



NORTH STAR GUIDANCE CENTER, INC.

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INTAKE FORM

DATE:
NAME:
ADDRESS:
AGE & D.O.B.:
SOCIAL SECURITY #:
HOME PHONE:
WORK PHONE:
CELL PHONE:
EMAIL:
EMERGENCY CONTACT:
ALLERGIES:
DAYS &/ TIMES YOU CAN MEET:
INSURANCE CO:
INSURANCE CO PHONE #
SUBSCRIBER #:
COPAY AMOUNT:
SUBSCRIBER'S EMPLOYER #:
EMPLOYER GROUP NAME AND POLICY #:
EMPLOYER ADDRESS:
MARRIED/ PARTNER/ SINGLE/ WIDOWED/ DIVORCED/ SEPERATED:
IF MINOR CHILD:
PARENT NAME
PARENT ADDRESS
CUSTODY STATUS
PERSON RESPONSIBLE FOR PAYMENT:
BILLING ADDRESS:
TERMS OF SELF PAY:
REASON FOR REFERRAL:
REFERRED BY:
<p>CONSENT FOR TREATMENT: I give permission for _____ to participate in treatment at North Star Guidance Center, Inc. I understand the benefits and risks of treatment. Therapy may involve discussing unpleasant aspects of my life; that i may experience feelings of anxiety, sadness, guilt, anger, frustration, loneliness and helplessness. Distressing and unresolved memories may surface through counseling. Subsequent to treatment sessions, the processing of incidents and material may continue and dreams, memories, flashbacks, and feelings may surface. Memory is imperfect and research has shown that there is no guarantee that all information recovered during therapy, unless it can be corroborated is factually accurate. On the other hand, information which is so revealed may in fact be accurate. The benefits may be improved relationships, solutions to specific problems and significant reductions in feelings of distress. I agree to treatment and understand that i can withdraw my consent at any time by notifying my primary therapist that I no longer wish to participate.</p> <p>SIGNATURE:</p>
<p>PAYMENT & APPOINTMENT POLICY: Payment is expected at the time services are rendered. If payment is not made, North Star Guidance Center, Inc. reserves the right at any time to suspend treatment until payment is made. If you are unable to keep your scheduled appointment, kindly cancel 24 hours prior to that time. Without a 24 hour cancellation notice, you will be charged for the time reserved. This charge is not covered by any private insurance. You may also risk your previously arranged appointment time with your therapist. I have read this policy and I agree to the terms of the payment and appointment policy. All professional services rendered are charged to you unless prior arrangements with us have been made. Your copay is expected at the time of each session. If you have insurance we can bill and submit your claims pending coverage verification. In the event your coverage is not valid. All charges incurred will be your responsibility. I accept the financial responsibility for any charges not covered by insurance. I authorize information to be released to insurance carriers and or my designated private physician. I have read the notice of patient rights. I have been given a copy of the privacy practices and have read and understand them. I have read and understand the consent to use health information.</p> <p>SIGNATURE:</p>