Journey of Self Discovery, LLC

You Are the Essence of Greatness…Be You!

Date: _____

Welcome!

Thank you for the opportunity to serve you as a guide on your journey of self-discovery and development. I hope our time together will assist you in addressing your concerns and meeting your goals. To help us get started, please fill out the following information as completely as possible. All information is confidential.

Client's Name_____ Social Security: _____ ☐ Adult ☐ Minor

Client's DOB: _____ Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ W ☐ D

Address:_____ City:_____ State:____ Zip:_____

Cell Phone #: _____ Email Address: _____

Payment Information:

☐ Self-Pay Agreed Payment:_____ ☐ Insurance (Complete insurance info below)

Primary Insurance Company _____ ID# _____

Group/Policy#:_____ Co-pay: $_____

Employer's Name:_____ Phone #: _____

Spouse/Partner's Name: _____ Phone #: _____

Is there any secondary insurance? ☐No ☐Yes: Insurance Company's name _____

ID#_____ Phone#_____

☐ EAP _____ Authorization #: _____ No. of sessions _____

Insured Client Employer Information:

If client is a student; please indicate student status ☐Full time ☐Part time

PAYMENT POLICY:

I understand that I will be responsible for any co-payments, deductibles or other allowable charges which are not covered by my insurance carrier including any Medicare Reductions. In the event that my account in turned over to a collection agency, I understand and agree that I will be responsible for any collection fees, attorney fees, court costs, etc. Returned checks (NSF) will be assessed a $25.00 fee. A 24-hour notice of cancellations is required. ***There will be a $35 charge for all missed appointments & a $35 charge for late cancellations (without a 24 hours notice).*** Cancellations can be made by voice mail at (770) 882-4240, or e-mail: ajourneyofself@gmail.com.

Assignment of Benefits:

I authorize payment of medical benefits to Warren Mitchell LCSW, dba Journey of Self Discovery, LLC., for all professional services rendered.

Release of Information:

I authorize the release of any medical information needed to process this claim:

_____ Date: _____

(Client)

Email: ajourneyofself@gmail.com Blog: journeyofselfdiscovery.org Phone: (770) 882-4240
4319 Covington Highway, Suite 319 Decatur, GA 30035

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Emergency Contact: _____ Relationship: _____ Phone: _____

How did you find me? ☐ EAP ☐ Private Insurance ☐ Word of Mouth ☐ Self-Referral ☐Online Site: _____
☐ Other _____

Name of Person who referred you: _____

TELL ME A LITTLE ABOUT THE REASON(S) YOU ARE SEEKING ADDITIONAL SUPPORT IN YOUR LIFE TODAY:

_____

_____

_____

_____

_____

DO YOU HAVE ANY HABITS OR BEHAVIORS THAT YOU OR LOVED ONE(S) IS CONCERNED ABOUT?

_____

_____

_____

IS THERE ANY HISTORY OF SUBSTANCE USE/ABUSE, MENTAL ILLNESS, OR RECURRING PHYSICAL ILLNESS OR DISEASE:

_____

_____

_____

Previous Counseling

Start-End Dates	Who/Where	Reasons	How beneficial was your experience?

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Medications

Name	Dosage	Purpose

WHAT WOULD YOU LIKE TO ACCOMPLISH THROUGH THIS COUNSELING/LIFE COACHING JOURNEY?

IS THERE ANYTHING ELSE YOU WOULD LIKE ME TO KNOW?

Sessions are approximately 50-60 minutes long, unless I see it necessary to go a little longer. If you decide to end the counseling sessions, I would encourage you to schedule a final appointment; being able to say goodbye is important.

Client's Signature: _____ Date: _____

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