ALMA VIA
COUNSELING SERVICES, LCC

36 Munroe Falls Avenue
Munroe Falls, OH 44262
330-801-7148

Personal Information:

Name (Last, First, MI):_____

Parent/Legal Guardian Names (If under 18):_____

Date of Birth:_____ Age:_____ Gender:_____

Ethnicity/Race:_____Marital Status:_____

Occupation:_____ Religious/Spiritual Affiliation:_____

Address:_____

Street (Apt No.) City State Zip

Telephone number:_____Ok to leave message?_____

Email address:_____Ok to leave message?_____

Preferred Method of Contact:_____

Emergency contact (for medical emergency only)

Name:_____Phone #:_____Relationship?_____

Do I have permission to contact this person in event of emergency?_____Y/N_____Initial

Insurance Information:

Will you be using insurance benefits for your sessions? Yes ☐ No ☐

If yes, complete the following:

Name of Insurance Company:_____

Policy Owner's Name: _____Policy Owner's Date of Birth:_____

Insurance ID #:_____Policy or Group#:_____

Policy Owner's Address (only if different than above): _____

Please be prepared to provide your therapist with your insurance card & driver's license so that we may make a copy.

If no, complete the following (initial on each line):

_____I have selected to not use my insurance for my counseling sessions.

_____I understand that opting out of using my insurance means I must pay out of pocket for the counseling sessions.

_____I have made my therapist aware that I have opted to not use my insurance for counseling sessions even if she/he is in network or out of network.

_____I have agreed to let my therapist know if anything changes and I either obtain alternative insurance and or decide that I would like my sessions billed to my insurance.

_____I understand that if I opt out of using my insurance I cannot use the payment of sessions towards my deductible because I have elected to opt out of using my insurance.

_____I understand that if I choose to later use my insurance, my therapist is not liable and is not obligated to reimburse previous sessions where I have chosen to opt out of billing my insurance. My opt in to use insurance will start from the day I notify my therapist of the change and cannot be backdated to previous sessions.

Counseling Information:

Please give a brief summary of the reasons that you are seeking counseling:_____

_____

What are the most important qualities you look for in a counselor?_____

_____

Past experiences with counseling or mental health treatment:

Name:_____Date:_____Positive? Y/N

Would you like me to contact your prior therapist? Y/N (will complete ROI if Yes)

Please list any medications you are currently taking:_____

_____

How did you find out about our practice?_____

_____ _____

Client Date

_____ _____

Therapist Date