Confidential Client Intake Form

General Information

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #'s Home: _____ Work: _____ Cell: _____

Please **DO NOT** contact me at: ☐ Home ☐ Work ☐ Cell E-mail:_____

Sex: ☐ M ☐ F Date of Birth: _____ Age: _____

Employer: _____ Occupation/Title:_____

Years at job: _____ Highest level of education completed: _____

Do you regularly attend church, synagogue or other religious institution? ☐ Yes ☐ No

Name of church/institution: _____

How did you hear about our services?:_____

Relational Information

Marital status: **0** Single **0** Engaged **0** Married **0** Separated **0** Divorced **0** Widowed

If engaged, married, divorced or widowed, how long have you been so? _____

Number of previous marriages for you? _____ For your current spouse? _____

Name of spouse: _____ Spouse's age: _____

Spouse's Occupation: _____

Please provide a brief description of your spouse (e.g., angry, controlling, outgoing, supportive): _____

_____

Please list your children, including step, adopted and foster children (use back of sheet if necessary):

Name	Sex	Age/Year of death	Relationship to you	Living with whom?

Family of Origin

Please list your mother, father, brothers, sisters, stepfamily and/or relatives who had a significant effect upon your life (positive or negative).

Name	Sex	Age/Year of death	Relationship to you	Describe him/her

Please identify any of the following you experienced in your family:

☐ Physical Abuse ☐ Emotional Abuse ☐ Sexual Abuse ☐ Abortions ☐ Gambling
☐ Drug/Alcohol Addiction ☐ Religious Upbringing ☐ Major Losses ☐ Multiple Marriages

Please describe the kind of family you grew up in: _____

_____

Counseling History

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the name of the therapists and/or programs (use back of this sheet if necessary):

Name of Therapist/Program	Issues Addressed	Dates in Treatment

Has anyone in your family ever been treated or hospitalized for substance abuse, mental health issues, or psychiatric conditions? ☐ Yes ☐ No

If yes, please describe: _____

Have any of your family or friends ever attempted or committed suicide? ☐ Yes ☐ No

If yes, who and when: _____

Medical History

Name and Town of Current Physician: _____

Date and outcome of last physical exam: _____

Please list any conditions, illnesses or surgeries that might be relevant to your reason for seeking counseling:

_____

Please list current medications you are taking even if use is seldom or as needed (use back of sheet if necessary):

Name of Medication	Dosage	Reason for taking medication

Present Issues and Goals

Please describe why you are coming to counseling (issues, problems, symptoms, how long, etc.):

_____

_____

_____

Check any of the following symptoms or problems that you are currently or have recently experienced:

☐ Stress	☐ Grief	☐ Verbal abuse	☐ Impulsive behavior	☐ Anxiety
☐ Chronic pain	☐ Sexual abuse	☐ Controlling	☐ Sexual problems	☐ Fears
☐ Loneliness	☐ Sexual addiction	☐ Obsessive thoughts	☐ Depression	☐ Panic
☐ Indecisiveness	☐ Poor concentration	☐ Shyness	☐ Gender identity	☐ Anger
☐ Fatigue	☐ Low self-esteem	☐ Hearing voices	☐ Loss of appetite	☐ Bad dreams
☐ Marital problems	☐ Aggression	☐ Racing thoughts	☐ Trouble sleeping	☐ Apathy
☐ Relational issues	☐ Eating problems	☐ Physical Abuse	☐ Unwanted memories	☐ Alcohol use
☐ Feeling worthless	☐ Emotional Abuse	☐ Loss of control	☐ Pregnancy/Abortion	☐ Work issues
☐ Financial issues	☐ Spiritual apathy	☐ Drug use	☐ Career choices	☐ Loss
☐ Compulsive behavior	☐ Controlled by others		☐ Seeing things others don't	

Please place an "X" on the scale to indicate how distressing your problems are to you.

{----------}
Very minimal distress Moderate distress Very extreme distress

Are you currently experiencing any suicidal thoughts? ☐ Yes ☐ No
Have you experienced suicidal thoughts or attempted suicide in the past? ☐ Yes ☐ No
Are you currently experiencing any violent or homicidal thoughts? ☐ Yes ☐ No

We trust that your involvement with Life Counseling Center will be helpful to you. If you have any questions regarding any aspects of your relationship with us, please discuss them with your therapist or our office staff. My signature certifies that I have completed the Intake & thoroughly read, understand and agree to all the Policies & Procedures of Life Counseling Center listed on pages 7 & 8 of this packet.

_____ _____
Client's Signature Date

Life Counseling Center HIPAA Signature

As a client of Life Counseling Center, I acknowledge that I have been given the Privacy Notice (on pages 9 & 10 of this packet) required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that prescribes legal duties and privacy practices to protect the privacy of my individually identifiable health information, by LCC.

Client Name or Guardian (Print)_____

Client Signature_____Date_____

8737 Brooks Dr., Suite 203, Easton, MD 21601
410-822-6223 – FAX 410-820-4033 – www.lifecounsel.org

AUTHORIZATION TO RELEASE INFORMATION

I authorize LIFE COUNSELING CENTER to release to and receive from (Select one, fill out additional forms if necessary)

___MHPG ___Hospital ___Primary Care Physician
___Pediatrician ___Court System ___School System
___Family Member/Support person ___Other_____

Release to Name:_____
Address:_____
Phone Number:_____

_____ _____
(Patient Name) (DOB)

___Medical Records ___Academic Records/Educational Evaluation
___Clinical Records ___Treatment Plan/Patient Progress
___Neurological Evaluation ___Special Education File
___Results of Drug & Alcohol Treatment/Testing ___Other (Specify)_____

For the purpose of_____

I have been informed of the type of information being released, the benefits and disadvantages (if any) and understand that treatment services are not contingent upon my decision concerning the signing of this release. I have also been informed that my photocopied signature is as valid as the original.

Signature of Patient:_____Date:_____

Signature of Parent/Guardian:_____Date:_____
(if patient is a minor)
Signature of Witness:_____Date:_____

Note: Remember to ask for permission to release information to any key person who has worked with the patient and family (i.e. probation officer, hospital clinician, private practice clinician, teacher, guidance counselor, attorney, etc.)

As required by Section 2.32(a) PROHIBITION ON DISCLOSURE – rule: “This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

CREDIT CARD AUTHORIZATION

Client Name:_____

Counselor:_____

Type of Card: (Visa, MasterCard, Discover, Amex)_____

Name on Card:_____

Billing Address:_____

Cardholder's Phone Number:_____

Credit Card #:_____

Expiration Date:_____/_____

Security Code:_____

I,_____, authorize Life Counseling Center to bill my credit card for the amount above and/or for any ongoing balances on my account.

Note: There will be a time delay in the processing of charges to your credit card due to the nature of our billing system.

Life Counseling Center Policies & Procedures

The purpose of Life Counseling Center (LCC) mental health treatment is to help you achieve your goals and overcome any obstacles that led you to seek counseling with LCC. You are encouraged to work with your counselor in the development of your treatment plan and be informed of any new modes used within your treatment process. The associated risks of mental health counseling are limited. You may experience some emotional difficulty, which your counselor will do their best to help you work through. The benefits to be gained from counseling are vast. Some potential benefits of counseling are an improved outlook on life, more effective coping skills, greater understanding of yourself and better communication tools that will not only have positive effects on your relationships, but also through many other aspects of your life.

1. **Participation in Counseling**
   a. As a client of LCC, you are not required to accept treatment from LCC at any time. You have the right to decline part or all of your treatment, including withdrawal from our services should you not be willing to participate.
   b. The Counselor-Client relationship is a professional relationship engaged in for purpose of working on client-identified goals, using the professional and academic experience of the counselor and the relationship built in sessions. While this relationship may be significant, it is in no way of a personal or romantic nature.
   c. While your counselor will do their best to assist you, counseling is a collaborative process, and there are no guarantees that you will be satisfied with your treatment.

2. **Informed Consent for Medical Record**
   I understand and consent to LCC having one medical record for me. I understand that every counselor who provides treatment for me at LCC will have access to all clinical notes in my clinical record.

3. **Release of Information Form**
   a. All information obtained/derived during the course of treatment is fully confidential; Disclosures you share with your therapist are confidential unless you have SIGNED a consent form to release part or all of the information to another professional state licensed counselor. If this is your wish, then upon signing a consent form for said notes, they will then be sent directly to that counselor. **Personal therapist session notes will not be given to clients, they are the property of the therapist and will only be handed over to another state licensed counselor upon the client's signed consent (or) if ordered to do so by the court or by a judge. If you desire LCC to either release or obtain information from a specific individual or agency, a *Release of Information* form must be obtained, signed and dated. Exceptions to this guideline include instances when 1) the client is a clear danger to (a) themselves or (b) others, 2)when a client disclosed abuse or neglect that as a minor (client is either currently a minor or past abuse occurred when client was a minor), 3) if there is any suspected abuse to a child or vulnerable adult, or 4) when judicially required (e.g. subpoena)
   b. In addition, cases are occasionally discussed by the Life Counseling Center staff to obtain feedback and provide alternative treatment plans and continuity of care (e.g. your therapist, if unlicensed, will discuss your case with his/her Clinical Supervisor). In these cases, identifying information is not disclosed and only clinically relevant information is discussed.

4. **Length of Session**
   Psychotherapy sessions are varied in length between 38 and 90 minutes. It is to your benefit to arrive a few minutes in advance of the appointment time. Since your counselor has additional sessions after yours, the session must end at the appointed time regardless of your arrival time.

5. **Fees & Payment**
   Our current fee per session is $115-$170. All payment is due at the time services are rendered. Payments may be made in the form of cash, check or credit. Make checks payable to Life Counseling Center. If you choose to pay by credit card, please use the "Credit Card Authorization Form" contained in this packet. If any or all outstanding balances are not paid in a timely manner, LCC reserves the right to release a client's

6. Cancellations and Missed Appointments/Inclement Weather

a. When an appointment is scheduled, that time is reserved for you. If the appointment is missed or canceled without sufficient notice, the therapist is unable to make use of that time. It is your responsibility to give at least **24 hours** notice if you must miss or cancel an appointment. **There will be a $60 charge for a Late Cancellation and the full session fee for a No Show.**

b. The counselor is responsible for determining if the weather is too hazardous to commute to your practice location. If your counselor decides to cancel your session, they or the office staff will contact you to inform you of the change.

7. Insurance

a. Life Counseling Center, Inc. is in-network with CareFirst BlueCross BlueShield and/or CareFirst Blue/Choice, Inc. If we take your insurance, we will bill your insurance company for all sessions unless otherwise agreed upon. You are responsible for any balance that insurance does not cover and agree to pay any unpaid balance on your account in a timely manner.

b. All balances will be collected from clients 90 days after insurance has been billed. this means that LCC is giving your insurance company 90 days to pay the claim. The law states that it must be processed within 30 days of receipt. After 90 days, you are responsible to pay LCC directly. We will give you a receipt to submit to your insurance to pursue reimbursement.

8. Safety Consent

I understand that my counseling records are kept confidential, where disclosure is required by law (e.g. child abuse/elder abuse reporting requirements, serious threat of harm to self or others) or I have signed the appropriate release of information forms.

PRIVACY NOTICE OF
LIFE COUNSELING CENTER (LCC)

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE GIVES YOU INFORMATION REQUIRED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) that prescribes legal duties and privacy practices to protect the privacy of your individual identifiable health information; this is, *Protected Health Information (PHI),* as that term is defined in the HIPAA.

THE EFFECTIVE DATE OF THIS NOTICE IS APRIL 14, 2003. LCC is required to follow the terms of this Notice until it is replaced. LCC may make changes to the terms of this Notice at any time. **UPON your request,** we will provide you with a copy of the current Notice. LCC reserves the right to make the changes apply to your *Information* maintained in my files before and after the effective date of the new Notice. The following is a general description of how Federal and State law permits me to use and disclose your *Information.*

Purposes for which LCC May Use or Disclose Your Mental Health Information with your Consent
LCC may request your consent for the use and/or disclosure of your *Information* for *treatment, payment or health care operations* as directed below:

- *Treatment*. LCC with use and disclose your *Information* to provide, coordinate, or manage your mental health care and any related services. LCC may disclose your *Information* to physicians, therapists, other mental health providers, or other health care providers who are treating you or assisting in your diagnosis, treatment or recovery.

- *Payment***.** Your *Information* will be used and disclosed, as needed, to obtain payment for your mental health care services. This may include certain activities that your health insurance plan undertakes before it approves or pays for the mental health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and utilization review activities. If more than one, third party payer is responsible for payment for your health care, LCC may disclose your *Information* to more than one health plan and those health plans may share your *Information* with each other. Your *Information* may also be used and disclosed as needed to obtain payment for mental health care services rendered to you by other providers.

- *Mental Health Care Operations.* LCC may use or disclose, as needed, your *Information* in order to support my delivery of mental health care services. LCC may call you by name in the waiting room area. LCC may use or disclose your *Information* as necessary, to contact you to schedule an appointment or remind you of your appointment.

- *Business Associates:* LCC may share your *PHI* with third party business associates who perform various administrative services. Whenever an arrangement between a business associate and LCC involves the use or disclosure of your *PHI*, we will have a written contract that contains terms that will protect the privacy of your *PHI.*

- *Health Care Services.* Your *Information* may be used and disclosed to contact you and to give you information about treatment alternatives or other health benefits and services that may be of interest to you.

Uses and Disclosures With Your Verbal Consent
Your *Information* may be disclosed to a family member, friend, or other person designated by you or as designated by the law, if you verbally agree.

Uses and Disclosures With Your Written Authorization

Except as provided below, your *Information* will not be used for any non-routine purposes unless you give your written authorization to do so. If you give written authorization to use or disclose your *Information* for a purpose that is not described in this Notice, then, with certain exception, you may revoke it in writing at any time. Your revocation will be effective for the *Information* LCC maintains, unless LCC has taken action in reliance on your authorization.

Uses and Disclosure Without Your Consent

- As required by law;
- To comply with legal proceedings, such as a court or administrative order or subpoena;
- To law enforcement officials for limited law enforcement purposes;
- To a coroner, medical examiner, or funeral director about a deceased person;
- To avert a serious threat to your health or safety or the health or safety of others;
- To a governmental agency authorized to oversee the mental health care system or government programs;
- To federal officials for lawful intelligence, counterintelligence, and other national security purposes; and
- To public mental health authorities for public health purposes.

Your Rights

You may make a written request to me to do one or more of the following concerning your *Information:*

- Put additional restrictions on use and disclosure of your *Information.*
- Communicate with you in confidence about your *Information* by a different means than LCC is currently doing.
- See and get copies of your *Information.*
- Receive a list of disclosures of your *Information* that LCC has made for certain purposes for six (6) years prior to your request (after April 14, 2003), with certain exceptions permitted by law, which includes exceptions for disclosure made directly to you or made pursuant to your authorization.

If you want to exercise any of these rights or require further information about privacy practices, please contact me at the address below. In certain instances, LCC is not required to agree to your request. LCC will give you the necessary information and forms for you to complete and return to request your *Information.* LCC is permitted, by law, to charge you a fee for copying any documents requested in accordance with your rights as listed above. (Fee $1.00 per page.)

Complaints

If you believe that LCC violated your privacy rights, you have the right to complain to me or to the Secretary of the U.S. Department of Health and Human Services (DHHS). You may file a written complaint with me at the address below. An individual must file a complaint within 180 days of when he/she knew or should have known that the act or omission occurred, unless the time limit is waived by the Secretary of DHHS. LCC will not retaliate against you if you choose to file a complaint.

Contact Addresses:

Life Counseling Center, Inc.
8737 Brooks Dr., Suite 203
Easton, MD 21601
Phone: 410-822-6223

USDHHS
200 Independence Ave. SW
Washington, DC 20201
Phone: 1-877-696-6775