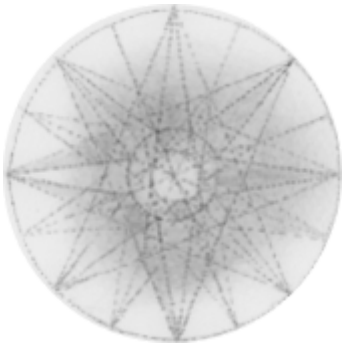

Orion Counseling & Consulting LLC · Marian Frick Rigsbee, LCSW, MAC
6524 North Carrollton Avenue · Indianapolis, IN 46203
marian@orioncounselingandconsulting.com · 317.225.0380

I truly appreciate you taking the time to fill out this important information. Please let me know if you have any questions or concerns.

Name: _____ DOB: _____

Address: _____

E-mail address: _____ Phone Number: _____

Marital Status: _____

Gender identity: _____

Have you ever served in the Military? _____

Employer: _____

Self-Pay: _____

Insurance Information

Insurance Company _____

Policy Number/ID: _____

Group Number/ID: _____

Policy Holder's name and DOB if different from yours: _____

Credit/Debit Card to keep on file (this is a requirement to begin services):
Card Number: _____Exp: _____CVV: _____

Physical, Mental Health, & Substance Use Information

How did you hear about Orion Counseling? _____

What is your primary reason for seeking therapy?_____

_____

Last Physical Exam by a Medical Provider: _____

Please list any medical/physical conditions or concerns: _____

_____

Please list any current medications (including over-the-counter) and dosages:

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Have you ever made preparations for or attempted suicide? If so, when? _____

_____

Please share any previous counseling experiences (including psychiatric hospitalizations):

_____

_____

Please share any family history of mental health/substance use challenges, or suicide:

_____

_____

Please share any substance use, including tobacco, vaping and caffeine:

_____

_____

_____

Do you have any current/past legal problems? If so, please describe: _____

_____

Please circle any symptoms that you have had in the past month:

difficulty falling asleep difficulty staying asleep poor appetite/overeating low energy

difficulty concentrating hopelessness helplessness worthlessness guilt shame

frequent tearfulness mood swings weight loss weight gain bodily aches/pains

repeatedly going over thoughts irritability isolating yourself suicidal thought

difficulty relaxing feeling nervous/anxious/on edge psychosis (hallucinations/delusions)

panic attacks nightmares flashbacks mania thoughts of hurting others

thoughts of hurting yourself intrusive thoughts

Other symptoms not listed: _____

Please read and *initial* each statement indicating your understanding and agreement to each of the following:

_____I agree I have provided and will continue to provide accurate information to the best of my ability.

_____I give my permission to Orion Counseling, LLC to administer assessments, treatments and procedures as are deemed necessary.

_____I have received Privacy Rules and notification of my rights of confidentiality of alcohol and drug abuse records. I understand that disclosure of information will not be released to others without my signed consent, except in cases of emergency, or when required by law (child abuse or neglect, imminent danger to myself or others).

_____As authorizing signature, I guarantee to assume sole financial responsibility for myself or my minor, including services not paid for by my verified and assigned insurance within 60 days.

_____I understand that there is a 24-hour cancellation policy and that I may be charged for a full session for not canceling within this time frame or for a missed appointment.

_____I understand that I can call the confidential voicemail or e-mail the confidential e-mail address of Orion Counseling LLC at any time, but that Orion Counseling LLC cannot ensure immediate availability. I understand that my calls and/or e-mails will be returned within 24 hours on the next business day. I also understand that Orion Counseling has the right not to respond to e-mail or text. I understand that text will only be used for scheduling and routine communication.

_____I authorize Orion Counseling, LLC and their staff to release all or any part of my medical records to my insurance company(s) and assign all insurance benefits to be paid to Orion Counseling, LLC, that would have been otherwise payable to me.

I understand and agree to the above statements:

_____ _____

Client Signature **Date**

_____ _____

Therapist/Owner Signature **Date**