LIFEWORKS Counseling

CONFIDENTIAL

Client Intake Form

Please provide the following information and answer the questions below.

Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it with you to your first session. Please write legibly.

Date of Initial Session_____

Name:_____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date:_____/_____/_____Age:_____Gender: □ Male □ Female

Marital Status:
□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Please list any children/age: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) May we text/leave a message? □ Yes □ No

E-mail:_____May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner:_____

Are you currently taking any prescription medication?
□ Yes
□ No

Please list: _____

_____

Have you ever been prescribed psychiatric medication?
□ Yes
□ No

Please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in? _____

4. Please list any difficulties you experience with your appetite or eating patterns:

_____

5. Are you currently experiencing overwhelming sadness, grief, or depression?
□ No
□ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?
□ No
□ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
□ No
□ Yes

If yes, please describe: _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship?_____

11. What significant life changes or stressful events have you experienced recently:
_____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

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ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation?

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

_____

4. What do you consider to be some of your weaknesses?

_____

_____

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

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LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____
Client Signature (Client's Parent/Guardian if under 18)

_____
Today's Date

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HIPPA Patient Authorization

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

In the course of your care as a patient at the office of **Lifeworks Counseling, LLC** we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment, or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or in worker's comp cases to your employer, if they are or may be responsible for the payment of your services.
- Our name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not available to receive an appointment reminder, a message may be left. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care, however, full payment will be expected at the time of services.

Under federal law, we are also permitted or required to use or disclose your health information with your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communication with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you personally at the time you receive counseling services from us. We may also mail information to you regarding your health care or information about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy, or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide to the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. We will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notices, our privacy practices or any aspect of our privacy activities, or if you would like any additional information regarding our privacy policies, please contact our office.

This notice is effective as of the date below. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Signature _____ Date _____

Name (printed)_____

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CANCELLATION POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment.

Thank you for your consideration regarding this important matter.

_____

Client Signature (Client's Parent/Guardian if under 18)

_____

Today's Date

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AUTHORITY TO RELEASE/OBTAIN PROTECTED HEALTH INFORMATION

_____ _____ _____ _____
(Last Name) (First & Middle Name) (ID #) (DOB)

Authorized Personal Representative (if applicable): _____

I, _____ hereby authorize LifeWorks Counseling, LLC, to

(individual / judicially authorized representative) release / obtain my protected health information/records to/from:

_____

_____
(Name of Person & Title or Entity and Address to whom/from information will be disclosed /obtained)

I specifically authorize the release/ obtaining of health information and/or records pertaining to the following (**Must indicate by initialing and/or describing the amount and type of health information to be obtained/released**):

*_____ Identifying Information
*_____ Admission/Intake Summary
*_____ Discharge/Termination Summary
_____ Medical History and Physical
_____ Substance Abuse Assessment/Treatment Records
*_____ Summary of Contacts
*_____ Emergency Medical Information/Hospitalization
_____ Psychological Assessment/Testing
*_____ Psychiatric Records
_____ Other (Describe other information/records to be disclosed/obtained) _____

* Indicates required fields

My authorization of the release or obtaining of this information and/or records is for the specific purpose of:

_____
(Describe purpose or nature of the information to be disclosed/obtained)

Dates of service for which the information/record is requested or will be released: From: _____ To: _____
I understand that this authorization will be effective on the date signed and will expire one year from date signed.

I understand that I have the right to revoke this authorization at any time. I understand that to revoke this authorization, I must provide a specific request to revoke the authorization in writing to the HIPAA Coordinator/LifeWorks Administrator. I understand that my revocation will not apply to any information that has already been released/obtained in response to this authorization. I understand that my authorizing the disclosure/obtaining of this health information is voluntary. I understand that I do not have to sign this form in order to receive treatment. I understand that I may inspect or copy information to be used or disclosed as provided for by law. I understand that any disclosure of information carries with it the potential for a re-disclosure and that the information may no longer be protected by federal confidentiality laws. If I have questions about disclosure of my health information, I can refer to the Notice of Privacy Practices or contact the HIPAA Coordinator.

_____ _____
Signature of Individual, if applicable Date

_____ _____
Signature of Witness (es), if applicable Date

Note to Person(s) Receiving Information Addressed in this Authorization: This information has been disclosed to you from records whose confidentiality is protected by state and/or federal law(s) or regulations. These laws/regulations prohibit you from making further disclosure of this information without the specific written authorization/consent of the person to whom pertains or of other persons as permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.

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CONFIDENTIALITY CONTRACT FOR MARITAL OR COUPLE THERAPY

This contract is an agreement between the interested parties that neither party shall for any reason attempt to subpoena our testimony or records to be presented in a deposition or court hearing of any kind for any reason, such as a divorce case.

Both parties acknowledge that the goal of psychotherapy, either individual or marital or couples counseling, is for the sole purpose of developing healthy relationships in accordance with a Christian worldview and that the process of counseling depends on trust and openness during the therapy sessions.

Therefore, it is understood by both parties that if they request our services as counselors, they are expected not to use information given to us during the therapy process against the other party in a judicial setting of any kind, be it civil, criminal, or circuit.

AGREEMENTS REGARDING COUPLES THERAPY

When entering couple's therapy and beginning a therapeutic relationship, we take on an ethical duty to each member of the coupleship that involves joint consent to and ownership of the information you share and the right to not have secrets kept between one member of the couple and the therapists.

INDIVIDUAL MEETINGS IN COUPLES THERAPY

At times we will meet with couples individually, as this can be helpful for certain concerns. If we meet in individual sessions, we will only do so when we have agreed to this beforehand and in a way that makes each member of the coupleship have equal time with the therapist. The therapist will not keep secrets from one member of the coupleship. If one person admits to something like an affair or some other issue of concern, the therapist will help that person to plan how to talk about that in joint sessions. If the person is unwilling to discuss this issue, the therapist reserves the right to terminate treatment without explaining why to the other member of the coupleship. We realize that this could raise questions about the ending of treatment and may force the secret to be named in some way, but we cannot maintain our duty to each of you if we hold secrets.

CONTINUING WITH INDIVIDUAL TREATMENT AFTER COUPLES TREATMENT

At times, one member of a couple will request that we continue with individual treatment after couple's therapy has ended. Both members of the couple have to agree to this, as we are maintaining confidentiality (as discussed in other paperwork you have signed) with each of you. Because it would make sense that the person who remains in therapy will want to discuss the couple's issues we have talked about, the person who will no longer be in therapy will have to give their consent for one individual to continue, so that we do not violate our confidentiality agreement. In the event that this happens in our treatment, your signature below gives your permission for your spouse/partner/significant other to continue in treatment and to talk about their relationship with you.

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CONFIDENTIALITY CONTRACT FOR MARITAL OR COUPLE THERAPY (cont.)

It is important to note that if we end couple's treatment and one or both of you continues in individual therapy, the individual confidentiality agreements will then apply. Because of the unique nature of our practice, in working together as joint therapists, we can continue individual therapy as needed.

In working with couples as joint therapists, we will make every effort to both be present in sessions. This approach has been proven to be effective in marital counseling and provides valuable insight to each partner. However, due to scheduling conflicts, illness, etc., we cannot always guarantee both of us will be in session. If for any reason one of us is not in the couple's session, be assured that we review case notes and discuss progress on a daily basis. This way we both stay current on the progress made in each session and can continue in the consistent, intentional work in subsequent sessions.

If, at any time, you decide that this approach does not work for you we will be happy to make referrals for either of you if so desired.

The signatures below reflect that all parties agree to the terms set forth above.

Client Signature_____Date_____

Client Signature_____Date_____

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Rates
Charges vary according to the type of services rendered including diagnostic interview, family counseling, two therapists in session, psychological testing/assessment and group therapy.

Insurance
Lifeworks Counseling is an In-Network provider for Blue Cross Blue Shield of Mississippi. Please make your insurance card available for photocopying. We will be happy to electronically file your BCBS insurance claim. If you have a different insurance provider, your counselor will provide you a statement that you may personally file with your individual provider. We can file out-of-network claims through the BCBS clearinghouse but there is no guarantee of coverage - in these cases our established fee must be paid until any coverage is determined.

For coverage with any other insurance provider you are responsible for determining your rate of reimbursement. Remember your health insurance is a contract between you and your insurer. **Therefore, you are responsible for payment of services rendered regardless if and what amount your insurance company pays.** The following questions are important for you to ask your provider as services may be covered in full or in part by your health insurance or employee benefit plan. Please check your coverage carefully by asking these specific questions:

- Do I have mental health insurance benefits?
- What is my deductible and has it been met?
- How many sessions per year does my health insurance cover?
- What is the out-of-network coverage amount per therapy session?
- Does the plan require pre-authorization by me or the provider? *(if so this should be done prior to the first session)*

Reduced Fee
If you do not have insurance and are referred by a church that is part of our referral network we offer reduced fee services on a limited basis. Unusual circumstances will be considered on an individual basis.

Payment
Payment is due at the end of session - cash, check and all major credit cards accepted for payment.

NO SHOW AND CANCELLATION POLICY
The appointment time is reserved for you. If you must cancel your appointment, it will be necessary for you to give 24 hours' notice. Clients who fail to give 24 hr. notice will be responsible for their full fee. Insurance companies will provide coverage for these charges.

Your signature below confirms your acknowledgement and understanding of these policies.

Signature: _____ Date:_____

Phone:_____ E-mail:_____

In Case of Emergency, Please notify:_____

Relationship:_____ Phone:_____

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Personal Agreements

Client Commitment

I understand that I may be asked to do certain "homework exercises" such as reading, praying, attending groups, attending church and otherwise acting in my own best interest. I understand that I am entirely responsible for my own actions and I will always make my own final decisions regarding counseling.

I further understand that much of the work done will be to resolve issues and will depend on my honesty, and willingness to do the things I need to do to move forward even if it is painful and difficult.

I understand that whatever I say in a session is strictly confidential and will not be released to anyone without my consent unless I am violating codes of abuse, harm to myself or others.

_____
(Client signature and date)

LifeWorks' Counselor Commitment Statement

As your therapist/counselor, you honor me by sharing your life and growth with me. I will not hide myself behind silence or position and will have high regard for you as a person. I will bring the best that I know from my study and experience. I will bring you the highest of my insight, wisdom, and spiritual guidance.

I will keep a holistic perspective in our work together because I believe that the Physical, Spiritual, and Soul (mind, will, emotions) all work together to form the wholly healthy person.

You can expect truth from me even when you may not want to hear it. I will always have compassion and empathy for you in all that we do. I value you as a person in need of care. I will do my best to honor that.