



Kelly Cremeans, MS, LMFT

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Client Information

The information in this section should pertain to the **individual who will be receiving services at SFCC**. If that person is you, please provide this information about yourself. If the patient is your child, please provide information about your child. If you are seeking help for your marriage, we do need to identify only one of you as the "Patient" for purposes of account-keeping and filing of insurance (if applicable). Below, you will be able to give us information about the other spouse or parent (in the case of a child as the patient).

FIRST NAME _____ MI ____ LAST _____

SUFFIX _____ NICKNAME _____

ADDRESS 1 _____

ADDRESS 2 _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE (_____) _____ WORK PHONE (_____) _____ EXT. _____

CELLPHONE (_____) _____ E-MAIL _____

SEX (Circle One): Male Female MARITAL STATUS (Circle One): Single Married Divorced Widowed

DATE OF BIRTH: ____/____/____ SOCIAL SECURITY NO. _____-_____-_____

PLEASE INDICATE HOW OUR OFFICE SHOULD LEAVE MESSAGES FOR YOU (Check as many as preferred):

Home Phone Work Phone Cell Phone E-Mail

EMPLOYMENT (Check Appropriate): Employed Full-Time Employed Part-Time Not Employed

On Active Military Duty Retired Self-Employed

EMPLOYER: _____

STUDENT (Check if Appropriate): Full-Time Part-Time

PRIMARY CARE PHYSICIAN: _____ PHONE: (_____) _____

WHO REFERRED YOU TO SFCC? _____

Health Insurance Policy Information ~ PLEASE PROVIDE COPY OF INSURANCE CARD

INSURANCE COMPANY NAME: _____

INSURANCE TYPE (Check One): Group Policy Individual Policy

EFFECTIVE START DATE: ____/____/____ EFFECTIVE END DATE (If Applicable): ____/____/____

MEMBER ID #: _____

GROUP NAME: _____

GROUP/POLICY #: _____

PLAN CODE: _____

Client Name: _____

PLEASE SKIP IF RESPONSIBLE PARTY IS SAME AS ABOVE
COMPLETE THIS PORTION FOR INSURANCE POLICY HOLDER

Responsible Party Information

FIRST _____ MIDDLE INITIAL _____ LAST _____
RELATIONSHIP TO PATIENT: _____
DATE OF BIRTH: ____/____/____ SEX (Circle One): Male Female
CHURCH/ORGANIZATION/BUSINESS (If Appropriate :) _____
HOW MUCH DOES THE INDIVIDUAL/CHURCH/ORGANIZATION INTEND TO ASSIST? _____
ADDRESS 1 _____
ADDRESS 2 _____
CITY _____ STATE _____ ZIP CODE _____
HOME PHONE (____) _____ WORK PHONE (____) _____ (EXT.____)
CELLPHONE (____) _____ E-MAIL _____
EMPLOYER: _____

HIPAA / HITECH ACKNOWLEDGEMENT

My signature above indicates I have read and understand all of the information presented in this form, and I have received my personal copy of this document, if requested.

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and The Health Information Technology for Economic & Clinical Health Act (HITECH). I understand this information will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in the treatment directly and indirectly.
- Obtain third party payment for my mental health care services, as applicable.
- Conduct mental health care operations such as quality assessment and improvement activities.

I have been informed of Solution Focused Counseling's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected mental health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my mental health provider has the right to change the Notice of Privacy Practices and that I may contact this office to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or mental health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

AUTHORIZATION FOR TREATMENT AND/OR SERVICES:

This signed Consent authorized SFCC Clinicians to provide Counseling Treatment, Therapy Services, Psychiatric Treatment, and/or Other Services as indicated by your provider and further affirms that all statements in this form are true and accurate, including custodial status of minor children.

Signature of Client/Patient *(Required)*

Signature of Spouse if also Receiving Treatment *(Required)*

Date *(Required)*

Date *(Required)*