

Dena Crosby Counseling, LIMHP

Clinical Intake Form

Please Print Clearly. This sheet must be filled out completely. Couples seeking counseling must submit two forms, one per person.

First name _____ Last name _____

Sex: Male ___ Female ___ Age: _____ Date of Birth: _____

Address: _____ City: _____ State: ___ Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Is it okay to leave a message on Cell? (Y) ___ (N) ___ Home? (Y) ___ (N) ___ Work? (Y) ___ (N) ___

Is it okay to text you on this cell phone? (Y) ___ (N) ___

Email: _____ Okay to contact you via this email? (Y) ___ (N) ___

Emergency Contact: Name _____ Phone number _____

Legal Status: Single ___ Married ___ Separated ___ Divorced ___ Widow(er) ___ Minor ___ (Under 19 years)

Occupation: _____ Employer/School: _____

Education (highest level): _____ Graduation Year: _____

Current Living Situation: ___ Alone ___ With Spouse/Partner ___ With Parents ___ With Children ___ Other

Spouse/Partner/Guardian Name: _____ Phone _____

Address: _____ City: _____ State: ___ Zip: _____

Person responsible for payment _____ Birth date _____

Insurance Company Name _____

ID Number _____

Group Number if available _____

Address on the back of the insurance card for billing purposes _____

Name(s) of Children	Age	Sex	School/College/Employed	Living with you?
1.				(Y) ___ (N) ___
2.				(Y) ___ (N) ___
3.				(Y) ___ (N) ___
4.				
5.				(Y) ___ (N) ___
6.				(Y) ___ (N) ___

Counseling and Medical History

Are you in treatment with another counselor at this time? Yes _____ No _____ If yes, with whom _____

Have you (or spouse) ever received counseling in the past? Yes _____ No _____ If yes, when: _____ Where: _____

_____ What was the result: _____

Reasons for considering counseling at this time _____

Have you ever been hospitalized for any mental health reasons? Yes _____ No _____ If yes; when _____ Where _____

Please list any current addictions to behaviors or substance (porn sex, video gaming, internet, drugs, food, gambling, shopping, etc. _____

Are you currently under a physician's care for physical problems? Yes _____ No _____

Current Medications: _____

Name of physician _____ Phone _____

Are currently involved in the legal system? (Yes) _____ (No) _____

If Yes, Please give details: _____

What problems are you presently experience (please be specific)

What do you expect from therapy?

How did you hear about me? (Or from whom)?

Contact Agreement

Phone calls and emails will be responded to within 48 hours. I understand and agree _____ (initials)

Therapy Service Agreement

Rights and Risks: Please feel free to ask questions about any aspect of the counseling process. If you have been referred by a court or state agency you have the right to divulge only what you want to be included in a report. You need to be willing to discuss what troubles you and be open to change. As a result of counseling, you may remember unpleasant events, arouse intense emotions, and/or alter relationships.

Confidentiality: Confidential Information shared will be held in confidence in compliance with applicable state and federal law. "Confidential Information" includes any recordings or transcripts of therapy sessions, therapist notes, medical reports or therapy progress reports. Information will not be released without your written consent, except for professional consultation if needed or if disclosure is required by law. Your therapist is required by law to disclose information pertaining to suspected child abuse, or elder abuse, inability to care for one's basic needs for food, clothing or shelter, and threatened harm to oneself or others. Should your therapy be involved or be the subject of court proceedings or litigation, your counseling records may be subject to subpoena. It is understood that information regarding treatment and diagnosis may be provided to an insurance company. You may want to discuss further limits or exceptions of confidentiality.

Appointments: All office visits are by appointment with your therapist directly. The usual length of an appointment is 45 to 50 minutes. Late cancellation (Less than 24 hours before) and/or no-show appointments are billed to the client at a rate of

\$60 per missed session. IN the case of illness, please notify us no later than 9 am the day of the appointment. Please leave a message if you get the voice mail. If your appointment is cancelled or missed, contact your therapist for a new appointment time. Insurance companies will not pay for no-show charges or late cancellation charges or for telephone consultations.

I acknowledge that I received, read and understand the Therapy Service Agreement. By signing below I agree to the terms of the agreement:

Client/Guardian Signature: _____ Date: _____

Privacy Practices (HIPPA)

I may use or disclose PHI (protected health information) for purposes outside of treatment, payment, or health care operations with your authorization. In those instances when we are asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing this information. We also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes that some providers choose to make about conversations during a private, group, joint, or family counseling session, which are kept separate from the rest of your record. These notes include recordings and transcripts of any therapy sessions. These notes are given a greater degree of protection than PHI. You may revoke all such authorization (of PHIS or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have taken some action in reliance on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, as applicable state and federal law provides the insurer the right to contest the claim under the policy.

We may use your disclose PHI without your consent or authorization in the following circumstances:

Child Abuse – If we have reasonable cause to believe a child known to us in our professional capacity may be an abused child or a neglected child, we must report this belief to the appropriate authorities.

Adult and Domestic Abuse – If we have reason to believe that an individual protected by state law has been abuse, neglected, or financially exploited, we must report this belief to the appropriate authorities.

Worker's Compensation – We may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws retaining to worker's compensation or similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information by any party about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law, and we must not release such information without a court order. We can release the information directly to you on your request. Information about all other psychological services is also privileged and cannot be released without your authorization or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is pursuant to court order. You will be informed in advance if this is the case.

Serious Threat to Health or Safety – If you communicate to us a specific threats of imminent harm against another individual or if we believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, we may make disclosures that we believe are necessary to protect that individual from harm. If we believe that you present and imminent, serious risk of physical or mental injury or death to yourself, we may make disclosure we consider necessary to protect you from harm.

I have read and understand the above HIPPA guidelines.

Client/Guardian signature: _____ Date _____