CANANDAIGUA LAKE COUNSELING SERVICES

42 North Main Street, Canandaigua, NY 14424
(585) 919-0014

Welcome to Canandaigua Lake Counseling Services. We thank you for choosing our services, and hope to provide you with the best possible experience. We acknowledge that coming for counseling takes courage, and we hope to support you through your growing process, and provide you with the coping skills to help you lead a more fulfilling life.

We ask for your cooperation in filling out the following forms. All information provided on these documents is confidential, and will help your counselor assess your needs so he/she can provide you with services tailored to you.

You will be asked to read, understand, and fill out the following documents:

- Notice of Privacy Practices (HIPAA)
- Billing and Disclosure Agreement
- New Client Intake Information

These forms can be found on our website: www.canandaigualakecounselingservices.com under the “Forms” tab, or in our office.

If you have any questions concerning these documents, please contact our administrative assistant by calling (585) 919-0014, or emailing info@canandaigualakecounselingservices.com

Thank you,
Canandaigua Lake Counseling Staff

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BILLING AND DISCLOSURE AGREEMENT

It is understood that deductibles and co-payments are due when services are rendered unless other arrangements are made. It is understood that you, as the client, are responsible to make sure that your insurance will cover treatment, and you will be responsible for any costs not covered by your insurance. You also agree to have Canandaigua Lake Counseling Services submit a claim to your insurance company on your behalf.

24-Hour notice is required for appointment cancellations or changes. If you fail to provide 24-hour notice, you will be billed for your missed, cancelled, or changed session. Appropriate fees will be determined by your practitioner. You are responsible for paying fees for missed appointments or late cancellations. These charges cannot be billed to your insurance company. After 45 days we reserve the right to refer your account to a collection agency for recovery. In such event, you will be fully responsible for all collection and attorney fees.

Please feel free to review the Notice of Privacy Practices (HIPAA), which is posted under the "Forms" page on our website: www.canandaigualakecounselingservices.com and is available from our administrative assistant upon request.

Signing below indicates that you have read, understand and agree to the above billing and disclosure policies, and have been provided with an opportunity to read the Notice of Privacy Practices.
Your signature also indicates that in case of emergency, we may communicate limited information that is necessary for your care to your emergency contact person listed on the Intake Information Packet, as indicated by the Notice of Privacy Practices.

If you have questions regarding your personal information or billing procedures, please contact us at info@canandaigualakecounselingservices.com or by calling 585.919.0014.

Signature: ___________________________________ Date: ___________

Relationship to Client: __________________
(If other than client, or minor)

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PERSONAL INFORMATION   Date: _________

Name: _____________________________________ Date of Birth: ____________

Social Security: _____--_____--______

Parent's Names (if a minor): ____

Address: ____

Phone: Home: _____________________ Cell: _____________________

Email Address: ____

Employer/School: _____________________________

Address: ____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

MEDICAL INFORMATION

Name of Primary Care Doctor: ___________________________ Phone: ___________________

Address: ____

List ANY Medications you are currently taking: _______________________________________

____

____

PAYMENT INFORMATION

How will you be paying for your sessions? ☐ Self-Pay ☐ Insurance ☐ EAP

Insurance/EAP Provider: ___________________________

Policy Holder: ____________________________________

Policy Holder's SS#: ______________ DOB: ___________

Policy Number: ___________________________________

COUNSELING INFORMATION

Who referred you to Canandaigua Lake Counseling? ___________________________________

List Reasons for Seeking Counseling: ____

____

____

CONFIDENTIAL

PREVIOUS TREATMENT

Have you ever been to counseling before? ☐ Yes ☐ No

If yes, who did you see? ________________________________

Address: ____

Reason(s): ____

Have you ever been hospitalized for mental health reasons? ☐ Yes ☐ No

If yes, where? ____

Reason(s): ____

Have you ever been on medication(s) for mental health reasons? ☐ Yes ☐ No

If yes, what medications? ____

Reason(s)? ____

LEGAL HISTORY

Are you required by a court of law to receive counseling as part of a legal proceeding?

☐ Yes ☐ No If yes, please describe: ____________________________________

____

Have you ever been arrested? ☐ Yes ☐ No If yes, when? ________________________

Where? ____

Reason(s): ____

FAMILY HISTORY

Have any close relatives ever been hospitalized for mental health reasons? ☐ Yes ☐ No

Does anyone in your family have a mental health illness? ☐ Yes ☐ No

Has anyone in your family ever struggled with substance abuse? ☐ Yes ☐ No

Has anyone in your family ever attempted or completed suicide? ☐ Yes ☐ No

EMERGENCY CONTACT

Name: ______________________________________ Phone: ______________________________

Relation to Client: ____

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Date: ___________

Child's Name: _______________________________ Date of Birth: ____________

Your Name: _________________________________ Relation to Child: _______________

Inventory of Common Problems

Child Form – Please complete about your child if he/she is under 16 years of age.

The following is a set of common problems children and adolescents face. Please rate how much each of these problems has affected your child over the past two weeks. Please complete a separate inventory for each child that you would like to receive counseling.

Not at all	***A little bit***	***Moderately***	***Very Much***
0	1	2	3

To what degree is your child?

1. Defiant or oppositional ……..0 1 2 3
2. Throwing tantrums ………..0 1 2 3
3. Not following directions 0 1 2 3
4. Impulsive 0 1 2 3
5. Sad, depressed, blue 0 1 2 3
6. Anxious or worried 0 1 2 3
7. Having panic attacks 0 1 2 3
8. Refusing to go to school 0 1 2 3
9. Experiencing headaches 0 1 2 3
10. Experiencing stomach aches or nausea ……...……...........0 1 2 3
11. Having difficulty concentrating 0 1 2 3
12. Easily distracted 0 1 2 3
13. Frequently constipated 0 1 2 3
14. Soiling him/herself 0 1 2 3
15. Wetting the bed 0 1 2 3
16. Having seizures 0 1 2 3
17. Experiencing dizziness 0 1 2 3
18. Having Tics 0 1 2 3
19. Seeing things that aren't there 0 1 2 3

20. Hearing things that aren't there 0 1 2 3
21. Having difficulty separating from their caregivers …………...0 1 2 3
22. Not making eye contact ……………………………………….0 1 2 3
23. Unaware of other people ……………………………………...0 1 2 3
24. Agitated or grouchy ……………………………………......0 1 2 3
25. Having difficulty calming him/herself ……………………......0 1 2 3
26. Experiencing hearing problems …………………………......0 1 2 3
27. Experiencing vision problem ………………………………..0 1 2 3
28. Irritated by certain types of fabrics or labels on clothes ………0 1 2 3
29. Having difficulty getting along with their siblings …………....0 1 2 3
30. Having difficulty getting along with adults …………………....0 1 2 3
31. Stealing …………………………………………………….....0 1 2 3
32. Lying ………………………………………………………0 1 2 3
33. Wanting or trying to hurt him/herself …………………………..0 1 2 3
34. Wanting or trying to hurt others ………………………………..0 1 2 3
35. Making him/herself vomit ……………………………......0 1 2 3

Please review your above answers and determine which items you marked as moderately or very much a problem for your child (2s and 3s). For each of these numbered items, please list below the approximate date the problem began, and provide a short description.

#_____. Date: _________ Describe: ____
____

#_____. Date: _________ Describe: ____
____

#_____. Date: _________ Describe: ____
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#_____. Date: _________ Describe: ____
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#_____. Date: _________ Describe: ____
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#_____. Date: _________ Describe: ____
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#_____. Date: _________ Describe: ____
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#_____. Date: _________ Describe: ____
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