Kelly Ewalt counseling, LCPC

# Confidential Application for Services

*305 1st Ave. West • Columbia Falls, MT 59912 • Phone: (406) 249-9153*

## Complete this Form with Information Specific to the Applicant Seeking Services

Name:_____ Date of Birth:_____ Sex: ☐ F ☐ M

Address: _____
*Street or P.O. Box* *City* *County* *State* *Zip*

Home #:_____ Work #:_____ Leave a Message _____Yes_____ No Place of birth _____

## Complete Only if the Applicant Seeking Services is Under Age of 18

Name of Parent or Guardian:_____ Date of Birth:_____

Address:_____

Home #:_____ Work #:_____ Leave a Message _____Yes_____ No_____

Email Address:_____

## Reason for Seeking Services:

## Family Composition: *(List everyone including applicant currently residing in the home)*

| **Complete Name:** *(include middle initial)* | *Relationship to Applicant* | *Date of Birth* | *Name of School / Employer* |
|---|---|---|---|
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## Billing Information

**Person Responsible for Payment** *(for minors it is the Guardian)*

Home #: ( )_____

Work #: ( )_____

Name:_____

Address: _____
*Street or P.O. Box* *City* *County* *State* *Zip*

## Health Insurance Information

Insured's Name:_____ Sex:☐ F ☐M Birthdate:_____SSN:_____

Address: _____
*Street or P.O. Box* *City* *County* *State* *Zip*

Employer's Name:_____ Phone #: (  )_____

Insurance Company:_____ Phone #: (  )_____

Address: _____
*Street or P.O. Box* *City* *County* *State* *Zip*

*Group / Policy #:*_____ *Certificate / ID #:*_____

**Health Insurance Information** *(If Applicable)*

Insured's Name:_____ Sex:☐ F ☐M Birthdate:_____SSN:_____

Address: _____
*Street or P.O. Box* *City* *County* *State* *Zip*

Employer's Name:_____ Phone #: (  )_____

Insurance Company:_____ Phone #: (  )_____

Address: _____
*Street or P.O. Box* *City* *County* *State* *Zip*

*Group / Policy #:*_____ *Certificate / ID #:*_____

## Consent to Use & Disclose Protected Health Information

I authorize the release of any medical or other information necessary to process an insurance claim or to collect payment.

This authorization and assignment shall be valid for the duration of the claim.

I have read and agreed to the payment policy of **Kelly Ewalt** and agree to pay for all charges as described in the client disclosure statement.

I further agree that a photocopy of this authorization and assignment shall be valid as the original.
Client / Authorized Signature:_____ Date:_____

By signing this form, I consent to the use and disclosure of my protected health information by my provider, **Kelly Ewalt Counseling, LCPC**, her staff and business associates for purposes of treatment, payment, and health care operations:

I understand I have a right to review the Notice of Privacy practices prior to signing this consent. I acknowledge that I have been provided with a copy of my provider's notice of privacy practices and I have been given an opportunity to review the notice prior to signing the consent. My provider reserves the right at any time to change the privacy practices described in the notice of privacy practices and the client disclosure form. I understand that I can obtain a revised copy.

Client's Signature or Guardian_____ Date:_____

Printed Name: _____

## Health Information

### List Client's Medical Issues:

_____

_____

## Previous Treatment and / or Counseling

| Mental Health Counseling Dates: | Provider: | Outcome: |
|---|---|---|
| Drug / Alcohol Counseling Dates: | Provider: | Outcome: |

Primary Care Physician: _____

Medical Exam Done in the Past Year: ☐ Yes ☐ No ☐ Unknown

## Please List ALL Prescribed and Over the Counter Medications Client is Currently Taking:

| Name of Medication | Dosage: | For: | Prescribed By: |
|---|---|---|---|
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## Goals

What do you Hope to Accomplish in Counseling?

## Consent to Mental Health Services for a Minor Child

I understand, in my capacity as Parent / Legal Guardian / Social Worker, for _____ consent to Mental Health Services for the above named Minor. This consent becomes effective _____ and terminates at the end of therapy. I am aware that I may terminate this consent at any time. I also agree to be present throughout the session with said minor.

completed this _____ day of _____

x _____ Parent / Legal Guardian / Social Worker

## RACE / ETHNICITY (Please Mark ALL that Apply)

☐ 1. Caucasian ☐ 3. American Indian / Alaskan Native ☐ 5. Asian or Pacific Islander

☐ 2. African American ☐ 4. Hispanic ☐ 6. Other:

## Source of Referral

How did you find us? _____

| MARITAL STATUS | EMPLOYMENT STATUS | OCCUPATION |
|---|---|---|
| ☐ Married ☐ Separated<br>☐ Divorced ☐ Never Married<br>☐ Widowed<br>☐ Maiden / Previous Names<br>_____<br>_____<br>_____<br>_____<br>**Student Status**<br>☐ ESPDT<br>☐ School Name:<br>☐ IEP | ☐ 01 Full Time<br>☐ 02 Part Time<br>☐ 03 Unemployed but Desiring and able to Work<br>☐ 04 Student / Preschool<br>☐ 05 Homemaker<br>☐ 06 Retired<br>☐ 07 Disabled<br>☐ 09 Supported / Sheltered / Transitional Employment<br>☐ 10 No interest in work<br>☐ 11 Non Paid Work / Volunteer<br>☐ 12 Other<br>☐ 99 Unknown | Employer: _____<br>_____<br>For Children:<br>Mother's Employer:<br>_____<br>_____<br>Father's Employer:<br>_____<br>_____ |

## Spiritual Preference

**What is your Spiritual Preference?** _____

**Do you attend a Place of Worship? If so, where?** _____

## Educational

| | | |
|---|---|---|
| ☐ No Formal Education | ☐ College Part-time | ☐ Private School |
| ☐ Adult Education Classes | ☐ College Full-time | ☐ Graduate School |
| ☐ Attending Vocational School | ☐ Home Schooled | ☐ Other |
| ☐ GED | ☐ Public School K-12 | ☐ Last Grade Completed by Client: _____ |

## Legal Custody

**Who has Legal Custody of the Applicant?:** ✓ or X appropriate boxes

☐ **S=**self ☐ **P=**parent ☐ **G=**guardian ☐ **D=**department of family services

☐ **C=**department of corrections or juvenile justice ☐ **B=**bureau of indian affairs / tribal court

☐ **O=**other (please specify):