PETTIGRU COUNSELING ASSOCIATES, INC.
405 Pettigru Street
Greenville, SC 29601
864-271-3549

Client Intake

CLIENT: ______________________________ SSN: ____________________

ADDRESS: ____
LIST STREET ADDRESS AND MAILING ADDRESS, IF DIFFERENT

____

TELEPHONE: HOME:____________________ CELL:____________________

WORK:____________________

NO CALLS TO HOME ☐ NO CALLS TO WORK ☐

BIRTH DATE: __________ AGE: ______ SEX:______ MARITAL STATUS: ______________

CONTACT IN CASE OF EMERGENCY: ______________________________

ADDRESS AND PHONE NUMBER OF CONTACT: ______________________________

____

MEMBERS OF CURRENT HOUSEHOLD (LIST AGE AND RELATIONSHIP TO YOU):

______________________ ______________________

______________________ ______________________

______________________ ______________________

EDUCATION: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17+
(CIRCLE HIGHEST GRADE LEVEL ATTAINED)

DEGREE(S): ______________ CURRENT SCHOOL: ______________________

EMPLOYER: ______________________________
NAME AND ADDRESS

OCCUPATION: ______________________________

HOW WERE YOU REFERRED TO PETTIGRU COUNSELING? ______________________

MAY WE ACKNOWLEDGE THE REFERRAL? ☐ YES ☐ NO

PLEASE GIVE A BRIEF DESCRIPTION OF YOUR CURRENT SITUATION/REASON FOR APPLYING FOR SERVICES AT PETTIGRU COUNSELING:

____

____

PRIOR MENTAL HEALTH SERVICES: ☐ YES ☐ NO
(IF YES, PLEASE GIVE A BRIEF DESCRIPTION OF PROBLEM, WHO YOU SAW, AND WHEN.)

____

PRESENT PHYSICIAN: ____ DATE OF LAST PHYSICAL ____________________________________

Have you ever had any of the following?

	YES	NO	NOT SURE
Frequent headaches	____	____	______
Seizures/convulsions	____	____	______
Loss of consciousness	____	____	______
Fainting spells	____	____	______
Impaired vision	____	____	______
Impaired hearing	____	____	______
Arthritis	____	____	______
Heart disease	____	____	______
High/low blood pressure	____	____	______
Chest pain	____	____	______
Mitral valve prolapse	____	____	______
Autoimmune illnesses	____	____	______
Asthma/ Allergies	____	____	______

	YES	NO	NOT SURE
	____	____	______
Gallbladder disease	____	____	______
Recurrent vomiting/diarrhea	____	____	______
Other intestinal problems	____	____	______
Kidney or bladder disease	____	____	______
Thyroid disease	____	____	______
Diabetes	____	____	______
Drug/Alcohol Dependence	____	____	______
Hepatitis	____	____	______
Gonorrhea, syphilis or AIDS	____	____	______
Exposure infectious diseases	____	____	______
Exposure to toxic chemicals	____	____	______

Current Health Problems: ____

Current medications: ____

Prescribed by: ____

Drug allergies: (Drug name and type of reaction) ____

Operations: ____

Hospitalizations (Type, where, when): ____

____

Have members of your family ever had any of the following problems?
(Please refer to parents, grandparents, brothers, sisters and children)

	YES	NO	NOT SURE
Mental retardation	____	____	______
Learning disability	____	____	______
Manic depression	____	____	______
Depression	____	____	______
Anxiety	____	____	______
Schizophrenia	____	____	______
Drug or alcohol abuse	____	____	______
Suicidal attempt	____	____	______
Completed suicide	____	____	______
Cancer	____	____	______
Allergies/Asthma	____	____	______

	YES	NO	NOT SURE
Hepatitis	____	____	______
AIDS	____	____	______
Diabetes	____	____	______
Thyroid disease	____	____	______
Heart disease	____	____	______
Dementia/Alzheimer's	____	____	______
ADHD	____	____	______
Kidney disease	____	____	______
Gastrointestinal disease	____	____	______
Epilepsy /seizures	____	____	______
Migraine headache	____	____	______

If client is a child, please complete:

	YES	NO	NOT SURE
Complications during pregnancy	____	____	______
Drug or alcohol use during pregnancy	____	____	______
Complications during delivery	____	____	______
Sit, crawl, and walk at right times	____	____	______
Problems with bowel and bladder training	____	____	______
Problems with speech and language development	____	____	______
Problems learning social skills	____	____	______
Is there tension in the household			

PETTIGRU COUNSELING ASSOCIATES, INC.

Assignment of Insurance and Release of Information Regarding Billing

It is the policy of the professionals at Pettigru Counseling Associates, Inc. to file insurance claims only with those insurance/managed care companies which include our therapists on their provider panels. If you wish to file for reimbursement on your own, the superbill you receive as a receipt may be attached to a completed claim form and mailed to your claims office. **Payment is expected at the conclusion of each session**. Any other arrangement must be made in advance and in writing with your individual therapist. Exceptions are specifically negotiated EAP/managed care contracts and prior agreement to file with your insurance company. You will be charged for any scheduled appointments you fail to keep unless you give 24 hours notice of cancellation. Insurance will not reimburse for missed appointments.

Your signature below certifies the following:

- I have read and understand fully this billing policy and agree to make payment in full and/or satisfactory arrangements if asked to do so as specified above. I understand that I am financially responsible for any amount of unpaid deductibles, all charges and/or co-payments whether or not paid by my insurance company.
- Pettigru Counseling has the right to refer unpaid balances for collection and the patient will be responsible for all reasonable expenses. I hereby authorize Pettigru Counseling Associates to release all information necessary to my insurance company to secure payment.
- I hereby assign all benefits to which I am entitled, including private insurance, Worker's Compensation, Victim's Compensation, etc. This assignment applies to all charges until revoked in writing. A photocopy of this assignment is to be considered as valid as the original. I also understand that by signing this that I am granting Pettigru Counseling Associates, Inc., permission to electronically bill my insurance company.
- I understand it is my responsibility to determine: if myinsurance policy provides mental health benefits; to call for precertification; amount of deductible, if any, and whether it has been met; copayment amount; and limitations of services. If preauthorization is required you must ensure it is in place prior to your session.
- A diagnosis is usually requested from the insurance company as a condition of payment. You will be informed of the diagnosis prior to claims being filed. Any diagnosis will become a part of your permanent insurance records.

Do you or any dependents have any other health or Medicare coverage? ☐ No ☐ Yes

Date: ____ ______________________________________

Signature

South Carolina provides the client opportunity to file inquiries with the Licensing Board of the respective professional (Psychologists, Licensed Social Workers and Licensed Professional Counselors):

SC Board of Examiners
PO Box 11329
Columbia SC 29211-1329

I have read the Application and Services Agreement. I fully understand and agree with its provisions. I specifically agree to accept full responsibility for payment of my account. I have been sufficiently advised and give my informed consent to engage in psychotherapy, medical treatment, psychological assessment, psychoeducational evaluation, and/or related mental health services with ____.

Client Name: ____

Date: ____________________________ ____

Signature

ALL THERAPISTS AT PETTIGRU COUNSELING ASSOCIATES, INC. ARE IN INDEPENDENT PRACTICE AND ARE NOT EMPLOYEES OF PETTIGRU COUNSELING ASSOCIATES, INC.

Missed Appointments & Late Cancellations

Please note that your therapist commits a specific hour to you alone.

Unlike other professionals; such as physicians and dentists, we do not double schedule, nor can we operate on an inexact schedule. Thus, a cancellation without sufficient notice means lost therapy hour/lost income for the therapist, since it is difficult to reassign the hour to another person on a short notice.

Therefore, we require a 24 hour notice of cancellation prior to your appointment. We have an answering service that you may call anytime day or night. If a 24 hour notice is not given or you forgot to come to your appointment, you will be charged the regular fee for the reserved hour. Insurance companies will not cover the charges for your missed appointments. That will be your responsibility.

____

Client Signature

____

Printed Name

____

Today's Date