Dr. Tracy's Counseling Services
Client Intake Form

Please fill in your personal information:

Name: _____Date: _____DOB_____
Social Security Number:_____
Street address:_____
City:_____ State:_____ Zip code:_____
Mailing address (if different):_____
City:_____ State:_____ Zip code:_____
Home phone:_____ Work phone:_____
Cell phone:_____ Email Address:_____
May I call you at home?_____ Work?_____
May I leave a message at home?_____ Work?_____
Are you currently employed?_____ What line of work?_____
Where are you currently employed?_____
Are you single?_____ married?____ widowed?____ separated?__ divorced?____
Name of spouse:_____ Date of marriage:_____
Spouse Date of Birth:_____ Spouse SS#:_____

Do you have children?_____Please list names and ages:

Medical Information:

Are you currently under a physician's care?_____
Name of physician:_____
Date of last physical examination:_____
Are you currently under psychiatric care?_____
Name of psychiatrist:_____
Have you ever had a formal psychological assessment?_____
Have you had any prior counseling?_____
Name of counselor?_____

Are you currently using any medications?_____
Please list all medications and for what it is prescribed for:

Have you ever been diagnosed with:
_____Anxiety Disorder _____Schizophrenia
_____Borderline Personality Disorder _____Anger
_____Obsessive/Compulsive Disorder _____Alcoholism
_____Bipolar Disorder _____Chemical Dependency
_____Eating Disorder _____Depression
_____Anorexia _____Seasonal Affective Disorder
_____Bulimia _____Dissociative Identity Disorder
_____Sexual Dysfunction _____Other

Please explain:_____

Have you ever served in the armed forces?_____
Please explain_____
Have you ever been suicidal?_____ When?_____
Have you ever been homicidal?_____ When?_____
Do you have any current legal problems?_____
Please explain:_____
Church Affiliation?_____ Pastor?_____

Addictions:
Please identify:_____
Do you consume alcohol regularly?_____ How often?_____
Do you take non-prescribed drugs?_____ How often?_____
Do you smoke?_____ How much?_____

Any other information that you feel is important for your counselor to know or may impact therapy:

Would you sign a release form to obtain information from medical/psychological professionals you've worked with? Yes_____ No_____

How did you hear about Dr. Tracy's counseling services?
___Word of Mouth:
Name of Person_____
___Advertisement
___Internet
Professional_____
___Other
Please Explain _____

What primary concerns, issues, or problems do you want to work on ?
_____
_____
_____

What to Expect

- The first few times you come in for counseling will be focused on gathering information.
- This will include information about your personal and social history.
- Counseling sessions run approximately fifty(50) minutes in length.
- The total number of times you will come in for counseling depends on the types of issues you are working on and the goals you set.

Choices Regarding Treatment

You have the right and responsibility to choose a counselor and treatment modality that best suits your needs and purposes. You also have the right to:

- confidentiality, except as provided by the law in RCW 18.19.180.
- refuse counseling, if you so desire; and,
- ask questions now or at any time in the future regarding this material and/or the services being provided to you.

Confidentiality

I place a high value on confidentiality. All notes, records and personal information about my clients are kept confidential.

If, for some reason, you wish to have information in your file disclosed to another party (e/g. your physician or another counselor) you should consult with me. You will be asked to sign a "release of information form" authorizing the transfer of the information. You may revoke your permission at any time by giving me written notice.

State Specified Mandatory Reporting Policy

I will make every reasonable effort to safeguard the personal information that you share with me. However, the laws of this state mandate licensed clinicians to report to governmental authorities specifics actions or intentions. Failure to do so may result in civil and/or criminal prosecution of the clinician. Confidentiality may be broken in these specific situations:

1. Any known or reasonably suspected cases of *child abuse or neglect.*
2. Any known or suspected *intentions of harming oneself (suicide).*
3. Any known or suspected *intentions of harming others.*
4. When written *consent is given by the client* to release information.
5. When charges are brought against a counselor in response to a *subpoena from a court of law or administrative agency.*

By signing below I acknowledge that counseling is provided on the condition that counselees (clients) recognize this policy of and agree that a licensed clinician will and are free to break confidentiality under any of these specific circumstances.

Signed: _____ Date: _____

Signed: _____ Date: _____

Cancellation Agreement

- We request that if you need to change or cancel an appointment, I request that you call at least 24 hours in advance of your appointment time. For appointments that are not canceled with 24-hour notice, you will be charged for a full session.
- A cancellation fee will be assessed to anyone who is more than fifteen minutes late to an appointment without prior notice.
- Occasionally I may need to change an appointment time and will call you in advance to do so.

No Show Policy

- If there are two "No Shows" (No show, no call) I reserve the right to stop service.

Ending Therapy

Once sessions begin, the duration and termination of counseling is something that should be discussed with me. Thoughts and feelings around wanting to stop counseling are important and should be raised in counseling sessions.

Signed: _____ Date: _____

Signed: _____ Date: _____

Client Consent and Acknowledgment:

By signing this form I acknowledge that I have read, received true copies of if requested, and understand the information disclosed on this form that explains the laws regarding confidentiality. I have reviewed the *Notice of Privacy Practices*. I understand that I am financially responsible to Tracy Miksell-Branch for all charges. I further acknowledge that I have discussed all of this information with my clinician including: the exceptions to confidentiality, my right to terminate counseling at any time, and the importance of discussing termination with my counselor.

Signed: _____ Date: _____

Signed: _____ Date: _____

NOTICE OF PRIVACY PRACTICES (NPP)

This notice describes how medical information about you may be used and disclosed and how your can get access to this information. Please review it carefully and ask questions.

Contents of this notice

A. Introduction.

The *Notice of Privacy Practices (NPP)* is required due to the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Because this law and the laws this state are very complicated some parts have been simplified. If you have questions, please ask.

B. What is Protected Healthcare Information (PHI)?

PHI refers to any information that is collected about you and your physical and/or mental health any time you visit a counselor, doctor or other "healthcare provider." It may be information about your past, present or future health or conditions, or the treatment or other services you received at this office or from others, or about payment for healthcare. The information that is collected by Bridging Counseling goes into a medical record. In this office and setting for counseling, this information is likely to include:

- Demographic information including your name, address, birthday, age, sex.
- Personal history that may be relevant to the condition for which you sought service.
- Diagnoses or the medical terms used to describe your condition or symptoms.
- Treatment plan(s).
- Progress and/or psychotherapy notes from each session.
- Records from other healthcare providers who have treated you that are pertinent to your counseling.
- Information from your doctor.
- Billing and/or insurance information.

This information is used for many purposes including:

- To plan your treatment and assess the effectiveness of your treatment.
- To prove that you received the services for which you were billed.

- For teaching or training other professionals.
- For improving public health.
- To improve the way counseling is conducted.

When you understand what is in your record and what it is used for you can make better decisions about who, what, when and why others should have this information.

Although your mental health record is the physical property of the healthcare practitioner, the information belongs to you. You can request to inspect, read or review it. If you desire a copy, one can be made for you for a small charge to cover costs. In some situations you may be prohibited from seeing all of your record if to do so could result in emotional harm. If you review and find anything in your record that you believe is incorrect or missing, you can request an amendment. Final determinations on amendments are made by the practitioner.

C. Privacy and the Law.

The HIPAA law requires that healthcare practitioners to keep your PHI private and to give you this notice of our legal duties and our privacy practices which is called *the Notice of Privacy Practices or "NPP"*. The rules of the NPP will be followed in this office and apply to all records. If the NPP is changed a new version will be posted in the office for review and you may receive an updated copy at any time.

D. How your PHI can be used and/or shared WITH your consent.

When your PHI is read it is considered "*use*." If and when the information is shared with or sent to others outside this office it is considered "*disclosure*." Except in special cases, when your PHI is disclosed, only the minimum amount of information necessary for the purpose is shared. Your signature on the *Client Information and Consent Form* will grant permission to use some of your PHI for payment and business operations. If you do not sign the *Client Information and Consent Form*, you cannot receive treatment.

- Payment. In order to receive payment for services, information must be gathered and shared with business associates including the insurance company (if indicated) and billing service. Only the minimum amount of information necessary to facilitate claims processing is disclosed. These "business associates" also operate under strict confidentiality practices.
- Business Operations. Information may be used for the internal business operations of this counseling practice, e.g., quality reviews.

E. Uses and disclosures requiring your *Authorization*. According to the laws of the state of IA, your written authorization is required for the disclosure of any information concerning mental health or substance abuse treatment. You will be asked to sign an authorization form if information needs to be disclosed beyond what is granted under your consent for payment and business operations.

F. Uses and disclosures *NOT* requiring your Authorization

- Public health and safety or when required by law.
- Law enforcement. When required by law or to protect you or another person from imminent harm.
- Suspected or known abuse or neglect of a child or older adult as required by law.
- Court processes or proceedings. As ordered by the court or in response to legal action.
- Military and National Security. As required by law.

G. Uses and disclosures requiring you to have an opportunity to object.

Information will be disclosed under the conditions allowed by your consent and/or authorization and/or as required by law. No other information will be disclosed without your permission except in case of emergency. In the case of an emergency, the minimum amount of information will be released.

H. Accounting of disclosures.

When your PHI is disclosed, a record of the disclosure is made of what information was disclosed, when, to whom and for what purpose. You can request an accounting of these disclosures. If a request of accounting of disclosures is made more than once a year, you may be charged a fee.

I. If you have questions or problems.

If you need more information or have questions about the privacy practices described above, please let me know. If you have problems with the way your PHI has been handled or if you believe that a violation has occurred, you have the right to file a complaint with this practice and/or with the Secretary of the Federal Department of Health and Human Services. Any complaints will not in any way limit your care nor will any actions be taken against you if you file a complaint.

Authorization and Release: I authorize payment of insurance benefits directly to Tracy Miksell-Branch, LISW, PhD. I authorize the clinician to release all necessary information to communicate with personal physicians and other healthcare providers and payors to secure the payment of benefits. I understand that I am responsible for all costs of my counseling services, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my counselor, all fees for professional services will be immediately due and payable. I understand that I am financially responsible to Tracy Miksell-Branch, LISW, PhD for all charges. I further acknowledge that I have discussed all of this information with my clinician including the exceptions to confidentiality, my rights to terminate counseling at any time, and the importance of discussing termination with my counselor.

Patient Signature:_____Date:_____

The patient understands and agrees to allow Tracy Miksell-Branch, LISW, PhD to use their Patient Health Information for the purpose of treatment, payment, healthcare operations and coordination of care.

Emergency Contact Person:

Name:

Phone Number: