Serene Pathways Counseling, LLC

516 S. Creyts Rd., Suite F
517.323.1767
Fax: 517.580.7180

All submitted information is confidential. If an item does not apply to you write "NA".

Updated Adult History

Today's Date: ____________________

Client Information

Name:____ Date of Birth:______________________________

Marital status: ______ married _____ never married _______separated ______divorced ______other

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Address:____

Best phone number(s) to reach you at:____

Okay to leave messages? ______________________email: ____

Emergency contact and phone number: ____

Employer: ____

Responsible Party/Insurance information

Primary Insurance information (please present card if new insurance since last session)

Insurance:_____________________________________Employer:____

Subscriber or enrollee ID number: ____

Policy holder's name: ____DOB: ______________________________

Secondary Insurance information (please present card)

Insurance: ______________________________________Employer: ____

Subscriber or enrollee ID number: ____

Policy holder's name: ____DOB: _________________________________

Medical Information

Primary Care Physician:_____________________________ Date of Last Physical:______________

Have there been any changes in your health since your last session? If so, please list:
____

____

List any current medication, dosage, and reason (including vitamins/herbs/over the counter medication).

____

____

Physical concerns ______Headaches ______Sleep ______ Stomach ______Other

Please explain: ____

____

Emotional Concerns (Please check any that apply)

_____Depression _____Anxiety _____ Anger _____Other

_____Nightmares _____Family Problems _____ Stress ______ Fear

_____ Suicidal thoughts or actions

Please explain: ____

____

Are you currently or have been in the past under the care of another mental health professional (i.e. psychiatrist, psychologist, counselor, etc.)? ______Yes ________No If yes, please explain:

____

____

Are any family members currently under the care of a mental health professional (i.e. psychiatrist, psychologist, counselor, etc.)? If yes, please explain:______________________________________

____

____

Communication by Email/Texting

_____I disagree with sending or receiving communication through either of these forms of communication.

_____I agree with sending or receiving communication through the following:

_____Email- address is: ____

_____Text- phone number is: ____

Notice of Privacy Practices Receipt and Acknowledgment

I, the undersigned, hereby acknowledge receipt of the Notice of Privacy Practices given to me by Serene Pathways Counseling, LLC.

Cancellation Policy

I, the undersigned, understand that the therapists of Serene Pathways Counseling respect my time and ask that I respect theirs as well. I understand that if I cannot give 24 hours' notice of a cancellation that I may be charged a $35 fee which is payable prior to resuming counseling services. This fee is not billable to my insurance company (third party payer)

Financial Responsibility

I, the undersigned, hereby authorize release of information necessary for SPC to file a claim with my insurance company (third party payer) and assign benefits otherwise payable to me to the provider or group indicated on the claim. I understand that I am financially responsible for any balance not covered by the third party payer, i.e. co-payments, co-insurance, deductibles or non-covered services.

Consent to Treat

I verify that the information given is correct and I consent to receiving therapy services.

Signature of Client: ____Date______________________

Signature of Staff Member: ____ Date______________________