Only)

Referral Source:	Diagnosis  -----	Therapist Initial	Crystal Lake EAP Therp Insurance	Gurnee EAP Billing Mgr. Self-Pay
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**Myers  
Counseling  
Group, Ltd.**

501 N. Riverside · Suite 208 · Gurnee, IL 60031  
(847) 263-1269 Fax: (847)263-1310

## Permission for Services

I/we \_\_\_\_\_ grant permission for  
Myers Counseling Group to provide services to \_\_\_\_\_  
for Mental Health Counseling. I/we understand that all information shall be treated as  
confidential in accordance with state laws.

\_\_\_\_\_  
Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent (if client is under the age of 18 years).

\_\_\_\_\_  
Date

**Myers**  
**Counseling**  
**Group, Ltd.**

**Client Consent/Waiver For Primary Care Physician Notification of Service Provision**

Pursuant to Illinois Law (PL 86-1434) you are hereby notified that it is desirable that you confer with your primary care physician, if you have one, about seeking and receiving mental health services. Unless you waive such notification, I am required to notify your primary care physician that you are seeking or receiving mental health services.

Please indicate your desire by checking the appropriate box.

- ( ) I do not have a primary care physician and don not wish to see or confer with one. I therefore **WAIVE NOTIFICATION** of a primary care physician that I am seeking or receiving mental health services.
- ( ) I **WAIVE NOTIFICATION** of my primary care physician that I am seeking or receiving mental health services, and I direct you **NOT** to notify him or her.
- ( ) I **AGREE TO YOUR NOTIFYING** my primary care physician, that I am seeking or receiving mental health services.

My primary care physician is:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone number: \_\_\_\_\_

Please act in accordance with these, my instructions:

Client name: \_\_\_\_\_ Date: \_\_\_\_\_

Client signature: \_\_\_\_\_

Parent\Guardian signature: \_\_\_\_\_  
(required if minor)

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

## Myers Counseling Group E- mail Permission Notice

I, \_\_\_\_\_ grant permission to Myers Counseling Group  
(Name)

to include my name on their e-mail distribution list. I understand my e-mail address will only be used for follow up surveys, newsletters, and notices regarding Myers Counseling Group services. It will not be distributed to any third parties. I also am aware that I could unsubscribe at any time.

Name of Client: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

E- Mail address: \_\_\_\_\_

Additional e-mail address: \_\_\_\_\_

*Myers Counseling Group*

**CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT,  
PAYMENT, AND HEALTH CARE OPERATIONS (TPO)**

Patient Name \_\_\_\_\_

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities (known as “health care operations.”). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, the revised Notice will be posted in the office. You may ask for a printed copy of our Notice at any time.

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my Protected Health Information as specified above.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_