

# 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](http://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](mailto: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. If you have an outstanding balance due for more than 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.

**If you fail to appear for three visits, we reserve the right to discharge you from the practice for a time period not to exceed three months..**

Please feel free to review the Notice of Privacy Practices (HIPAA), which is posted under the "Forms" page on our website: [www.canandaigualakecounselingservices.com](http://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 well as your Primary Care Physician 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](mailto:info@canandaigualakecounselingservices.com) or by calling 585.919.0014.*

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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

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## CONFIDENTIAL

### PERSONAL INFORMATION

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security: \_\_\_\_ -- \_\_\_\_ -- \_\_\_\_

Parent's Names (if a minor): \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ ZIP \_\_\_\_\_

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: \_\_\_\_\_

\_\_\_\_\_

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## 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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## CONFIDENTIAL

Name: \_\_\_\_\_

Date: \_\_\_\_\_

### Inventory of Common Problems

Adult Form – Please complete if you are over 16 years of age

The following is a set of common problems people face. Please circle the rating of how much each of these problems has caused you distress, worry, or bother in the past two weeks.

<i>Not at all</i>	<i>A little bit</i>	<i>Moderately</i>	<i>Quite a bit</i>	<i>Very Much</i>
0	1	2	3	4

*To what degree are you?*

- |                                                                      |   |   |   |   |   |
|----------------------------------------------------------------------|---|---|---|---|---|
| 1. Feeling sad, depressed, dejected .....                            | 0 | 1 | 2 | 3 | 4 |
| 2. Feeling discouraged, or like a failure .....                      | 0 | 1 | 2 | 3 | 4 |
| 3. Feeling fearful.....                                              | 0 | 1 | 2 | 3 | 4 |
| 4. Having spells of terror or panic.....                             | 0 | 1 | 2 | 3 | 4 |
| 5. Feeling like you are “falling apart”.....                         | 0 | 1 | 2 | 3 | 4 |
| 6. Blaming, criticizing, or condemning yourself.....                 | 0 | 1 | 2 | 3 | 4 |
| 7. Experiencing extreme mental or emotional distress.....            | 0 | 1 | 2 | 3 | 4 |
| 8. Thinking about or feeling like hurting yourself.....              | 0 | 1 | 2 | 3 | 4 |
| 9. Thinking about or feeling like hurting someone else.....          | 0 | 1 | 2 | 3 | 4 |
| 10. Feeling isolated or lonely.....                                  | 0 | 1 | 2 | 3 | 4 |
| 11. Experiencing headaches, faintness, or dizziness.....             | 0 | 1 | 2 | 3 | 4 |
| 12. Facing problems with eating, appetite or weight.....             | 0 | 1 | 2 | 3 | 4 |
| 13. Facing problems related to your use of alcohol.....              | 0 | 1 | 2 | 3 | 4 |
| 14. Facing problems related to your use of other drugs.....          | 0 | 1 | 2 | 3 | 4 |
| 15. Having trouble falling asleep.....                               | 0 | 1 | 2 | 3 | 4 |
| 16. Having trouble staying asleep .....                              | 0 | 1 | 2 | 3 | 4 |
| 17. Experiencing problems with romantic or sexual relationships..... | 0 | 1 | 2 | 3 | 4 |
| 18. Experiencing family problems.....                                | 0 | 1 | 2 | 3 | 4 |

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- |                                                             |   |   |   |   |   |
|-------------------------------------------------------------|---|---|---|---|---|
| 19. Having problems getting along with others.....          | 0 | 1 | 2 | 3 | 4 |
| 20. Experiencing physical health problems .....             | 0 | 1 | 2 | 3 | 4 |
| 21. Having trouble concentrating.....                       | 0 | 1 | 2 | 3 | 4 |
| 22. Experiencing occupational distress.....                 | 0 | 1 | 2 | 3 | 4 |
| 23. Facing financial problems.....                          | 0 | 1 | 2 | 3 | 4 |
| 24. Feeling like you have to be perfect.....                | 0 | 1 | 2 | 3 | 4 |
| 25. Facing the death of a loved one.....                    | 0 | 1 | 2 | 3 | 4 |
| 26. Having trouble feeling motivated.....                   | 0 | 1 | 2 | 3 | 4 |
| 27. Having trouble being confident in yourself.....         | 0 | 1 | 2 | 3 | 4 |
| 28. Feeling angry, irritable, or hostile.....               | 0 | 1 | 2 | 3 | 4 |
| 29. Facing feelings surrounding rape or sexual assault..... | 0 | 1 | 2 | 3 | 4 |
| 30. Having difficulty managing time.....                    | 0 | 1 | 2 | 3 | 4 |

Name: \_\_\_\_\_

Date: \_\_\_\_\_