Counseling Intake Form

Today's Date: _____

A. Demographic Information

Legal Name: _____ Preferred name: _____ Gender: ❑ M / ❑ F / ❑ Trans

Date of Birth: _____Age: _____ Social Security #: _____

Home street address: _____Apt. : _____

City, State, Zip Code: _____

Is mailing address the same as street address? ❑ Y / ❑ N

If no, enter mailing address? _____

Mobile phone: _____Home phone: _____ Work: _____

Best Number to Reach You (check one): ❑ Mobile ❑ Home ❑ Work

E-mail: _____

B. Reason for Seeking Treatment

_____

_____

C. Referral Source

How did you hear about us? (If person/organization, list name): _____

❑ Internet Search ❑ Insurance ❑ Personal (i.e. friend) ❑ Website ❑ Social Media ❑ Psychology Today

D. Insurance Information (if applicable)

Insurance Company _____ Primary Insured Name: _____

ID#: _____Group#: _____

**If applicable, copy of your insurance card will be required at initial appointment.*

E. Emergency Contact

In case of emergency and we cannot reach you directly, whom should we call?

Name: _____ Relationship: _____

Address: _____ Phone: _____

F. Racial/Ethnic Background (optional)

Race: ❑ American Indian/Alaskan Native ❑ Asian ❑ African American ❑ Pacific Islander ❑ Caucasian

Ethnicity/national origin: ❑ Hispanic or Latino ❑ Not Hispanic or Latino

G. Marital Status/Relationships

❑ Single ❑ In a relationship ❑ Domestic partnership ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

H. Medical/Health Information

Primary Physician/Clinic Name _____

Office Location/Address: _____ Phone: _____

Check any current or history of the following health conditions:

❑ Arthritis
❑ Asthma
❑ Cancer
❑ Chronic Pain
❑ Celiac Disease
❑ Cystic Fibrosis
❑ Diabetes
❑ Epilepsy/Seizure Disorder
❑ Gastrointestinal problems
❑ Heart Attack/Disease
❑ High Blood Pressure
❑ High Cholesterol
❑ Hypothyroidism
❑ Hyperthyroidism
❑ Low Blood Pressure
❑ Migraines
❑ Multiple Sclerosis
❑ Muscular Dystrophy
❑ Skin Disorder
❑ Stroke
❑ Traumatic Brain Injury
❑ Allergies: _____
❑ Other: _____

List current medications for above referenced medical conditions: _____

_____

_____

I. Mental Health Information

Have you ever received services from a psychiatrist or psychiatric provider? ❑ Y / ❑ N

Current Psychiatrist Provider, if applicable: _____

Office Location/Address: _____ Phone: _____

List any prior mental health diagnoses: _____

List current mental health medications: _____

_____

Have you ever been hospitalized for mental health reasons? ❑ Y / ❑ N If yes, list most recent date: _____

Have you ever received residential mental health services? ❑ Y / ❑ N If yes, list treatment dates: _____

Have you ever received counseling services? ❑ Y / ❑ N If yes, list treatment dates: _____

Have you ever, or are you currently experiencing any of the following symptoms? Check all that apply:

❑ Alcohol/Drug abuse
❑ Anger problems
❑ Appetite problems
❑ Crying spells
❑ Depressed mood
❑ Difficulty concentrating
❑ Disordered eating behaviors
❑ Excessive worrying/Anxiety
❑ Forgetfulness
❑ Hallucinations/Delusions
❑ High anxiety/Panic attacks
❑ Impulsivity/Lack of control
❑ Low self-esteem
❑ Parenting concerns
❑ Relationship concerns
❑ Self-harm/cutting
❑ Sleep disturbance
❑ Thoughts of harming self/others

J. Family Mental Health History

List any family members impacted by the following (i.e., mother, father, siblings, grandparents, aunt, uncle):

Depression _____ Eating Disorder _____

Bipolar Disorder _____ Trauma/Abuse _____

Anxiety/Panic _____ Schizophrenia _____

OCD _____ Intellectual Disability _____

ADHD _____ Alzheimer's/Dementia _____

Autism Spectrum _____ Substance Abuse _____

K. Social History

Are you currently employed? ❑ Y / ❑ N Employer:_____ Job Title:_____

Do you work: ❑ Full-time ❑ Part-time ❑ Other _____ Are you retired? ❑ Y / ❑ N List date: _____

Are you currently enrolled in school? ❑ Y / ❑ N Where do you attend? _____

What is your highest level of education?

❑ 5-8th grade
❑ 9-12th grade
❑ H.S. Diploma/GED
❑ Some college: Degree_____
❑ College graduate: Degree_____
❑ Graduate school: Degree_____
❑ Vocational/technical degree or certification
❑ Other _____

If college is applicable, what was your area of study/degree earned? _____

Have you ever served in the military? ❑ Y / ❑ N If so, what branch? _____

Which best describes your service? ❑ Active Duty ❑ Reserves ❑ Retired ❑ Discharged ❑_____

Do you have any children? ❑ Y / ❑ N If so, how many? _____ List ages/gender: _____

Check all that apply: ❑ Biological ❑ Step ❑ Adopted ❑ Foster ❑ Relative/family placement

Do you consider yourself: ❑ Spiritual ❑ Religious ❑ Agnostic ❑ None ❑ Other _____

If any, what is your faith and/or religious affiliation? _____

List your hobbies and/or interests:_____

Have you experienced any of the following in the past year?

❑ Birth/Adoption/Parenting
❑ Caregiver stress/fatigue
❑ Death
❑ Divorce/Separation
❑ Domestic Violence
❑ Job loss
❑ Infertility
❑ Injury/Onset of medical issues
❑ Relocation/Transition
❑ School difficulty
❑ Social isolation
❑ Trauma/Abuse

By signing this document, I acknowledge that this information is true and correct to the best of my knowledge.

Client Signature: _____ Date: _____

Legal Guardian Signature, if applicable:_____ Date: _____

Client Acknowledgement Form

Client Expectations

-It is expected that clients keep their scheduled appointments or **provide at least 24 hours' notice to cancel** or reschedule. Counselors do not get paid for missed appointments so please be courteous by giving adequate notice.

-It is expected that clients arrive on time for scheduled appointments. Clients **must arrive within 15 minutes of scheduled appointment time**, or session will automatically be forfeited and subject to cancellation policy fees.

-If you are late for a session, the scheduled end time will remain the same. If a late start is due to the counselor, the full length of session will be provided.

-It is expected that clients arrive free of any alcohol, drugs, and/or any intoxicating substances. If the counselor feels it is necessary, the session may be canceled and asked to reschedule at another time. This will be subject to cancellation policy fees.

-I agree to follow these expectations and understand that any violation can result in temporary or permanent discharge from receiving services from Empowered Life, LLC and its counselors.

Client Initials_____

Agreement to Pay for Professional Services

-I acknowledge that if I am opting to use my insurance benefits, I am responsible for understanding my benefit plan (i.e. coverage, deductible, copayment, coinsurance).

-I acknowledge that Empowered Life, LLC is not responsible for incorrect information provided by my insurance provider when verifying benefits and processing claims for dates of services.

-I acknowledge and understand when utilizing insurance benefits, my financial responsibility is subject to change based on my benefit plan's eligibility and coverage status, and claims information.

-I hereby accept financial responsibility to pay Empowered Life, LLC all amounts not covered by my health plan, including amounts for copayments, coinsurance, deductibles, non-covered services, and services which I have not received a proper authorization or referral.

-I authorize my health plan to make direct payment to Empowered Life, LLC, for services rendered. I also authorize Empowered Life, LLC, to use and disclose my health information as necessary to obtain payment.

-I also understand if my insurance plan is not being billed directly (either at my request or due to the provider not being a network provider), I may request Empowered Life, LLC, to provide me with a superbill for services rendered which I can directly submit to my insurance provider to request reimbursement for services. *Note: I understand if I select this option, my health plan may or may not reimburse a portion or the full amount paid for services.*

-In the circumstance that I am not utilizing my health insurance plan, I understand I will be financially responsible for services rendered at the beginning of each session.

-I understand that Empowered Life, LLC, accepts payment by cash, check, or credit/debit card. I hereby acknowledge that I will be financially responsible for any returned check(s) in the amount of the check in addition to any bank fees.

-I understand the self-pay rate for services is as follows:

- $125 for 75-minute initial assessment
- $100 for 55-minute therapy session
- $150 for 90-minute therapy session

-I have read and understand my financial responsibility for services, and hereby agree to make payment for professional services. I also understand if I do not make payment, the provider can seek methods of obtaining payment via legal action, collections, etc.

Client Initials_____

Cancellation Policy

-I understand my counselor must be notified **at least 24 hours in advance to cancel an appointment** by phone call, voicemail, email, or text message. I acknowledge a **$75 fee will be incurred if cancellation does not occur at least 24 hours prior to scheduled appointment**. I hereby authorize my credit card on file to be charged or payment must be made at the start of the next session. *Note: Insurance benefits do not cover missed or canceled appointments. Cancellation fees will only be charged to clients utilizing EAP benefits per specific guidelines. Does not apply to clients who have previously utilized EAP benefits and are currently paying privately or using insurance coverage.*

-I have read and understand the cancellation policy and agree to follow guidelines or understand I will be subject to fees outlined within the policy. ***Client Initials_____***

Electronic Communication

There are some considerations when using electronic forms of communication that must be explained. **Communication through electronic methods (e.g., internet, mobile devices, texting, email) is not fully secure and privacy and confidentiality CANNOT be guaranteed.** It is important to consider the risks when using electronic communication and decide if the benefits and convenience outweigh those risks.

-Empowered Life, LLC, is able and willing to use electronic forms of communication via email and/or text messages; however, these methods will only be used for purposes of scheduling appointments and/or brief follow-up messages.

-Empowered Life, LLC, will not utilize electronic communication methods to discuss a client's diagnosis, treatment plan, treatment progress, and/or any other personal information. In addition, these methods will only be used upon written permission and acknowledgment of risk involved from the client.
Choose one of the following options:

I hereby acknowledge and accept the risks of using electronic communication and give permission to utilize these methods for scheduling and brief follow-up purposes. ***Client Initials_____***

*I **DO NOT** authorize using electronic methods of communication for scheduling and brief follow-up purposes, and would prefer to be contacted via phone or spoken to directly in-person.* ***Client Initials_____***

Printed Name of Client: _____ **Date of Birth:** _____

Signature of Client and/or Legal Guardian: _____ **Date:** _____

Informed Consent to Treatment Form

-I acknowledge that I have received, read (or have had read to me), and understand the "Client Acknowledgment Form" and/or other information about the counseling I am seeking. I have had all my questions answered fully.

-I understand that Empowered Life, LLC, will gather information regarding identifying problem(s), symptoms, diagnosis, and goals and will explain treatment recommendations and interventions as part of my treatment plan. I also acknowledge that my counselor may make diagnostic and treatment recommendations with which I may or may not agree (e.g., duration of treatment, frequency of visits).

-I do hereby seek and consent to take part in my treatment provided by Empowered Life, LLC,. I understand that developing a treatment plan with my counselor and reviewing my progress toward treatment goals are in my best interest. I agree to play an active role in this process.

-I understand that no promises or guarantees can be or have been made to me by Empowered Life, LLC, as to the results of treatment or of any procedures provided by my counselor.

-I have been informed and am aware that there are some risks in participating in psychotherapy, also referred to as counseling services. I understand risks and benefits may be further discussed with my counselor. Some risks may include, but are not limited to addressing painful emotional experiences, being challenged on a particular issue, and/or being inconvenienced financially for counseling.

-I am aware that I may stop my treatment through Empowered Life, LLC, at any time, although I understand that my counselor may want to discuss reasons and goals for continuing/discontinuing services. I further acknowledge I will still be responsible for paying for any services I have already received.

-I understand that I have the right to an Interpreter (sign or language), if necessary. In the case that one cannot be secured for services, I understand I will be referred to another provider.

-I understand that Empowered Life, LLC, does not provide a 24/7 answering service. In the case of a life-threatening emergency I acknowledge and understand that I am to call 911, go to the nearest emergency room, or contact the National Suicide Lifeline at 1-800-273-TALK.

Confidentiality/Limits to Confidentiality – What Clients Need to Know

The information you share with Empowered Life, LLC, is confidential. Your information will be handled with great care and Empowered Life, LLC, and its counselors will uphold their ethical duty and obligation to keep what it discussed private.

If you would like your attendance, diagnosis, progress, treatment, and/or other information to be discussed with members of your support system, and/or other medical providers such as a psychiatrist, or other professional, a separate release form is required. Your written permission is required in order to share and/or exchange any information with any individual.

There are certain circumstances when information can and will be shared legally without your permission. It is important for you to be aware of these circumstances prior to working with Empowered Life, LLC. These circumstances legally require counselors to provide information to the appropriate individuals.

The following circumstances outline **limits to confidentiality:**

-Suicide: If you are assessed to be a danger to yourself, and your physical safety cannot be guaranteed, such as having immediate suicidal plans, this information is no longer confidential. Actions would be taken to ensure your safety, including the possibility of initiating a Baker Act/involuntary hospitalization.

-Homicide: If you are assessed to be a danger to others, and others' physical safety cannot be guaranteed, such as having immediate or specific plans to cause harm and/or injury to another person, the information is no longer confidential. Action may be taken to protect the safety of others, including the possibility of notifying law enforcement and the intended victim.

-Child and Elder Abuse and/or Neglect: Florida law requires that all mental health professionals, including your counselor and all Empowered Life, LLC, employees and/or affiliates, report all suspicion or evidence of child or elder abuse and/or neglect to the appropriate authorities (i.e. Department of Children and Families). This is referred to as being a "mandated reporter." All residents of Florida are considered "mandated reporters," giving an ethical duty to all to report all suspicions and/or evidence of child or elder abuse and/or neglect.

-Court Order/Subpoena: Your counselor may be required to relinquish a copy of your mental health record if provided with a court order to do so, or he/she may also be subpoenaed to testify in court without your consent.

-Insurance/3rd party payors: Your insurance company or 3rd party payor source has the right to review your mental health records. Necessary information, including but not limited to, diagnostic codes and/or treatment provided, will be shared in order to obtain payment for services.

-Case Consultations: Your primary counselor at Empowered Life, LLC, may share information with colleagues during case consultations. Information will only be shared with colleagues who are also required to uphold the ethical duty and obligation to keep information confidential. Consultations are for the client's benefit to ensure your counselor is providing best practices and evidenced-based therapeutic interventions.

My signature below indicates that I have read and understand this document in its entirety and have had all of my questions answered.

Printed Name of Client: _____ **Date of Birth:** _____

Printed Name if other than client: _____

Relationship to Client: _____

Client/Legal Guardian Signature: _____ **Date:** _____

Consent to Use and Disclose Your Health Information

This form is an agreement between you and Empowered Life, LLC. When the words "you" and "your" are used below, this can mean you, your child, a relative, or some other person if you have identified by writing his or her name here: _____.

When you are examined, diagnosed, treated, or referred, information will be collected which is what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, how we use and share your information may change, and so our notice of privacy practices would be updated. If we do change it, you can get a copy by calling your provider, Katherine Roth, LCSW at (813) 658.8071.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to your provider. Empowered Life, LLC, will then stop using or sharing your PHI, but may already have used or shared some of it, and cannot change that.

_____ _____

Signature of client or legal guardian Date

_____

Printed name of client

_____

Printed name of legal guardian and relationship to the client (if applicable)

_____

Signature of Counselor

Date of NPP: _____

Notice of Privacy Practices (Brief Version)

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.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This is a shorter version of the attached, full, legally required notice of privacy practices. Please talk to your provider about any questions or problems.

How we use and disclose your protected health information with your consent

We will use the information we collect about you mainly to provide you with **treatment**, to arrange **payment** for our services, and for some other business activities that are called, in the law, **health care operations.** After you have read this notice we will ask you to sign a **consent form** to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your health information without your consent

There are some times when the laws require us to use or share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
2. When we are required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For workers' compensation and similar benefit programs.

There are some other rare situations. They are described in the longer version of our notice of privacy practices.

Your rights regarding your health information

1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.
2. You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.
3. You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you for it. Contact your provider to arrange how to see your records. See below.
4. If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to your provider. You must also tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this notice, we will post the new version in our waiting area, and you can always get a copy of it from your provider.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our privacy officer and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way. Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise.

If you have any questions regarding this notice or our health information privacy policies, please contact your counselor, Katherine Roth, LCSW, who can be reached by phone at (813) 658.8071 or by e-mail at Kathy@AnEmpoweredLife.org