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Description automatically generated

House Of Sanctuary LLC Intake Form

**By initializing each line, I acknowledge that the privacy rights and other intake forms were explained to me and that I received a copy of the form in this entirety.**

Client First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M / F

Social Security: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_ Notice of privacy practices HIPPA**

**\_\_\_\_ Informed consent to treatment and limits of confidentiality**

**\_\_\_\_ Client bill of rights**

**\_\_\_\_ Client billing & Fee release for clients with insurance**

\_\_\_\_ **Cancellation Policy**

**\_\_\_\_ Transportation policy**

**Text Authorization**

House of Sanctuary LLC would like to send you text messages reminders of when your next upcoming appointments will be. If you choose to have text message reminders sent to your phone you would receive a text message 2 days prior to your appointment and a second text message 2 hours before your appointment. The text message would also include our phone number in case you need to call and cancel your appointment for any reason. You also have the option to decline this service or opt out at any time. Any messaging or service fees from your mobile provider are your responsibility when you accept this service.

\_\_\_\_ **Yes, I want** to receive text messages at this number Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ **No, I DO NOT** want to receive text message reminders.

**Client Initials:** \_\_\_\_\_\_\_\_\_

**Emergency Contact information**

Emergency contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Medical Contacts:

Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MHP Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Billing & Fee release for clients with insurance:**

**Ad*d*ress: release of information to insurance Company, HVO, managed care company: (all referred to as "insurance company'**

**Billing release**: I authorize House of Sanctuary LLC to disclose to my insurance company the following information necessary *t*o determine reimbursement for serv*i*ces, a statement of diagnosis, services received*,* persons providing and supervising these services and dates services were prov*id*ed.

**Release For Pre-Authorization of Benefits:**

I understand that my insurance company may require the release of additional information for authorization of the USA of health care benefits befor*e* servi*ces* and prov*ided.* The point at which additional informat*i*on is required by company and pl*a*n. Thisinformation may include the treatment plan goals, discharge criteria, history, and mental status data to document diagnosis, *s*tressors, report on progress and level of functioning or other relevant information. I authorize the release of this information as required by my plan, I understand that failure to provide this information may require the denial of payment for services by my insurance company.

**REVOCATION AND EXPIRATION OF RELEASE:**

I understand that I may revoke this *Rel*ea*s*e of Information at any time and that, in any event, it expires within one year of this date or when the purposes for which it was granted have been accomplished, whichever comes first.

**ASSIGNMENT OF BENEFITS:**

I authorize payment of medical benefits directly to House of Sanctuary LLC for its services described on this claim form.

**FINANCIAL RESPONSIBILITY**:

I Acknowledge receipts of the House of Sanctuary LLC Rate Schedule and Client Handbook and I understand my obligations. I Understand, in the event House of Sanctuary LLC has been unable to collect pa*y*ment due from the services provided, in accordance with my insurance company's advice, my name, address, telephone number and amount owed may be referred to outside collection services. I further say that the information above *g*iven by me is true and correct. I understand if any *o*f the above information changes or my **insurance benefits are maxed** or do not cover my service, I must notify House of Sanctuary LLC for a re-determination of my fee obligation under the sliding fee schedule.

Policy Holder Initials: \_\_\_\_

HSS Initials: \_\_\_\_\_\_

**Medical Insurance:**

Policy group Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anyone in the home smoke?

o Yes

o No

Anyone ill in the house?

o Yes

o No

Are there any pets in the house?

o Yes

o No

Are you allergic to anything?

o Yes

o No

Are there any weapons in the house?

o Yes

o No

**Cancellation Policy**

House of Sanctuary LLC has a policy related to missed appointments and chronic cancellations. Three consecutive missed appointments will result in services ending. Chronic cancellations will also be discussed and may result in discontinuation of services. If services are discontinued and you are interested in resuming services in the future, you will need to contact our office and you may be reassigned based on availability.

Please be ready to begin your appointments on time, please cancel appointments at least 24 hours in advance. Together we will determine when and where the appointments will be, who will attend, how long they will last and how many times a month you will meet. The duration of services will be determined together, based on your needs and the resources available to support the service.

**Transportation and Group meetings outside HOUSE OF SANCTUARY LLC**

If your services include transportation or a group meeting at a location other than the office, House of Sanctuary LLC aims to provide you with safe and secure transportation, but we cannot assume liability. House of Sanctuary LLC staff carry appropriate vehicle insurance, however, by signing this release you assume all risks and hold harmless House of Sanctuary LLC and all their staff from all claims, demands, suits, causes of action or judgements which I ever had, not have, or may have in the future for injuries, death or illness that might occur during transportation or a group meeting at a location other than the office of House of Sanctuary LLC. I understand that during transportation each passenger will be required and expected to wear a seatbelt and abide by the age-related safety restraint guidelines as well as any pedestrian and all laws related to travel.

**I agree to the above and authorize House of Sanctuary LLC** **to transport or lead a group meeting outside the office for myself and the following members.**

**By signing this you’re authorizing House of Sanctuary LLC** **to release the above emergency medical contacts in case of an emergency.**

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HSS Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_