Family Counseling of Springfield

Client Intake Information: Adult

Name:_____Date: _____

DOB:___/____/_____ Age:_____Social Security Number: _____

Address:_____City_____State:_____Zip: _____

Phone numbers: Home: (_____) _____-_____ Work: (_____)_____-_____

Cell: (_____)_____-_____ Email Address_____@_____ ._____

Employer: _____ Position:_____

For how long?_____Highest Level of Education: _____

Marital status: Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered ❑

Significant other's name: _____ Age_____ Sex _____ Year together _____

Names, ages and relationship of all individuals in the home: _____

_____

_____

Emergency Contact _____Relationship_____Phone #_(____)_____- _____

Why are you seeking counseling at this time? _____

_____

Who referred you to Family Counseling? _____

Please call your insurance company and request the following **REQUIRED INSURANCE INFORMATION**

Policy Holder's Name _____ DOB: ___/___/_____ SSN _____-_____-_____

Relationship to Client_____Insurance:_____Policy #_____

Deductible: $_____Has it been met? Yes/ No How much deductible remains? $_____

Copayment $_____Coinsurance_____% Who will pay noninsured balance_____

Is preauthorization required? Yes / No If required, please provide the following information:

Authorization # _____ # visits authorized _____ Start date: ___/___/___ End Date ___/___/___

Additional Information **TRICARE ONLY** ❑ PRIME ❑ STANDARD ❑ ACTIVE ❑ RETIRED

Primary Care Physician (MD or DO only) Name_____ Phone # _____

All clients using health insurance please sign below.

I hereby authorize Family Counseling of Springfield to release any Protected Health Information that is necessary for billing (except Psychotherapy Notes) to my insurance company, in order to process my claim for payment of services.

Signature _____ Date _____

Name: _____Date: _____

Primary Care Physician:_____Phone number: (_____) _____-_____

Approximate date of your most recent physical examination: _____

Please list all current or past health problems, and any major operations:

Health Problem or Surgery	Date	Currently a problem?	Doctor

List all current medications and dosages, including supplements:

Name of Medication	Reason Taking Medication	Dosage	Prescribing Doctor	Date Started

List any allergies you have:_____None _____

Have you ever been prescribed medication for ADHD or ADD **Y / N** —— Depression **Y / N** —— Anxiety **Y / N**

Please list all therapists or psychiatrists you have seen, and approximate dates you worked with them:

Therapist and location	Approximate Dates Seen

Please list any substance abuse treatment or inpatient psychiatric treatment and approximate dates:

Name of Substance Abuse Program or Psychiatric Hospitalization	Approximate Dates	Inpatient	Outpatient

Name:_____Date: _____

Please indicate if you are currently, or have in the past, experienced any of the following:

Symptom	Current	Past Year	More than 1 year ago	Symptom	Current	Past Year	More than 1 year ago
Depression				**Anxiety**			
Shortness of breath				Avoid Public Places			
Chronic Sadness				Trembling/Shaking			
Low frustration level				Agitation			
Crying Episodes				Fear of Dying			
Irritability				Panic Attacks			
Hopelessness				Chest Pain			
Thoughts of Suicide				Fearfulness			
Difficulty concentrating				Avoid social situations			
Withdrawing from Others				Fear of leaving home			
Weight Loss				Restlessness			
Difficulty functioning at work				Fear of loss of Control			
Weight gain				Excessive Worry			
Difficulty functioning socially				**Attention**			
Loss of appetite				Difficulty Waiting			
Low energy/fatigue				Don't finish what you start			
Over eating				Racing thoughts			
Reduced interest/pleasure				Constantly moving/pacing			
Nausea/Vomiting				Taking on too much at once			
Feelings of worthlessness/guilt				Difficulty starting a new task			
Difficulty making decisions				Difficulty concentrating			
No interest in daily activities				Difficulty Organizing			
Recurring thoughts of death or				Impulsive			
Sleeping too little/too much				Forgetfulness			
Extreme lows/highs				Difficulty following Directions			
Pounding heart/palpitations				**Substance Abuse**			
Difficulty Falling Asleep				Relationship issues due to Alcohol or Substance use			
Eating Problems				Health problems/accidents due to Alcohol or substance use			
Worry about being underweight				Others think I have a substance problem			
Worry about being overweight				Adult child of an alcoholic parent			
Self-induced vomiting				Excessive use of alcohol/drugs			
Laxative use				Fail at effort to reduce use of alcohol/drugs			
Extreme exercising				Use of substances to cope with stress			
Obsessed with food				Legal problems related to substance use			
Obsessed with weight				Cigarette use			
Other Problems not listed:				**Other Problems not listed:**			

Problem	Current	Past Year	More than 1 year ago	Problem	Current	Past Year	More than 1 year ago
Stress/Trauma				**Other Problem Areas**			
Feeling detached from others/life				Grief/Loss			
Flashbacks/reliving bad experiences				Excessive gambling			
Intrusive thoughts or bad memories				Parent-child relationship issues			
Easily startled/upset				Financial concerns			
Nightmares				High risk sexual behavior			
Difficulty concentrating				**Thinking Problems**			
Feeling tense				Hearing voices/seeing things others do not			
Hyper-vigilance				Fearful others are talking about you			
Self-abuse/cutting				Fearful someone is plotting against you			
				Feelings of being followed/stalked			

Personal Drinking Patterns	**Number**	**Prefer to Discuss in Person**
Number of days of the week you drink		
Number of drinks per day you consume		
Total number of drinks per week you consume		
Number of times in the last two weeks you had four or more drinks at a sitting		
Number of times in the last two weeks you had five or more drinks at a sitting		
Number of times in the past 30 days when you drank enough to get drunk		
Approximate number of times each month you have used alcohol in the past year		

Other Drug Use in Past 12 Months

Other Drugs Names:	Several times per day most days	Several times per day weekends	1-2 times per week some weeks	1-2 times per week, most weeks	3-4 times per week, some weeks	3-4 times per week, most weeks	More than 5 times per week	Prefer to Discuss in Person

ADDITIONAL INFORMATION

Be prepared to discuss your goals for treatment with your therapist, providing as much information as you can.

- How long have you had this issue or problem.
- Who is/was involved in your problem.
- Circumstances that may have led up to this situation.
- Information about your family of origin and early life.
- Information about any trauma or abuse you may have suffered.
- If you have sought counseling prior to this, what was helpful and not helpful about the work you did.
- Coping mechanisms and solutions you have tried so far; what worked, and what didn't.
- Your strengths and positive attributes. What challenges do may face?
- Who can you count on to be in your support network.
- Specific questions for your therapist about treatment methods, length of treatment, setting goals, etc.

Informed Consent for Therapy Services – Adult

THERAPIST-CLIENT SERVICE AGREEMENT

Welcome to **FAMILY COUNSELING OF SPRINGFIELD**. This document contains important information about our professional services and business policies. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

COUNSELING SERVICES Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in therapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. Your therapist has corresponding responsibilities to you. These rights and responsibilities are described below.

RISKS AND BENEFITS

Therapy has been shown to have benefits for many individuals who decide to participate. This work often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress, and resolution of specific problems. But, there are no guarantees about what will happen. Counseling requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the counseling process often requires recalling and discussing unpleasant aspects of your life. Despite our best efforts, therapy does not always work out well.

Please consider this information and make your own assessment about whether you feel comfortable working with your therapist. If you have questions about style, or the purpose of a technique, please bring them up when they arise so they can be addressed.

The first several sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, your therapist will be able to offer you some initial impressions of what your work might include. At that point, you will discuss your treatment goals and create an initial treatment plan.

APPOINTMENTS

Appointments are 45-50 minutes in duration, once per week at an agreed upon time, although sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, please provide your therapist with 24-hour's notice.

If you miss a session without canceling, or cancel with less than 24-hour notice, there is a **Missed Office Visit Fee of $75**, unless you and your therapist agree that you were unable to attend due to circumstances beyond your control. Insurance companies do not reimburse for cancelled sessions so you are responsible for this fee. Please plan to arrive at your session on time; if you are late, your appointment will still need to end at the scheduled time.

PROFESSIONAL RECORDS

We are required to keep appropriate records of the services that we provide, which are maintained in a secure location in the office or off-site. We keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records we receive from other providers, copies of records we send to others, and your billing records. You have the right to a copy of your file, but because these are professional records, they may be misinterpreted by an untrained reader. We recommend that you initially review them with your therapist, or have them forwarded to another mental health professional to discuss the contents. You may also request in writing that a copy of your file be made available to any other health care provider.

CONFIDENTIALITY

Our confidentiality policies, as well as other information about your privacy rights, are fully described in a separate document you received entitled **Notice of Privacy Practices**.

CONTACTING YOUR THERAPIST

In case of emergency, if you are unable to reach your therapist, please call 911 or go immediately to the emergency room.

Your therapist may not have time to respond to calls or read or return emails or texts when they are with clients or otherwise engaged. You may leave a message with the front desk during normal business hours or on your therapist's confidential voice mail and your call will be returned as soon as possible. It may take a day or two for non-urgent matters.

Your therapist will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the therapist who is covering their practice.

SOCIAL MEDIA POLICY

➢**Email:** Email is not secure or confidential. Any emails received and any responses sent become a part of your legal record. Please only use email to contact your therapist for administrative reasons (modifying appointments, billing information, etc.). Please do not email content related to counseling sessions.

➢**Text Messages:** Please do not send text messages, unless otherwise agreed upon. Your therapist will not respond to texting and any text message received will become part of your legal record.

➢**Friending:** Communicating with you on social media sites can compromise your confidentiality and our therapeutic relationship, therefore your therapist will not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.).

➢**Following:** If there is content you wish to share from your online life, please bring it into our sessions where we can explore it together. We do not follow any client on Twitter, Instagram, blogs, or other apps/websites.

OTHER RIGHTS You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about specific training and experience. You have the right to expect that your therapist will not have social or sexual relationships with former or current clients.

If you are unhappy with what is happening in therapy, please discuss this with your therapist so that he or she can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that your therapist refer you to another therapist and are free to end therapy at any time.

CONSENT TO PSYCHOTHERAPY Your signature below indicates that you have read and agree to the terms of this Agreement and the Notice of Privacy Practices.

_____	_____ _____/_____/_____
Printed Name of Patient or Personal Representative	Signature of Patient or Personal Representative Date
_____	_____ _____/_____/_____
Printed Name of Patient or Personal Representative	Signature of Patient or Personal Representative Date

Family Counseling of Springfield (FCOS) Counseling Services
Fee Agreement

Individual Counseling: The initial consultation fee is $150; additional sessions are $125 per 45 minutes.

Couples Counseling: The initial consultation fee is $200, which includes scoring and interpretiation of several assessments. Subsequent sessions are $150 whether you are seen alone or with your partner. Couples work is not covered by insurance because managed care requires a diagnosis. You may submit your claims and your insurance may reimburse you, but you are responsible for paying for all services at the time of your appointment.

Payment may be made by check, cash or credit card. Any returned checks are subject to an additional fee to cover the bank fee that we incur. All clients are requested to provide us with a credit card to keep on file.

Fees for additional professional services: We charge a prorarted amount based on our hourly fee for other professional services you require, such as letter or report writing, telephone calls longer than 15 minutes, attendance at meetings which you have requested, or the time required to perform any other service you may request. If you anticipate becoming involved in a court case, please discuss this fully before you waive your right to confidentiality. If your case requires therapist participation, you will be expected to pay the hourly rate, including travel time, even if your therapist is subpoenaed to testify.

INSURANCE
If your FCOS therapist has contracted with your insurance company to accept a lower fee, your deductible and any noninsured portion of each session's fee will be based on that contracted amount. Our billing service, Practice Solutions, will validate your eligibility and assist you **to the extent possible** in filing claims but **you are responsible for knowing your coverage and for letting us know if/when your coverage changes.** If your therapist is not a participating provider for your plan, we will submit your charges and they may reimburse you for all or part of our fee but not all insurance companies reimburse for out-of-network providers.

Deductibles are an out-of-pocket amount that must be paid before your insurance company will pay for services. Medical, mental health, or dental bills all count towards your deductible. You are responsible for paying for initial sessions until your yearly deductible has been met.

Advanced Authorization may be required before managed care will pay for treatment. If you did not obtain required authorization you will be responsible for full payment of the fee.

Co-insurance is a percentage of the fee charged, which is the portion your company requires you to pay. **Copayment** is a specific dollar amount which you are required to pay. Coinsurance and copayments are due at time of service unless an alternative fee arrangement has been signed.

All accounts are payable in full within 30 days after billing. Overdue accounts may be charged 10% interest per year.

Family Counseling of Springfield, LLC, reserves the right to use an attorney or collection agency to collect any unpaid balance if a client is not making regular monthly payments, as authorized by state or federal law, and the collections action will become a part of your credit record. Clients will be notified in writing before Family Counseling of Springfield takes action to collect.

Limit on Unpaid Balance: Family Counseling of Springfield may terminate treatment and refer you elsewhere for continued care if the unpaid balance exceeds $300.00

If you would like to create an alternative payment arrangement, please discuss this with your therapist.

I have read and understood this fee agreement, and agree to abide by its terms. I hereby authorize FCOS to provide my insurance company with my clinical diagnosis and additional requested clinical information necessary for payment.

_____ _____ _____/_____/_____
Printed Name of Patient or Personal Representative Signature of Patient or Personal Representative Date

HIPAA: Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable request

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you: We can use your health information and share it with other professionals who are treating you.

Run our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Bill for our services: We can share health information to bill and get payment from health plans or other entities.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Our HIPAA Compliancy Officer is Monica Zedalis famchirocontact@gmail.com 703-569-1300

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, and we will mail a copy to you.

Effective Date of this Notice: 5-1-18

Client or responsible party _____ Witness _____ Date _____