INTAKE FORM – DATA SHEET
FAMILY LIFE RESOURCE CENTER
273 Newman Avenue
Harrisonburg VA 22801

Name:	*Date:*
Address: *e-mail address:* _____ *Referral Source:*	*Home Phone:* *Cell Phone:* *Work Phone:* *In case of an emergency, call:* *Name:* *Phone:*

Messages may be left at: ☐ *home phone* ☐ *cell phone* ☐ *work phone* ☐ *emergency contact* ☐ *email*

Birthdate:	*Age:*	*Social Security #:*	*Employer:*

Marital Status:
☐ *Single* ☐ *Married/____ Yrs* ☐ *Separated* ☐ *Divorced* ☐
*Other:*_____

Spouse's Name:	*Birthdate:*
Employer:	

Other people living in your home:

Last Name	*First Name*	*Age*	*Relationship*

Have you ever been in outpatient counseling before? _____ *Yes* _____ *No*
Length of time: _____ *Inpatient hospitalization* _____ *Yes* _____ *No*

With whom/Location: *How Long Ago?*
1.
2.

Current Medications/Dosage:

List any Allergies:

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Primary Care Physician's Name:

Phone:

Do we have your permission to advise your physician that you are receiving care?
(if information is needed from your physician we will ask for completion of a different release)
_____ *Yes* _____ *No*

You may grant consent by signing here: _____
Client signature

Addictions:
If you have struggled with chemical dependencies (past or present) please complete:

1. *Type of dependency:* _____
2. *Quantity & frequency of use:* _____
3. *How ingested and date of last use:* _____
4. *Length of use/period of sobriety:* _____
5. *History of withdrawal symptoms in periods of abstinence:* _____

_____

Briefly describe the family in which you grew up: (family members ages, living or deceased, how you were raised, etc.)

Religious Affiliation (active or inactive):

Education/Special Training:

Reason you are seeking counseling at this time& what outcome you would hope for:

Current Symptoms

Name: _____ **SS#:** _____ **Date:** _____

Rank each below with corresponding number or leave blank

Blank = Seldom/Never 1= Moderate *(this sometimes occurs for me)* **2= Significant** *(this occurs often enough that it seems relevant)* **3= Severe** *(this occurs often)*

My Mood

_____ **Depressed mood**
_____ **Feel little emotion**
_____ **Feel sad**
_____ **Feel hopeless about the future**
_____ **Easily agitated**
_____ **Cry easily**
_____ **Feel hopeless**
_____ **Feel guilty**
_____ **Feel useless/worthless**
_____ **Feel helpless**
_____ **Feel angry/resentful**
_____ **Feel anxious/fearful**
_____ **Drastic mood changes**
_____ **Elated mood**

My Thoughts

_____ **Interrupted thoughts**
_____ **Feel inferior to others**
_____ **Difficulty concentrating**
_____ **Negative outlook**
_____ **Racing thoughts**
_____ **Thoughts go off on tangents**
_____ **See or hear things that aren't real**
_____ **Hold strange beliefs others don't share**
_____ **Grandiose thoughts**
_____ **Lose touch with things around me**
_____ **Ruminating past hurts/difficulties**
_____ **Persistent/obssessive thoughts**
_____ **Repetitive/compulsive behaviors**
_____ **Exaggerated mistrust**
_____ **Thoughts of death**
_____ **Inattentive**
_____ **Easily distracted**
_____ **Loss of bearings/disoriented**
_____ **Difficulty adjusting to loss**

My Physical Wellbeing

_____ **Low energy/tired**
_____ **Oversleep or sleeplessness**
_____ **Change in appetite/ or eating**
_____ **overeating: weight gain**
_____ **undereating: weight loss**
_____ **Sexual difficulties/lack of desire**
_____ **Anxiety/panic attacks**
_____ **Restless/fidgety**
_____ **Addictions:**_____
_____ **Headaches**
_____ **Chest discomfort/tightening**
_____ **Difficulty breathing**
_____ **Abdominal pain/nausea/diarrhea**
_____ **Shakiness/muscle tremors**
_____ **Feel tightness in muscles/body**

My Behaviors

_____ **Isolate myself from others**
_____ **Impulsive**
_____ **Engage in risky sexual behavior**
_____ **Want to hurt myself/end my life**
_____ **Injure or cut myself**
_____ **Excessive/hyperactive**
_____ **Uneasy, distressed**
_____ **Create disruption/Uncooperative**
_____ **Make poor choices**
_____ **Immature**
_____ **Overly dependent on others**
_____ **Dramatic/emotional**
_____ **Noncompliant**
_____ **Hostile/Aggressive**
_____ **Anger outbursts**
_____ **Underactive**
_____ **Poor self care**

_____ **Other:**_____

Family Life Resource Center

CLIENT-CLINICIAN SERVICE AGREEMENT & INFORMED CONSENT

Thank you for choosing Family Life Resource Center (FLRC) as your mental health provider. This document contains important information about FLRC's professional services and business policies. We would like to call your attention to the information below which includes summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. It is important that you understand these documents so please do not hesitate to ask questions. When you sign this document, it will also represent an agreement between us.

PSYCHOLOGICAL 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 psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should know. Your clinician has corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for many individuals who undertake it. Therapy can lead to a reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress, and resolutions to specific problems. But there are no guarantees about what will happen. Psychotherapy 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.

The first 2-3 sessions will involve a comprehensive evaluation of your needs. At the end of the evaluation, you and your clinician will discuss and create an initial treatment plan that will include goals. You should evaluate and make your own assessment about whether you feel comfortable working with your clinician. If you have questions about the clinician's or organization's procedures, you should discuss such things with the clinician or Director as soon as possible. If your doubts persist, the clinician will be happy to help you set up a meeting with another mental health professional for a second opinion.

APPOINTMENTS

Appointments will ordinarily be 45-50 minutes in length (after the first session which is 60 minutes), once per week at a time we agree on, although some 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, your clinician asks that you provide him/her with 24 hours notice. **It is important for you to understand that you will be charged $50 for all scheduled appointments that you fail to keep unless you give a 24 hour cancellation notice (or you and your clinician both agree that**

you were unable to attend due to circumstances beyond your control). Please be aware that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the portion of the fee discussed above. If it is possible, your clinician will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time. If you are late, your appointment will still need to end on time.

PROFESSIONAL FEES

Our fees for the initial evaluation and 45-50 minutes sessions thereafter differ depending on the counselor/doctor you see. You may be responsible for the full fee at the time of your appointment, if we do not bill insurance which can occur if your clinician does not determine that a mental health diagnosis is warranted or if the type of therapy (i.e., marital therapy) is not covered by your health insurance provider. If insurance is billed you will need to pay your co-payment or pay toward the deductible, if it has not been met. If you do not use insurance, you may ask the office manager about the alternatives. **Our fees are the same for all clients.**

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans such as HMOs and PPOs often require advance authorization, without which they may refuse to provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy, after a certain number of sessions. While a lot can be accomplished in short-term therapy, some clients feel they need more services after insurance benefits end. Some managed-care plans will not allow a clinician to provide services to you once your benefits end. If this is the case, we will do our best to find another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require you to authorize a clinician to provide them with a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems). Sometimes your clinician has to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank.

If you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. Many policies leave a percentage of the fee (which is called the co-insurance) or a flat dollar amount (referred to as a co-payment) to be covered by the client. In addition, some insurance companies also have a deductible, which is an out-of-the-pocket amount, that must be paid by the client before the insurance companies are willing to begin paying any amount for services. This will typically mean that you will be responsible to pay for initial sessions at FLRC until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year. Once we have all of the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits that are available and what will happen if coverage ends before you feel ready to end your sessions. It is important to remember that you always have the right to pay for FLRC services yourself to avoid problems described above, unless prohibited by a provider contract. If a provider does not participate in your insurance plan, FLRC can supply you with a

receipt of payment for services that you can submit to your insurance for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers.

By signing this Agreement, you agree that FLRC can provide requested information to your insurance carrier if you plan to pay with insurance.

We request that you handle any payments with the office manager at the beginning of each session. If the office manager is not in, please leave your payment with your clinician. **We expect your payment at the time of each appointment.**

In addition to weekly appointments, it is our practice to charge this amount on a prorated basis (the hourly cost will be broken down) for other professional services that you may require such as telephone conversations beyond 10 minutes, report writing , attendance to meetings or other services that are being requested of your clinician since these things cannot be billed to insurance companies.

FEE COMMITMENT

1. Remember that insurance was designed to defray the cost of treatment, not cover those costs completely. So while we accept payment from your insurance company, **you are ultimately responsible to see that the total amount of each visit is paid.**

2. In recognition of the service provided through Family Life Resource Center, I understand that I am responsible for $_____ per visit.

3. I understand that if conditions of employment, health, or other factors should warrant, I need to contact FLRC to work out a payment plan or necessary arrangements.

4. I understand that my insurance company will not pay for "no show" fees and I am responsible for payment.

5. I further agree to pay in full for services not covered by my insurance and for my portion of covered services, including any legal or other costs incurred in the collection of this amount, if it becomes delinquent.

6. Please <u>initial</u> one of the following regarding your choice of billing:

_____A. I authorize FLRC to submit my insurance claim for the service provided and I hereby assign all insurance payments directly to FLRC. I authorize FLRC to release my information necessary to process this claim. I understand that my insurance claim may be filed electronically by computer modem and I hereby release FLRC from any unintended use thereof by such person.

_____B. I choose to personally pay for my counseling sessions and choose to file my own claim with my insurance company. I understand that FLRC will provide me with a current statement of my account and I accept full responsibility to negotiate any reimbursement with my insurance company.

PROFESSIONAL RECORDS

Your clinician is required to keep appropriate records of psychological services that he/she provides. Your records are maintained in a secure location in the office. Your clinician keeps records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis (if there is one), topics we discussed, your medical, social, and treatment history, records received from other providers, copies of records sent to others (with your permission) and your billing records. FLRC does use electronic/telephone communications including but not limited to email, fax machines, wireless, cell and digital phones, pagers, and computers. FLRC will do the very best to ensure security/privacy of your communication and records. If you do not wish FLRC to use a specific type of communication device, talk to your clinician directly.

Client records are the property of FLRC, but you may request a copy of these in writing. Access to these records will be given according to Virginia State guidelines consistent with your condition and sound therapeutic treatment. Because these are professional records, they may be misinterpreted and or upsetting to untrained readers. For this reason, we recommend that you initially review them with your clinician, or have them forwarded to another mental health professional to discuss the contents.

CONFIDENTIALITY

Our policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during your time at FLRC.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is our policy not to provide treatment to a child under age 13 unless s/he agrees that the clinician can share whatever information he/she considers necessary with a parent. For children 14 or older, we request an agreement between the client and the parents allowing the clinician to share general information about treatment progress and attendance. All other communication will require the child's agreement, unless the clinician feels there is a safety concern, in which case the clinician will make every effort to notify the child of the intention to disclose information ahead of time and make every effort to handle any objections that are raised.

CONTACTING YOUR CLINICIAN & EMERGENCY SERVICES

Your clinician is often NOT immediately available by telephone. Typically, clinicians do not answer the phone when they are meeting with clients or otherwise unavailable. If you need to leave a message, you may do so by asking the office assistant to transfer you to the clinician's confidential voicemail. FLRC does have an answering service which answers calls after 4:30PM Monday through Thursday and all day Friday and on weekends. The answering service staff will try to contact your clinician or another FLRC clinician who may be covering for your therapist.

If you are ever suicidal or homicidal, you may call (540)434-8450 and the office assistant or the answering service will try to contact your clinician. If, for any reason, a therapist cannot be contacted immediately, go to your local emergency room or call 911 so you can be evaluated.

OTHER RIGHTS

If you are unhappy with what is happening in therapy, we want you to talk with your clinician so your concerns can be handled. Such comments will be taken seriously and handled with care and respect. You may also request that your clinician refer you to another therapist and you are free to end therapy at any time. 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 your clinician's specific training and experience.

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this agreement which includes the Notice of Privacy Practices and Confidentiality and agree to their terms.

Signature of Client or Personal Representative Date

Printed Name of Client or Personal Representative Date

Family Life Resource Center

Notice of Privacy Practices

This notice of Privacy Practices describes how information about you, the client, may be used and disclosed and how you can access this information. PLEASE REVIEW THIS INFORMATION CAREFULLY.

We understand that information about you is personal. We are committed to protecting your information. We create a record of care and services you receive at this office. We need this record to provide you with quality care and to comply with legal requirements. This notice tells you about the ways in which we use and disclose your records. We also describe your rights and the obligations we have regarding the use and disclosure of records.

Uses and Disclosures of Information:

We use information about you for treatment, to obtain payment for treatment, and for the purposes of ensuring the quality of care you receive. We may contact you about appointments, treatment alternatives or other benefits that may be of interest to you. We will contact you according to permission granted on the intake form. **We will provide information when required by law, such as for law enforcement in specific circumstances. *Confidentiality will be waived if there is concern of harm to yourself or to others and in child abuse or elder abuse situations.*** In all other situations, we will ask for you written authorization to disclose information. You can later revoke that authorization to stop any future uses and disclosures.

For the purpose of ensuring quality services, our staff is involved in ongoing training and supervision. As deemed necessary by your clinician, cases and review of case notes may be discussed confidentially in consultation with other staff members. If your clinician needs to consult other professionals in our community, a release of information is available for you to sign.

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice of Privacy Practices and post the new notice in the waiting area. You can also request a copy at any time. For more information, contact the office manager or your counselor. Please remember that you may reopen the conversation about these issues at any time during our work together.

Individual Rights

In most cases, you have the right to look at or get a copy of the information about you that we use to make decisions about you. If you request copies, we will charge you $0.50 for each page up to 50 pages and $.25 thereafter (fees charged are pursuant with Virginia State guidelines). You also have the right to receive a list of instances where we have disclosed information about your for reasons of treatment, payment, or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we not use or disclose your information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The office manager can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices described in this notice. If you have any questions or complaints, please contact: Family Life Resource Center office manager, Marie Bradley.

Family Life Resource Center

Acknowledgement of Receipt of **Notice of Privacy Practices**

By signing this form, you acknowledge that Family Life Resource Center has given you a copy of it Notice of Privacy Practices. This notice explains how your counseling information will be handled. HIPAA, the new Federal law concerning medical privacy, requires this notice.

I have received a copy of the Notice of Privacy Practices. FLRC has given me this opportunity to ask any questions about this notice and all my questions have been answered.

_____

Client's Signature or Guardian

_____

Date Signed

Provider Use Only

If client was not able to sign due to an emergency or did not want to sign, please document if client was given the notice and the reason why the client did not sign below.

Client was given the notice _____Yes _____No

Reason signature was not obtained:

_____

_____

_____

_____

Signature of Staff Date