COUPLES INTAKE PACKET
FAMILY LIFE RESOURCE CENTER
273 Newman Avenue
Harrisonburg VA 22801

Please both people complete this form individually, to the best of your ability. It will help your therapist and the therapy process to be as detailed as possible, and it's okay to be brief if any section feels overwhelming or too uncomfortable to write about.

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

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

Birthdate:	***Age:***	***Social Security #:***	***Employer:*** ***Full or Part time:***

Current Relationship Details: include length of time in the parentheses ( )

☐ ***Married (_____)*** ☐ ***Separated (_____)*** ☐ ***Cohabitating (_____)*** ☐ ***Dating (_____)*** ☐

☐ ***Other:_____***

Previous Relationships: if you've had previous relationship experiences & indicate how many times & length of time ☐

☐ ***Married (_____)*** ☐ ***Cohabitating (_____)*** ☐ ***Dating (_____)*** ☐

☐ ***Other _____***

Any other important details about significant relationships you've been in?

_____

_____

Partner's Name:	***Birthdate:***
Employer: ***Full or Part time:***	
Current Medications/Dosage: ***List any Allergies:***	

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Other people in your family or living in your home (please indicate if they're living in your home):

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

Have you ever had individual mental health services before? ☐ ***Yes*** ☐ ***No***

Which services? : Outpatient counseling ☐ ***Yes*** ☐ ***No*** ***Inpatient hospitalization*** ☐ ***Yes*** ☐ ***No***
Partial hospitalization program ☐ ***Yes*** ☐ ***No*** ***Residential/Crisis stabilization*** ☐ ***Yes*** ☐ ***No*** ***Other:*** _____

Previous Couples Counseling? ☐ ***Yes*** ☐ ***No***

Which counselor(s) and/or hospital(s) or service providers (Include Length of time):

_____

_____

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)
_____ ***No*** _____ ***Yes (Coordination of Care will be sent to your Physician)***

You may grant consent by signing here: _____
Client signature ***Date***

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Substance use:

How often do you drink caffeine and what kind of drink? _____
How often do you smoke cigarettes/vape (or use nicotine)? _____
How often do you drink alcohol and what kind? _____
Do you use any other recreational substances (cannabis, ecstasy, cocaine, pills, etc.)? ___No ___Yes, which ones and how often? _____
Any history of substance use treatment (date, provider, location, length of time, and outcome):

_____
Do you feel that substance use has ever been a problem for you OR has anyone ever expressed concerns about your use? ___Yes ___No Why or why not: _____
Other comments: _____

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

Religious Affiliation, Experience, and Spirituality:

Trauma History (to the extent you feel comfortable sharing right now):

Current Relationship Questionnaire:
Have there ever been any acts of aggression/violence in the relationship (physical restraint, striking, injury, intimidation, etc.)? ☐ ***Yes*** ☐ ***No***
If yes, who, how often, and what happened?

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Have there ever been threats of divorce (if married) or leaving the relationship? ☐ ***Yes*** ☐ ***No***
If yes, who, how often, and what happened?

Are there concerns regarding physical intimacy and the sexual relationship? ☐ ***Yes*** ☐ ***No***
If yes, please elaborate briefly:

Education/Special Training:

Describe the concerns you have in your relationship, how you understand the problem(s), and what you'd imagine to be an ideal relationship?

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Symptoms Questionnaire

Name: _____ **Date:** _____

Rank each below with corresponding number or leave blank if doesn't apply or never occurs

1 = Rarely *(this very rarely occurs for me)* **3 = Often** *(this frequently occurs for me)*

2 = Sometimes *(this occasionally occurs for me)*

My Emotion

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

My Mind

_____ **Interrupted thoughts**
_____ **Feel inferior to others**
_____ **Difficulty concentrating**
_____ **Negative outlook**
_____ **Racing thoughts**
_____ **Thoughts go off on tangents**
_____ **Easily distracted**
_____ **Difficulty adjusting to loss**
_____ **Dwelling on past hurts/difficulties**
_____ **Persistent/obsessive thoughts**
_____ **Repetitive/compulsive behaviors**
_____ **Difficulty trusting others**
_____ **Thoughts of death or dying**
_____ **Inattentive**
_____ **Loss of bearings/disoriented**
_____ **Lose touch with things around me**

_____ **Hold strange beliefs others don't share - please elaborate** _____

_____

_____ **See or hear things that others don't - please elaborate** _____

_____

My Body

_____ **Anxiety/panic attacks (circle one or both)**
_____ **Oversleep and/or sleeplessness (circle one or both)**
_____ **Chest discomfort/tightening**
_____ **Difficulty breathing**
_____ **Abdominal pain/nausea/diarrhea (circle which)**
_____ **Sexual difficulties/lack of desire (circle one or both)**
_____ **Low energy/tired**
_____ **Feel tightness in muscles/body**
_____ **Headaches**
_____ **Restless/fidgety**
_____ **Overeating: weight gain**
_____ **Undereating: weight loss**
_____ **Shakiness/muscle tremors**
_____ **Dislike my body/appearance**

_____ **Change in appetite/eating habits or any concerns about your relationship to food - please elaborate**

_____

_____

_____ **Addictions/Dependencies - please elaborate** _____

_____

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Symptoms Questionnaire

My Behaviors

_____ **Isolate myself from others**
_____ **Impulsive**
_____ **Depend on others for stability**
_____ **Hostile/Aggressive**
_____ **Angry outbursts**
_____ **Excessive energy/hyperactive**
_____ **Uneasy, distressed**
_____ **Wish I could change past actions**
_____ **Act in ways that others find immature**
_____ **Emotional reactions feel out of proportion**
_____ **Underactive/fatigue**
_____ **Challenges taking care of myself at times**
_____ **Create disruption/uncooperative**
_____ **Engage in risky sexual behavior**

_____ **Legal/court involvement (past or present) - please elaborate** _____

_____

_____

_____ **Self-harming behaviors (past or present) - please elaborate** _____

_____

_____ _____

Feeling suicidal/homocidal or thoughts of wanting to end my life or others, at times (past or present) - please elaborate

_____

_____

_____

Strengths and positive aspects of your life:

_____

_____

_____

_____

Anything else that feels important to have your counselor be aware of:

_____

_____

_____

_____

INDIVIDUAL ADULT INTAKE PACKET
LIFE RESOURCE CENTER
273 Newman Avenue
Harrisonburg VA 22801

NOTICE OF PRIVACY PRACTICES

PLEASE REVIEW THIS INFORMATION CAREFULLY.

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

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 with law enforcement in specific circumstances. Confidentiality will be waived if there is concern of harm to yourself or to others, such as abuse of a child, elder, or individual with special needs. 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 FLRC 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 FLRC Director 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 $0.25 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 you 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 FLRC Executive Director, Jonathan

Sutton. You also may send a written complaint to the U.S. Department of Health and Human Services. The office staff 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 Executive Director, Jonathan Sutton.

Family Life Resource Center - Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge that the Family Life Resource Center has given you a copy of its Notice of Privacy Practices. This notice explains how your counseling information will be handled, HIPAA, the 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 or Guardian Signature _____

Date Signed _____

Provider Use Only

If the client was not able to sign due to an emergency/health issue or refused signature, please document if the 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 (If Applicable): _____

_____

_____

FLRC Staff Signature _____

Date Signed _____

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, business policies, and summary information regarding the Health Insurance Portability and Accountability Act (HIPAA). When you sign this document, it represents a formal 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 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 know. Your clinician has corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Therapy 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 therapy often requires discussing unpleasant aspects of your life. However, therapy 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. Therapy requires a very active effort on your part. In order to be most successful, you will have to work on things you and your clinician have discussed outside of sessions.

The first 1-2 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 the FLRC 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 & CANCELLATIONS

Appointments will ordinarily be 45-50 minutes in length (after the first session which is 60 minutes), typically once per week, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. Please cancel your appointment with at least a 24 hours' notice: There is a waiting list to see the clinicians at Family Life Resource Center and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our clients or use the appointment for a client in crisis.

If less than a 24-hour cancellation notice is given, this will be documented as a "Late Cancel" appointment. In addition, you are responsible for arriving on time to your session. If you are late, your appointment will still need to end on time. If you are more than 15 minutes late, you still may be charged as a late cancel. If you do not present to the office for your appointment, this will be

documented as a "No-Show" appointment. After the "No-Show/Late Cancel" appointment, you will be charged a $50.00 fee per missed appointment if contractually applicable. Please be aware that insurance companies do not provide reimbursement for late cancel/No show sessions so you will be financially responsible for this fee. If you have three (3) "No-Show/Late Cancel" appointments within a one-year time, counseling services will be suspended for a minimum of six (6) months. If this occurs, the agency can provide you with a list of referrals from other mental health specialists in the community.

PROFESSIONAL FEES & INSURANCE

Our fees for the initial evaluation and 45-50 minutes sessions thereafter differ depending on the counselor 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., couples 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 staff about possible alternatives. Our fees are the same for all clients. Please note the clinicians are ONLY paid once fees are collected for the services rendered.

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 therapy.

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, in rare cases, copies of the entire record. This information will become part of the insurance company files and will likely be stored digitally. Though all insurance companies are held to similar standards regarding keeping this information confidential, your clinician has 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 database.

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 staff at the beginning of each session. If the office staff is not in, please leave your payment with your clinician. We expect your payment at the time of each appointment. In addition to scheduled 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. Court appearances and legal issues are billed at the rate of $100 per hour and are payable in advance.

FEE COMMITMENT

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.

In recognition of the service provided through Family Life Resource Center, I understand that I am responsible for the cost of services rendered.

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.

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

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.

Please initial 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 and I accept the possible risks involved with electronic transmission.

___B. I choose to personally pay for my counseling services. I understand that FLRC will not bill insurance for my services nor will they bill retroactively for services rendered. I acknowledge I have been

given the opportunity to use my insurance for covered services and have declined.

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 and/or in a secure electronic health record. Your clinician keeps records noting the date you were here, your reasons for seeking therapy, the goals and progress set for treatment, your diagnosis (if there is one), topics 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 may use electronic/telephone communications including but not limited to email, fax machines, phones, 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 given the opportunity to discuss any issues. Please remember that you may reopen the conversation at any time during your time at FLRC.

SOCIAL MEDIA POLICY

It is policy for FLRC staff to <u>not</u> accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, Instagram, etc.). We believe that adding clients as friends or contacts on these sites can compromise confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. FLRC does have a public Facebook page that is operated by the Executive Director and used for communication, marketing, and networking purposes. If you choose to connect with our public Facebook page, please know that you're accepting any risks involved regarding confidentiality and this page will not be used for individual communication purposes. If you have any questions or concerns about anything in this social media policy, please bring them up to your clinician to discuss further.

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 she/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

FLRC is an outpatient counseling practice and your clinician is often NOT immediately available by telephone. Typically, clinicians do not answer the phone or email when they are meeting with clients or otherwise unavailable outside of business hours. If you need to leave a message via phone, you may do so by asking the office staff to transfer you to the clinician's confidential voicemail. Staff will do their best to respond to voicemails in a timely manner. If for any reason you're in crisis and a clinician cannot be contacted immediately during business hours, or if the office is closed, please go to your local emergency room or call 911 or 988 to receive care.

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. If for any reason you do not feel comfortable addressing your concerns with your clinician directly, you're always welcome to discuss any concerns with FLRC's Executive Director, Jonathan Sutton.

CONSENT TO THERAPY

Your signature below indicates that you have read this agreement which includes the Notice of Privacy Practices, Client-Clinician Service Agreement/Informed Consent and the Social Media Policy and agree to the terms.

Client or Guardian Signature _____

Date Signed _____