**University Counseling Services**

**Truman State University**

**Intake Information**

**Today’s Date:** \_\_\_\_\_\_\_\_\_\_

**Patient Information**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_\_

Preferred First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pronouns: \_\_\_\_\_\_\_\_\_\_\_\_\_ Gender Identity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexual Orientation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race: \_\_\_\_\_\_\_\_\_\_\_\_\_ Religious Preference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever served in the U.S. military? \_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Primary Care Provider/Psychiatrist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact Information**

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_ Is it ok if we leave a message? ☐ Yes ☐ No

(We will only contact you in the event of a last minute appointment cancellation, ect.)

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

 ( Please list an email you check regularly)

We will send you emails (appointment reminders etc.) to the email address you listed above. Email is our primary method of communication. PLease know, if you are uncomfortable receiving emails from our office and/ or your counselor, you may discuss this with your counselor who can make changes to your record.

Current Kirksville Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(For on campus, please list Hall and Room Number)

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

(Please list your home address)

Emergency Contact Name and Telephone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Parent, Family Member, Guardian, etc.)

Emergency Contact Relationship to You: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Father, Mother, Grandmother, etc.)

**Truman Information**

Current Academic Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current GPA: \_\_\_\_\_\_\_\_\_ Credit Hours:\_\_\_\_\_\_\_\_

Are you an International Student? ☐ Yes ☐ No Banner ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If YES, what is your country of origin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you transfer to Truman from another institution? ☐ Yes ☐ No

Are you the first generation in your family to attend college? ☐ Yes ☐ No

Are you registered with the Disability Services Office at Truman as having a documented and diagnosed disability? ☐ Yes ☐ No

 If YES, please indicate which disability you are registered for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Today’s Date:** \_\_\_\_\_\_\_\_\_\_

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_

**UCS Information**

How did you hear about UCS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any significant others, family, or others you know that are currently receiving services at UCS that could potentially cause a conflict of interest if you happened to get scheduled with the same counselor?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please briefly indicate your reason(s) for coming to University Counseling Services (UCS): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently considering suicide? ☐ Yes ☐ No

Are you currently considering harming yourself or others? ☐ Yes ☐ No

Have you ever experienced a traumatic event that caused you to feel intense fear, helplessness, or horror? ☐ Yes ☐ No

Are you currently experiencing, or have you ever experienced abuse? (If YES, please check what applies)

 ☐ Yes ☐ No

 ☐ Sexual

 ☐ Physical

 ☐ Verbal/ Emotional

 ☐ Mental/ Psychological

How many alcoholic drinks do you have in an average week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you use drugs in an average week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are taking any medications (either over-the-counter) or prescribed by a physician or psychiatrist, please list the medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever attended counseling for mental health concerns? If so, when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever received treatment for alcohol or drug use? If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized for mental health concerns? If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**University Counseling Services**

**Truman State University**

 **Financial Intake Information**

**Today’s Date:** \_\_\_\_\_\_\_\_\_\_

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_

**Please initial one of the three options below BEFORE signing at the bottom:**

\_\_\_\_\_\_ I decline to provide insurance information or do not have insurance and do not need to complete this page. I understand that there are other financial assistance options available if needed.

\_\_\_\_\_\_ I am choosing to utilize my insurance but wish to go ahead and schedule an appointment before the benefit investigation is complete. I understand that if I do not complete additional financial assistance forms before the given due dates that I will be held responsible for the costs of counseling sessions (see prices below or Billing Flyer)

\_\_\_\_\_\_ I am using my insurance and am opting to wait until the below benefit investigation is complete.

Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Group Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Office Use Only)**

**Tax ID: 430662495 NPI: 1447789300**

**Benefits Investigation as of:** \_\_\_\_\_\_\_\_\_ **Completed By:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Current CFM Balance:**\_\_\_\_\_\_

**Reference # if Called Ins:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Insurance Contact Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  | Total Amount | Currently Met |
| --- | --- | --- |
| Individual Deductible |  |  |
| Family Deductible |  |  |

| CPT Codes | **Full Price Cost** | CoPay | CoInsurance | Other Notes |
| --- | --- | --- | --- | --- |
| 90791 | **$270** |  |  |  |
| 90832, 90834, 90837 | **$85, $100, $125** |  |  |
| 90853 | **$50** |  |  |

*\*Disclaimer: this information is not a guarantee of payment but compiled in an attempt to assist the client with understanding their insurance coverage. This information is available for you to keep for your records. UCS is not responsible for changes made by your insurance.*

*By signing below, I acknowledge that I have been made aware of how the billing for my UCS services works and have been notified of financial assistance options that are available to me.*

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_