Compassionate Hearts Therapy, LLC Shelly Johnson, LMHC CIFST

As a new client, I would personally like to WELCOME you to Compassionate Hearts Therapy. Self-.growth is one of the greatest gifts of self-care that an individual can give themself, and I look forward to working with you on your journey towards self-discovery and healing!

The following document contains paperwork that needs to be completed before your initial appointment. If you are unable to complete the forms in advance, please arrive early to allow time to complete them before we meet.

My office is located at: 1313 Pleasant Drive, Suite 160, West Des Moines, Iowa 50265. You will be in a residential area as this is a home business. It is a yellow home with black shutters. There are 2 driveways once you are facing the home. Please pull up and park your vehicle in the office driveway, located to the far left hand side of the structure.

When you arrive, please have a seat in the waiting room and I will take you back at your scheduled appointment time. When you come to your first appointment, please bring the following with you:

- **Your insurance card (if utilizing insurance)**
- **The included initial paperwork packet**

If you cannot keep your initial appointment, please call 515-635-5763 at least 24 hours in advance to reschedule or cancel.

Thank you and I look forward to meeting with you soon!

Shelly Johnson, LMHC CIFST
Psychotherapist
Email: shelly@chtherapy.care

Compassionate Hearts Therapy, LLC Shelly Johnson, LMHC CIFST

CLIENT INTAKE FORM FOR ADULTS or CHILDREN

PERSONAL INFORMATION

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Relationship Status: _____

Current Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Cell Phone #: (_____) _____ Ok to leave a message? Y N

Would you like to receive text message reminders of appointments? Y N

E-mail Address: _____ Ok to e-mail you? Y N

*Please note that e-mail is not considered to be a confidential form of communication.

Employer: _____ Current Occupation: _____

Emergency contact's name: _____ Phone #: _____

CONCERNS AND GOALS FOR THERAPY

What concerns would you like to address in therapy?

_____

_____

LIFE STRESSORS

Are there any current events adding stress to your life (legal, financial, illness, changes, losses, etc…)?

_____

_____

GOALS FOR THERAPY

What are your goals for therapy?

_____

_____

By signing below, I am indicating that the information provided on this form is true, accurate and complete.

_____ _____

Client's Signature Date

PAYMENT CONTRACT FOR SERVICES

_____ _____

Client's Name Date of Birth

_____ _____ _____

Name of Policyholder Insurance Company/Plan Group/Policy Number

_____ _____ _____

Employer of Policy Holder Relationship to Client Date of Birth of Policy Holder

_____

SSN of Policy Holder Address of Policy Holder

While I will file your insurance claim for you, it is a good idea to call your insurance company to find out your co-pay and deductible. When calling, ask about your coverage for "outpatient mental health services." **Co-payments must be paid at the time of each session.**

My fees include the following:

Initial Appointment	$175.00
30 Minute Psychotherapy Session	$80.00

45 Minute Psychotherapy Session	$125.00
60 Minute Psychotherapy Session	$160.00
School Staffing/Meeting Attendance (not covered by insurance)	$50.00
Late (less than 24 hours) cancel or no-show (not covered by insurance)	$50.00

I give consent to Compassionate Hearts Therapy, LLC to release mental health information to my insurance company, to provide utilization review or quality assurance service for the administration of claims for benefits. Also, I authorize Compassionate Hearts Therapy, LLC to directly receive all payment of benefits due for services provided. This authorization includes allowing Compassionate Hearts Therapy to release information to my insurance company, to administer claims submitted, or to be submitted for payment, to conduct a utilization and quality control review of mental health care services provided or proposed to be provided, or to conduct an audit of claims paid.

I certify that all the information is true, accurate, and complete and I agree to be personally responsible for all reasonable charges not paid by my insurance company.

_____ _____

Client's Signature or Guardian's Signature Date

By signing below, I am indicating that I have access to the Informed Consent for Psychotherapy, am voluntarily consenting to evaluation and/or treatment and agree to abide by this document's terms while working with Compassionate Hearts Therapy, LLC. I am also acknowledging that I have received a copy of the HIPAA Notice of Privacy Practices form. This Agreement, which may be revoked in writing at any time, will be binding unless we have taken action in reliance on it including obligations imposed by my health insurer in order to process or substantiate claims made under my policy, or if I have not satisfied any financial obligations I have incurred.

_____ _____

Signature of Client/Guardian/Representative Date Signed