Child Intake Form

Alexander J. Muzichuk, M.A., PLPC
- ✓ Individual Counseling
  Children • Adolescents • Adults
- ✓ Marriage and Family Counseling

Date:_____Child's Name:_____

Birth Date:_____Age:_____Gender:_____

Address:_____ Phone:_____

City:_____ State:_____ Zip Code:_____

Parent(s)/Gaurdian(s):_____

Email:_____

Name of School:_____Grade: _____

Teacher's Name:_____ Counselor's Name:_____

Special Placement (if any):_____

Doctor/Physician's Name:_____

List any Medications Currently Taking:_____

List any Health Problems:_____

Previous Therapy? Where? _____

List Siblings Name and Age: _____

_____

_____

List Other Significant Relatives: _____

_____

List Involvement in School or Community Activities: _____

_____

Fee and Payment Information

Fees for services are due and payable on the day of service unless other arrangements are made prior to the time of service. Cash, credit card, and checks are accepted. Many insurance plans are accepted. Clients should consult their insurance provider for information regarding co-payment, deductible, and number of authorized sessions. Regardless of what an insurance company states to this office or you about payment for services, this is not a guarantee of payment for services. You are still responsible for full payment for counseling services even if an insurance company states they will pay and do not. A copy of the insurance card should be on file with this office. Medicaid and MC+ are accepted. A copy of the Medicaid or MC+ card should be on file with this office. The average session time lasts 45-50 minutes. The standard fee per session is $90.00. Certain financial brackets may enable a sliding fee scale of $50.00 per session. Proof of income must be on file to qualify for the sliding scale fee.

Medicaid
Name of Child on Medicaid Card:_____

Medicaid Number:_____ Birth Date:_____

Private Insurance
Name of Responsible Party on Insurance Card:_____

Parent Social Security #_____Child Social Security #_____

Insurance Company/Plan:_____

Individual #_____ Group #_____

Insurance Company Billing Address & Phone Number: _____
_____
_____
_____
_____

Court Related Records, Testimony, and Appearance

If the therapist is requested or subpoenaed at any point in time to appear in court or participate in court related activities, the client will be responsible for payment reimbursement of the therapist's time which will be billed at the normal office session rate of $90.00 per hour. Travel time spent to and from court or other venues related to court activities will be considered part of the hourly time billed. If records or documents are requested or subpoenaed, a reasonable fee will be charged for providing a copy of your records or a summary of those records which would include cost of copying, postage, and preparation or an explanation or summary of the information.

I have read and understood the above related fee payment information and court related information and agree to the terms defined by this office.

_____ _____ _____
Client Name Client/Guardian Signature Date