Fountains Family Counseling
9953 Crosspoint Blvd. STE 400
Indianapolis, IN 46256
(317) 721-4801

New Patient Information Form

Office Use Only
Dt: _____
Dx: _____
Rf: _____

PLEASE DO NOT LEAVE ANY SPACES BLANK. READ REVERSE AND SIGN.

Full Name: _____ Date of Birth: _____

Referred by: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone:

Cell Phone: _____ E-mail:

_____

*_Circle preferred method of communication_ [May I leave messages at the above numbers?] _____

Relationship Status: ☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living with Partner

Profession: _____ Company:

_____

Education Level [total years of education]: ____ School(s) attended: _____

In case of emergency, contact: _____ Relationship: _____ Phone:_____

Please describe primary reason(s) for counseling: _____

_____

_____

Have you had prior counseling? ☐ YES ☐ NO

If YES, please identify *when*, *with whom* and approximate *length of treatment*: _____

_____

_____

Please list current medications: _____

_____

Family Physician [and/or Psychiatrist]: _____ Phone: _____

May I contact your physician regarding your medical treatment? ☐ YES ☐ NO ☐ Not Sure

Symptoms Checklist [Please circle all that apply in the past 6 months]

Aggression	Alcohol	Anger	Anxiety	Apathy
Confusion	Concentration	Crying	Current Abuse	Depression
Distraction	Drugs	Eating	Embarrassment	Fatigue
Fear	Forgetfulness	Grief	Impulsivity	Insomnia
Irritability	Isolation	Legal Issues	Loss	Memory
Moodiness	Nervousness	Panic	Past Abuse	Physical Illness
Rage	Restlessness	School	Self-esteem	Sexual Issues
Shame	Stress	Suicidal	Work	Worry

PLEASE READ CAREFULLY AND SIGN BELOW

A. I am giving my expressed permission for Fountains Family Counseling to provide psychological assessment, diagnosis, and treatment in order to assist me in reaching my intrapersonal and/or interpersonal goals.
B. As a client under the care of Fountains Family Counseling, I understand that no guarantees are being offered for the outcome of my therapy with the exception that my therapist will make every effort to understand my problem(s) and incorporate well-established, conventional psychological techniques to help ameliorate personal problems that are causing me and/or my family to experience hardship.
C. I further understand that, in relationship counseling, my therapist will be fair to both parties and does not take sides in therapy, but rather is on the side of being healthy in the relationship.
D. If the patient is a minor, I, as the parent, custodial parent, or guardian, give consent for treatment to said minor and will respect the confidential nature of the relationship between my child and her/his counselor.
E. In regard to risk of hurting myself or others, I agree to notify Fountains Family Counseling immediately and provide her with ample opportunity to help before taking any actions that may result in harm to myself or others.
F. Payment for Services: I understand that Fountains Family Counseling's hourly fee of $100 for individual, relationship and family counseling services as well as consultation services is to be paid in full *at the time of service* and that I authorize Fountains Family Counseling to charge my credit card for services rendered if other payment options are not present. If I qualify for a reduced rate for therapy, I understand that I may not file for insurance reimbursement.
G. Phone Consultations: I understand that there is no charge for brief administrative phone calls under 5 minutes. If a call results in a consultation for 5 minutes or longer, I will be charged for the entire duration of the phone consultation at Fountains Family Counseling's pro-rated hourly fee.
H. I understand that my personal information and my status as a patient will be held in the strictest confidence unless I give my expressed permission in advance. *Exceptions*: Court orders, and being a danger to self or others. In case of reported abuse/neglect of a dependent, appropriate Protective Services must be notified. Failure to do so may result in a Class B misdemeanor.
I. Cancellation Policy: As a courtesy to others, I understand that I am responsible for maintaining my appointments and my signature below indicates that I will provide Fountains Family Counseling with NO LESS THAN 24 HOURS notification when changing or canceling my appointment. Otherwise, I will be charged for the session.
J. Voicemail: I understand that Fountains Family Counseling will return my voicemail messages as soon as is possible for her and that if I have a psychological emergency that cannot wait for her returned call, I will contact my local emergency room for consultation in the interim.
K. E-mail: I understand that Fountains Family Counseling cannot guarantee my confidentiality if I contact her via e-mail and that she will not engage in e-mail / internet chat therapy.
L. Returned Checks & Non-Payment: I agree to pay a $25 fee for returned checks for insufficient funds, as well as each incident of non-payment at the time of service.
M. Insurance Receipts: I understand that I am responsible for photocopying and submitting my insurance receipts for psychological services with Fountains Family Counseling.

 By placing my signature below, I attest that I have read this document; I am consenting to treatment and agreeing to abide by the practice policies delineated by Fountains Family Counseling; and I have received a paper copy of Fountain's Family Counseling Notice of Privacy Practices.

Signature: _____ Date: _____
[Adult and/or Party Responsible for Payment]

Print Name: _____