Positive Alternatives Counseling

Intake Form- Adult

PLEASE PRINT CLEARLY Today's Date _____

PERSONAL INFORMATION

PATIENT (S) _____ **RESPONSIBLE PARTY** _____

Date of Birth _____ Gender _____ Responsible Party's SSN _____

Address _____ Address (if different) _____

_____ _____

City, State _____ Zip _____ City, State _____ Zip _____

Home Phone _____ Home Phone (if different) _____

Work Phone _____ Work Phone (if different) _____

Cell Phone _____ Cell Phone (if different) _____

Email Address _____

Please indicate with an * which phone numbers we may NOT leave a message.

Patients' relationship to Responsible Party (check one): Self_____Spouse_____ Child_____ Other _____

Relative or friend in case of emergency _____

Name Phone # Relationship

Source of referral _____ Reason for referral _____

How did you hear about Positive Alternatives Counseling?_____

Religious and racial/ethnic identification

Current religious denomination/affiliation ❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic ❑ Buddhist ❑ Hindu
Other (specify):_____

Involvement: ❑ None ❑ Some/irregular ❑ Active
How important are spiritual concerns in your life? _____
Which (if any) church, synagogue, temple, or meeting are you involved with? _____

Your current employer

Employer: _____ Address: _____

Work phone: _____ or other means of communication _____

Calls will be discreet, but please indicate any restrictions: _____

Marital/ relationship History

Spouse's name:_____ Years together: _____ Years Married _____
Spouse's age at marriage_____ Your age at marriage _____

Positive Alternatives Counseling

FINANCIAL

Primary Health Insurance: _____ Subscriber Name: _____

Relationship to Subscriber: _____ Subscriber Date of Birth: _____

ID number: _____ Group/Policy #: _____

Additional Health Insurance: _____ Subscriber Name: _____

Relationship to Subscriber: _____ Subscriber Date of Birth: _____

ID number: _____ Group/Policy #: _____

Type of Additional Coverage: Secondary EAP (Employee Assistance Program)

Structure and Costs of Sessions:

Your therapist agrees to provide counseling/treatment under the terms by the covered insurance, in which you have not met any deductibles and may be subject to pay the co-pay or co-insurance unless otherwise negotiated by you or your insurance carrier. If you are not covered by insurance, then you are considered self-pay and subject to the therapist's costs of $150.00 for individual intake/ $200.00 for couples counseling intake and $125.00 for individual/couples therapy for mental health which can be paid on a sliding scale and the patients can pay the amounts until the patient's next appointment. Doing counseling by telephone is not ideal, and needing to talk to your therapist between sessions may indicate that you need extra support. If this is the case, you and your therapist will need to explore adding sessions or developing other resources you have available to you. Telephone calls that exceed 10 minutes in duration will be billed at $2.00 per minute. The fee for each session is due at the beginning of each session. Cash, personal checks, Visa, MasterCard, Discover and American Express are all acceptable forms of payment, and we will provide you with a receipt.

Records:

Please note that any time our office is asked to fill out forms or medical records are requested there will be a charge $20.00 for forms and $.75 per page for the first 20 pages of records and $.65 for pages 21-100. There is a fee of $75.00 for court prepared documents. Any documents requiring a notary stamp will be a $7.50 charge in addition to any fees. If the therapist is requested by the client to appear in court the charges are as follows; $50 per hour for stand-by, and a fee of $150.00 per hour for time at the courthouse.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

Therapist Use Only
Therapist Name _____
Special Instructions _____
_____
_____

Billing
☐ Client Self Pay
☐ Client Self Pay
☐ EAP – Bill EAP Company _____
# of Approved Visits _____

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FAMILY INFORMATION

NAME	M/F	AGE	DATE OF BIRTH	RELATIONSHIP TO PATIENT &/or MARITAL STATUS	EDUCATION	OCCUPATION
Patient (s)						
1.						
2.						
Parent (s)						
1.						
2.						
Children/Step Children/Siblings						
1.						
2.						
3.						
4.						
5.						
6.						
Others Living in Household						
1.						
2.						
3.						
4.						
5.						
6.						

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MEDICAL INFORMATION

1. **Patient Name** _____

Have you ever been treated for emotional difficulties before (When and where?) _____

_____

Physician: Name/Practice _____ Address_____ Phone _____

Date of last physical exam _____ Height _____ Weight _____

How is your general health now? _____ Medications? _____

Are you presently being treated by a physician for any physical condition? _____

Have you had any serious illness? (List) _____

Have you ever had any surgery? (List) _____

2. **Patient Name** _____

Have you ever been treated for emotional difficulties before (When and where?) _____

_____

Physician: Name/Practice _____ Address_____ Phone _____

Date of last physical exam _____ Height _____ Weight _____

How is your general health now? _____ Medications? _____

Are you presently being treated by a physician for any physical condition? _____

Have you had any serious illness? (List) _____

Have you ever had any surgery? (List) _____

***If more than two patients, please indicate above medical information on separate sheet for other patients.**

Current Medications and who prescribed them:

Medication: _____ Dose: _____ Doctor: _____

Medication: _____ Dose: _____ Doctor: _____

Medication: _____ Dose: _____ Doctor: _____

Medication: _____ Dose: _____ Doctor: _____

Medication: _____ Dose: _____ Doctor: _____

Medication: _____ Dose: _____ Doctor: _____

Medication: _____ Dose: _____ Doctor: _____

Medication: _____ Dose: _____ Doctor: _____

Medication: _____ Dose: _____ Doctor: _____

Medication: _____ Dose: _____ Doctor: _____

Positive Alternatives Counseling

Privacy Practices Form

Acknowledgement of Receipt of Notice of Privacy Practices

In accordance with New federal laws (HIPAA, Health Information Portability and Accountability Act) regarding privacy of your medical file, we must ask that you read and sign acknowledgement that we provided you with our privacy practices. I have received a copy of the Notice of Privacy Practices for **POSITIVE ALTERNATIVES COUNSELING.**

Consent for Purpose of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by **POSITIVE ALTERNATIVES COUNSELING** for the purpose of diagnosis or treatment of me by **Candace M. Reed** may be conditioned upon my consent, as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **POSITIVE ALTERNATIVES COUNSELING** is not required to agree to the restrictions that I may request. However, if **POSITIVE ALTERNATIVES COUNSELING** agrees to a restriction that I request, the restriction is binding **on POSITIVE ALTERNATIVES COUNSELING** and **POSITIVE ALTERNATIVES COUNSELING** treating doctor/clinician.

I have the right to revoke this consent, in writing, at any time, except to the extent tha**t POSITIVE ALTERNATIVES COUNSELING** treating doctor/clinician or **POSITIVE ALTERNATIVES COUNSELING** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. **POSITIVE ALTERNATIVES COUNSELING** policy of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations **of POSITIVE ALTERNATIVES COUNSELING**. The Notice of Privacy Practices for **POSITIVE ALTERNATIVES COUNSELING** is also provided/posted in the waiting area. Then Notice Privacy Practices also describes my rights and **the POSITIVE ALTERNATIVES COUNSELING** duties with respect to my protected health information. **POSITIVE ALTERNATIVES COUNSELING** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Authorization Form

I authorize my physician and/or administrative and clinical staff to use my protected health information to for the purpose of evaluating health, diagnosing medical/mental health conditions, providing treatment, and securing payment for the same. This authorization shall be in force in perpetuity or as long as any open balances remain in effect.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact, Candace Reed, at **POSITIVE ALTERNATIVES COUNSELING**. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. The use or disclosure requested under this authorization will result in direct or indirect remuneration to my clinician/physician from a third party.

If more than one adult patient, each person should check and initial boxes.

☐ Yes ☐ No I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions.

☐ Yes ☐ No I have received a copy of the Privacy Practices Form.

☐ Yes ☐ No I consent to the exchange of treatment information between PAC and my primary care physician.

Patient(s):

Physician's Name/Office and Phone Number _____

Signed: _____ Date: _____

Signed: _____ Date: _____

Positive Alternatives Counseling

Notice of Privacy Practices

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 our privacy officer (see the end of this form) 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 our privacy officer 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 our privacy officer. 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 the privacy officer.
6. You 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 our privacy officer, Candace Reed and can be reached by phone at (912) 384-4357.

The effective date of this notice is January 1, 2016

CLIENT COPY – KEEP THIS FORM FOR YOUR RECORDS

Positive Alternatives Counseling

Consent to Use and Disclose Your Health Information

This form is an agreement between you, and me/us, When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here: .

When we examine, test, diagnose, treat, or refer you, we will be collecting 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, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy from our website, www.positivealternativescounseling.com, or by calling us at, (912) 384-4357.

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 our privacy officer. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

_____ _____ _____

Printed name of client or representative **Signature of client/representative** **Date**

_____ _____

Description of personal representative's authority **Relationship to the client**

_____ _____

Signature of authorized representative of this office or practice **Clients name** (if signed by a parent or personal representative)

Date of NPP: _____ ❑ Copy given to the client/parent/personal representative

Positive Alternatives Counseling

Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the "Information for Clients" brochure and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in individual/group/family/marriage counseling with Candace M. Reed, LPC. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by Candace M. Reed or anyone else at Positive Alternatives Counseling.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel and do not show up, I will be charged $25 for the first missed appointment, $50 for the second missed and each additional appointment and not further appointments will be made until this balance is paid in full. I also understand that I may be discharged as a patient. *I understand that my Insurance will NOT cover these charges and I am fully responsible.*
____INT

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, and payment arrangements cannot be agreed upon, Candace M. Reed may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

Positive Alternatives Counseling has discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of authorized representative of this office Date

Positive Alternatives Counseling

Adult Checklist of Concerns

Name: _____ Date: _____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

❑ I have no problem/concern bringing me here (if you are here because someone else thinks there's a problem but you don't)

❑ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals

❑ Aggression, violence

❑ Alcohol use

❑ Anger, hostility, arguing, irritability

❑ Anxiety, nervousness

❑ Attention, concentration, distractibility

❑ Career concerns, goals, and choices

❑ Childhood issues (your own childhood)

❑ Codependence

❑ Confusion

❑ Compulsions

❑ Custody of children

❑ Decision making, indecision, mixed feelings, putting off decisions

❑ Delusions (false ideas)

❑ Dependence

❑ Depression, low mood, sadness, crying

❑ Divorce, separation

❑ Drug use—prescription medications, over-the-counter medications, street drugs

❑ Eating problems—overeating, under eating, appetite, vomiting (see also "Weight and diet issues")

❑ Emptiness

❑ Failure

❑ Fatigue, tiredness, low energy

❑ Fears, phobias

❑ Financial or money troubles, debt, impulsive spending, low income

❑ Friendships

❑ Gambling

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❑ Grieving, mourning, deaths, losses, divorce

❑ Guilt

❑ Headaches, other kinds of pains

❑ Health, illness, medical concerns, physical problems

❑ Housework/chores—quality, schedules, sharing duties

❑ Inferiority feelings

❑ Interpersonal conflicts

❑ Impulsiveness, loss of control, outbursts

❑ Irresponsibility

❑ Judgment problems, risk taking

❑ Legal matters, charges, suits

❑ Loneliness

❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments

❑ Memory problems

❑ Menstrual problems, PMS, menopause

❑ Mood swings

❑ Motivation, laziness

❑ Nervousness, tension

❑ Obsessions, compulsions (thoughts or actions that repeat themselves)

❑ Oversensitivity to rejection

❑ Pain, chronic

❑ Panic or anxiety attacks

❑ Parenting, child management, single parenthood

❑ Perfectionism

❑ Pessimism

❑ Procrastination, work inhibitions, laziness

❑ Relationship problems (with friends, with relatives, or at work)

❑ School problems (see also “Career concerns ...”)

❑ Self-centeredness

❑ Self-esteem

❑ Self-neglect, poor self-care

❑ Sexual issues, dysfunctions, conflicts, desire differences, other (see also “Abuse”)

Positive Alternatives Counseling

❑ Shyness, oversensitivity to criticism

❑ Sleep problems—too much, too little, insomnia, nightmares

❑ Smoking and tobacco use

❑ Spiritual, religious, moral, ethical issues

❑ Stress, relaxation, stress management, stress disorders, tension

❑ Suspiciousness, distrust

❑ Suicidal thoughts

❑ Temper problems, self-control, low frustration tolerance

❑ Thought disorganization and confusion

❑ Threats, violence

❑ Weight and diet issues

❑ Withdrawal, isolating

❑ Work problems, employment, workaholic/overworking, can't keep a job, dissatisfaction, ambition

❑ other concerns or issues:

_____

_____

_____

Please look back over the concerns you have checked off and **choose the one** that you most want help with.

It is: _____

Anything else that you feel that we should be aware of and/or you want to address during therapy?

_____

_____

_____

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.