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 ___________________

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

Reasons for considering counseling at this time :

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

If Yes, Please give details: ____

What do you expect from therapy?

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

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:
____
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 _____________________

What was the result:
____

Contact Agreement

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

Therapy Service and Financial 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. Your appointment is either 30 minutes or 45 minutes as per your contractual preference. 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.

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 that 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 _____________