



**Expect Success Inc.**  
Peter G. McGourty, LPC  
Counseling, Life Coaching &  
Business Consulting

Ballantyne/Blakeney Client Office  
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## Counseling Intake Form

Today's date: \_\_\_/\_\_\_/\_\_\_ (Office Use: EAP \_\_\_ INS Card \_\_\_ DSM \_\_\_)

*Please write legibly to better facilitate insurance processing.*

Client Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Birth Date: \_\_\_/\_\_\_/\_\_\_ Sex:  M  F Status:  Single  Married  Other

Phone: Home (\_\_\_) \_\_\_\_\_ Work (\_\_\_) \_\_\_\_\_ Cell (\_\_\_) \_\_\_\_\_

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

City, State: \_\_\_\_\_ Zip \_\_\_\_\_ Email: \_\_\_\_\_

Employed:  Yes  No  Retired Company name: \_\_\_\_\_ Hire Date: \_\_\_\_\_

SSN # \_\_\_\_\_ Position: \_\_\_\_\_ How long in that position: \_\_\_\_\_

Would you like to receive our e-newsletter?  Yes  No \*\*\*We NEVER share emails or addresses!

How did you learn about Expect Success Inc.? \_\_\_\_\_

***Please have any EAP or insurance authorization or certification letters AND your insurance card ready for us to make a copy to facilitate insurance claims processing. We cannot file Medicare claims for you but can provide you with a detailed invoice/receipt to attach to your own claims submission.***

### **PRIMARY INSURED'S INFORMATION REQUIRED FOR INSURANCE CLAIMS PROCESSING**

Your Relationship to the Primary Insured:  Self \*\*  Spouse  Child  Other

***\*\*If you, the client, are the Primary Insured, you do not need to duplicate the above information here.***

Insured's name: \_\_\_\_\_ Sex:  M  F Birth Date: \_\_\_/\_\_\_/\_\_\_

Phone: Home (\_\_\_) \_\_\_\_\_ Work (\_\_\_) \_\_\_\_\_ Cell (\_\_\_) \_\_\_\_\_

Insured's Mailing Address: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip \_\_\_\_\_ SSN # \_\_\_\_\_

Employed:  Yes  No  Retired Company name: \_\_\_\_\_

**Emergency Contact** Please give the name and phone number of someone I may reach in the event of an emergency, or if I need to reach you urgently and cannot:

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Relationship to you: \_\_\_\_\_ Alternate Phone (\_\_\_\_) \_\_\_\_\_

Please list all others living in your residence and their relationship to you:

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**Medical Information**

Describe your health status:

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Primary care physician: \_\_\_\_\_ phone #: (\_\_\_\_) \_\_\_\_\_

May I have your permission to communicate with your physician if it seems advisable?  Yes  No

List current medications, dosages, and how long you have been taking each. (Continue on back if necessary.) \_\_\_\_\_

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**Therapeutic Information**

Have you ever been in therapy before?  Yes  No

If so, when? For how long? With whom? Issues worked on? (Continue on back if necessary.)

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**Please indicate the areas you would like us to address, if possible numbering them in order of priority:**

___ Relationship	___ Work issues	___ Addictive tendencies
___ Emotional	___ Finances	___ Health related issues
___ Behavior modification	___ Parenting	___ Depression
___ Stress and anxiety	___ Other _____	

Do you prefer to receive assignments in between our sessions?  Yes  No

As your counselor, I greatly value your input as to how well I have served your needs. Would you be willing to fill out a brief survey at some point during or nearing the completion of our treatment, as a way to help me improve my therapeutic skills?  Yes  No

**Optional information to help me better understand you:**

Country of origin: \_\_\_\_\_ How long in USA? \_\_\_\_\_

Level of Education:  High School  College 2yr  College 4 yr  Other \_\_\_\_\_

Degree obtained: \_\_\_\_\_ Name of institution: \_\_\_\_\_

Do you have any special interests, hobbies or pass times?

Please list: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have a religious affiliation?  Yes  No If so, what? \_\_\_\_\_

What socio-economic do you fit into (gross annual salary)?

\$25,000-\$50,000  \$50,000-\$75,000  \$75,000-\$100,000  \$100,000-\$150,000  \$150,000+

**Confidentiality, Insurance & Payment Responsibility**

I understand that even if I or the office of Peter G. McGourty, LPC, calls to verify insurance eligibility and benefits, that is not a guarantee of insurance payment. **I will be financially responsible for payment of all charges incurred for services rendered by this office.** I allow assignment of my insurance benefits to Expect Success Inc. and Peter G. McGourty, LPC. I authorize release of any medical or other information necessary to process insurance claims on my behalf. I acknowledge that the “Notice of Privacy Practices” is available to me and that I may contact Peter G. McGourty, LPC if I want additional information about the privacy practices or to request a printed copy. I understand that **confidentiality will be maintained per HIPAA compliance, except when required by law as in the instance of possible suicide, homicide, child, elder or disabled person abuse.**

I understand that I must call the primary office number at 704-831-6841, available 24/7, to cancel an appointment with at least 24 hours notice (excepting sudden illness or other unavoidable impediment) in order *not* to incur financial responsibility for the appointment. I understand that late cancellation and no show fees are not billable to insurance and that I am financially responsible.

**•Late cancellation/no show \$50 fee**

I understand that chart preparation for legal use and court appearance fees are not billable to insurance and that I am financially responsible and that payment is required in advance. **I understand that Peter G. McGourty, LPC, requests not to be pressed into any legal representation (ie: subpoena) in the best interest of confidentiality and relative to the undue burden placed upon him as a sole practitioner.**

**•Chart preparation for legal use and/or court appearance fee \$125/hour**

If I become delinquent on payment, Expect Success Inc. reserves the right to turn my account over to a collection agency to contact me and take necessary measures to collect fees owed, while maintaining confidentiality regarding the nature of services rendered, and never violating session content.

I understand while entering into this therapeutic agreement that it is a partnership between myself and my counselor where we both collaborate to help achieve the desired goals. My counselor will apply the tools of his profession to this end; however, if he believes I can be better served by another professional other than himself, he will discuss with me his thoughts and intentions to make a referral. Likewise, if I decide to discontinue therapy, I agree to discuss with or at least notify my counselor rather than merely cease to show up or reschedule. This is simple human courtesy and allows my case file to be closed in a timely manner.

Client Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Counselor Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_