

Life Christian Counseling Network, LLC

Confidential Client Intake Form

Please bring this completed form to your first appointment. All information contained herein is confidential in accordance with the attached policies and procedures and in accordance with the HIPAA Privacy Act. This information is requested to obtain the best level of treatment and care possible. **I have answered all questions truthfully and to the best of my ability to be able to achieve the best clinical outcome.**

Name: _____ Today's Date: _____
 Male Female Date of Birth: _____ Age: _____
 Home phone: _____ Work phone: _____ Cell phone: _____
 Any number you do not want to be contacted at: _____

PRESENT ISSUES AND GOALS

Please describe why you are coming to counseling. How long has this been going on? Please use the back of the form, if necessary.

What do you hope to gain from this counseling experience? _____

PSYCHOSOCIAL INFORMATION

Please check the level of education you have completed: HS Graduate GED some college AA/ 2 yrs college BA/BS/4 yrs college Some graduate school MA/2 yrs graduate Ph. D/4+yrs graduate school Post-graduate studies

Occupation _____ Level of satisfaction with your occupation _____

Were you "held back" or placed in special education classes? Yes No If yes, was this helpful to you? _____

Do you regularly attend a church or other religious institution? Yes No If yes, which one? _____

Religious background, practice, and spiritual goals if applicable: _____

RELATIONAL INFORMATION *Have you ever had, or do you currently have, protective order(s) in place?* Yes No

Current Relationship Status

Married how long?	<input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd marriage other: _____
Separated how long?	Why? _____
Cohabiting how long?	Plan to marry: <input type="checkbox"/> Yes/When: _____ <input type="checkbox"/> No
Divorced how long?	Reason for divorce: _____
Remarried how long?	_____
Widowed how long?	Lost spouse through: _____

If married, spouse's name: _____ Age: _____

Number of previous marriages for your spouse: _____

Is your spouse supportive of you seeking counseling? Yes No Unsure Spouse doesn't know

Please provide a brief description of your spouse (e.g., angry and controlling; outgoing and supportive): _____

Please list your children (including step, adopted, foster) below:

Name	Sex	Age or yr. of death	Relationship to you	Living with whom?

Who else lives with you? _____

How many times have you:

- | | | | | | | |
|---|-------------------------------|----------------------------|------------------------------|------------------------------|------------------------------|------------------------------|
| Fought with your spouse/parents (if a minor) | <input type="checkbox"/> None | <input type="checkbox"/> 1 | <input type="checkbox"/> 2-3 | <input type="checkbox"/> 4-6 | <input type="checkbox"/> 7-9 | <input type="checkbox"/> 10+ |
| Threatened to hurt your spouse/parents (if a minor) | <input type="checkbox"/> None | <input type="checkbox"/> 1 | <input type="checkbox"/> 2-3 | <input type="checkbox"/> 4-6 | <input type="checkbox"/> 7-9 | <input type="checkbox"/> 10+ |
| Physically fought with your spouse/parents (if a minor) | <input type="checkbox"/> None | <input type="checkbox"/> 1 | <input type="checkbox"/> 2-3 | <input type="checkbox"/> 4-6 | <input type="checkbox"/> 7-9 | <input type="checkbox"/> 10+ |
| Thrown things around the house | <input type="checkbox"/> None | <input type="checkbox"/> 1 | <input type="checkbox"/> 2-3 | <input type="checkbox"/> 4-6 | <input type="checkbox"/> 7-9 | <input type="checkbox"/> 10+ |
| Thrown things at your spouse/parents (if a minor) | <input type="checkbox"/> None | <input type="checkbox"/> 1 | <input type="checkbox"/> 2-3 | <input type="checkbox"/> 4-6 | <input type="checkbox"/> 7-9 | <input type="checkbox"/> 10+ |
| Broken/smashed something in anger | <input type="checkbox"/> None | <input type="checkbox"/> 1 | <input type="checkbox"/> 2-3 | <input type="checkbox"/> 4-6 | <input type="checkbox"/> 7-9 | <input type="checkbox"/> 10+ |
| Lost control disciplining your children | <input type="checkbox"/> None | <input type="checkbox"/> 1 | <input type="checkbox"/> 2-3 | <input type="checkbox"/> 4-6 | <input type="checkbox"/> 7-9 | <input type="checkbox"/> 10+ |
| Been arrested? | <input type="checkbox"/> None | <input type="checkbox"/> 1 | <input type="checkbox"/> 2-3 | <input type="checkbox"/> 4-6 | <input type="checkbox"/> 7-9 | <input type="checkbox"/> 10+ |
| Been convicted of a crime? | <input type="checkbox"/> None | <input type="checkbox"/> 1 | <input type="checkbox"/> 2-3 | <input type="checkbox"/> 4-6 | <input type="checkbox"/> 7-9 | <input type="checkbox"/> 10+ |

FAMILY OF ORIGIN HISTORY

How well did your parents/guardians get along with each other? Great Good Fair Poor Terrible

How well did you get along with your parents/guardians? Great Good Fair Poor Terrible

How were you disciplined by your parents/guardians (check all that apply)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> never disciplined | <input type="checkbox"/> Talked to about problem | <input type="checkbox"/> Yelled at by parent/guardian | <input type="checkbox"/> Spanked on bottom |
| <input type="checkbox"/> Slapped on hand | <input type="checkbox"/> Spanked with belt/twig/switch | <input type="checkbox"/> Face slapped | <input type="checkbox"/> Mouth washed out with soap |
| <input type="checkbox"/> Whipped on back | <input type="checkbox"/> Time out on chair/corner | <input type="checkbox"/> Locked in small room | <input type="checkbox"/> not allowed to eat/drink |

Did you ever run away from home? Yes No If yes, how long were you gone? _____

What was the reason? _____

Please list your father, mother, sisters, brothers, stepfamily relations, or other family members who had a significant effect on your life (either positive or negative). (Use the back of this sheet if necessary.)

Name	Sex	Age or year of death	Relationship to you	Describe him/her (e.g., angry, outgoing, supportive, controlling)

COUNSELING HISTORY/PREVIOUS MENTAL HEALTH CARE

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the names of the therapists or programs. (Use the back if necessary.)

Therapist's Name or Program	Major Issue	Dates

Has anyone in your family ever been treated or hospitalized for substance abuse, criminal behavior, mental health issues, or psychiatric conditions? Yes No If yes, please describe: _____

Have any of your family members or friends ever attempted or committed suicide? Yes No If yes, who and when: _____

MEDICAL HISTORY

Please list any conditions, illnesses, treatments, or surgeries that might be relevant to your reason for seeking counseling: _____

Have you ever had a head injury, a concussion, or lost consciousness? _____

Are you currently receiving any medical treatment? Yes No if yes, please describe: _____

Number of pregnancies _____ Number of live births _____ Post-partum depression? _____

Please list all medications and herbal remedies you are taking and the reasons for taking them.

Name of medication	Dose	Used for

Are you taking these medications according to the doctor's recommendations? Yes No if no, please explain: _____

Date and outcome of last physical exam: _____

ALCOHOL OR DRUG USE

Use of alcohol: None 1 drink/day 2-3 drinks/day more than 3/day 1/wk 1/month other _____

Please describe any use of recreational drugs or use of prescription drugs not as prescribed: _____

CURRENT SYMPTOMS

Are you currently experiencing any suicidal thoughts? Yes No

Have you experienced suicidal thoughts in the past? Yes/When _____ No

Have you attempted suicide in the past? Yes No **If yes, please explain: (use back of page if necessary)** _____

Are you currently experiencing any violent or homicidal thoughts? Yes No **If yes, please explain: (use back of page if necessary)** _____

Check any of the following symptoms or problems that you currently are or recently have experienced:

<input type="checkbox"/> Stress	<input type="checkbox"/> Marital Problems	<input type="checkbox"/> Compulsive Behaviors
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Other Relational Problems	<input type="checkbox"/> Hallucinations
<input type="checkbox"/> Panic	<input type="checkbox"/> Physical Abuse	<input type="checkbox"/> Hearing Voices
<input type="checkbox"/> Depression	<input type="checkbox"/> Emotional Abuse	<input type="checkbox"/> Racing Thoughts
<input type="checkbox"/> Apathy	<input type="checkbox"/> Verbal Abuse	<input type="checkbox"/> Eating Problems
<input type="checkbox"/> Fatigue/Lack of Energy	<input type="checkbox"/> Sexual Abuse	<input type="checkbox"/> Drug Use
<input type="checkbox"/> Loss of Appetite/Overeating	<input type="checkbox"/> Sexual Problems	<input type="checkbox"/> Alcohol Use
<input type="checkbox"/> Trouble Sleeping	<input type="checkbox"/> Gender Identity Issues	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Poor Concentration	<input type="checkbox"/> Anger	<input type="checkbox"/> Abortion
<input type="checkbox"/> Feeling Worthless	<input type="checkbox"/> Aggressive Behavior	<input type="checkbox"/> Legal Matters
<input type="checkbox"/> Recent Death	<input type="checkbox"/> Bad Dreams	<input type="checkbox"/> Work Stress
<input type="checkbox"/> Grief	<input type="checkbox"/> Unwanted Memories	<input type="checkbox"/> Career Choices
<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Loss of Control	<input type="checkbox"/> Indecisiveness
<input type="checkbox"/> Loneliness	<input type="checkbox"/> Impulsive Behavior	<input type="checkbox"/> Parenting Problems
<input type="checkbox"/> Fears	<input type="checkbox"/> Controlling	<input type="checkbox"/> Financial Problems
<input type="checkbox"/> Shyness	<input type="checkbox"/> Controlled by Others	<input type="checkbox"/> Spiritual Problems
<input type="checkbox"/> Low Self-Esteem	<input type="checkbox"/> Obsessive Thoughts	<input type="checkbox"/> Other: _____

Please circle the number that best indicates how distressing your problems are to you currently

1 **2** **3** **4** **5** **6** **7** **8** **9** **10**
 Minimally distressed Moderately distressed Extremely Distressed

Client's Signature _____

Date _____



Life Christian Counseling Network, LLC

POLICIES AND PROCEDURES

1. INFORMED CONSENT AND RELEASE OF INFORMATION

All information obtained/derived by the course of treatment is fully confidential. Disclosures you share with your counselor/therapist are confidential unless you have signed an *Authorization to Release Information* consent form to release part or all of the information. **Exceptions** to the need for a signed release include instances when 1) the patient is a clear danger to (a) themselves or (b) others; 2) instances when the patient is a minor (under the age of 18) and reports that he or she is or has been a victim of neglect, physical or sexual abuse; 3) disclosure of childhood sexual abuse; 4) elder abuse. In addition, cases are occasionally discussed by the clinic's professional staff to obtain feedback and provide alternative treatment plans and continuity of care (e.g. your counselor, if unlicensed, will discuss your case with his or her Clinical Supervisor). Although your counselor will attempt to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. In the event disclosure of your records, or testimony by LCCN counselor or personnel is required by law, you will be responsible for and shall pay the costs involved in producing the records and the counselor's normal session hourly rate for time involved in preparing for and giving testimony. Xerox copies are \$1/page. Such payments are to be made at the time or prior to the time the counselor renders the services. Your signature on this form will allow this process to proceed smoothly. Meetings, conference calls, and/or consultations held with school administrators, counselors, teachers, other school personnel and/or family members will be billed at your counselor's regular session fee. Travel time to and from the destination will also be billed at the hourly session rate. **Client files will be shredded 4 years after the file is closed.**

2. TELEPHONE CALLS

Occasionally the need to talk to your counselor may arise between normally scheduled sessions. Your counselor will respond to your call within 48 hours during his or her normal business hours. If you require more than a brief (e.g., five minute) conversation and you decide your issue or concern cannot wait until your next scheduled session, you will be billed as follows: 1-15 minutes, 1/3 of a full fee; 16-30 minutes, 2/3 of a full session fee; 31-45 minutes, full session fee. If you prefer, your counselor may schedule a telephone session with you at a later time and a full session fee will be applied to the phone session.

3. COUNSELING BY INTERNET, EMAIL, TELEPHONE OR INSTANT MESSAGING

For any online sessions (Skype, for example) to take place, you must have fast-enough online access that guarantees mutually satisfactory quality. It is crucial that you have a place (office/room where you can be alone) that can offer privacy at your end. Your counselor will do the same. After all technological issues have been resolved, you must know that online counseling has not been empirically tested in its effectiveness and does not guarantee the same experience as face-to-face counseling within the same room. ***I understand that if I engage in e-mail, phone, or instant messaging communication, or Skype (or other online communication using video and/or audio) with my counselor, my rights to confidentiality cannot be guaranteed in the same way they are safeguarded while meeting in an office.***

3. LENGTH OF SESSION

Psychotherapy sessions are 45-50 minutes in length beginning at your appointed time and concluding after 45-50 minutes. Since your therapist has sessions scheduled after yours, the sessions must end 45-50 minutes after the appointment time regardless of your arrival time, and the full fee for the session will be charged. Therefore, it is to your benefit to be on time. Longer sessions may be prearranged with your Therapist.

4. FEES AND PAYMENT

All payments are due at the time of service. We accept credit cards, cash, or check made payable to Life Christian Counseling Network or LCCN. A \$25.00 service charge will be levied on all checks returned by a bank for insufficient funds or if a credit card or debit card is declined. Our fees are based on a sliding scale using household income and are arranged through the corporate office in advance of appointments. If any or all outstanding balances are not paid, LCCN reserves the right to release a client's name and address to a collection agency. Also, a monthly interest fee of 2% will be charged for these balances until they are paid in full.

5. INSURANCE

You are responsible for all payments for sessions. We do not file with any insurance providers. If requested, we will provide you with a receipt for payment and a treatment plan if required by your insurance provider, so you may request reimbursement from your insurance company for payment.

6. CANCELLATIONS AND MISSED APPOINTMENTS

When an appointment is scheduled, that time is reserved for you. If the appointment is missed or cancelled without sufficient notice, the therapist is unable to make use of that time. **Therefore, sessions must be cancelled 24 hours in advance or a "full session" fee will be charged.** Please note that most insurance carriers do not reimburse fees for cancellations or missed appointments.

7. SCHEDULING POLICY

In most cases, issues are not resolved in one meeting. At the initial appointment counselors usually establish the next appointment within one week. Appointment frequency is based on the counselor's assessment of what will be most effective and productive for you. During the active phase of therapy, on-going appointments are generally scheduled weekly or bi-weekly and these appointments are generally set for the same appointment time slot, based on availability of the counselor and client. To retain your appointment time slot, it is our policy to allow one cancellation for every six months that you occupy a particular slot. The second time that you cancel an appointment you have an option: Either risk losing your spot or choose to pay the cancellation fee. *If you lose your time slot, you may have to return to your counselor's waiting list.* If a client cancels with less than 24 hours notice, the cancellation fee always applies.

7. EMERGENCY TREATMENT.

In the event of a psychiatric emergency, do not phone your counselor or the Life Christian Counseling Network office. Instead, call 911 or go immediately to your local Emergency room. Then you should call your counselor. If your counselor is unable to be reached, please leave a message and your counselor will contact you as quickly as possible.

In case of an emergency during a counseling session if I become unable to communicate or need non medical assistance the person I authorize you to contact is;

First Name, _____

Last Name, _____

Contact Ph #, _____

Our desire is that your experience with Life Christian Counseling Network will be helpful and productive for you. If you have any questions regarding these arrangements or other aspects of your relationship with us, please discuss them with your therapist or call our Practice Manager at 301-292-2778.

This is to certify that I have read, understand, and have been given a copy of this document. I have had the opportunity to have my questions answered.

Patient's Signature _____ Date _____

Reviewed with client and answered any client questions,

Date _____

(Counselor Signature)

PRIVACY NOTICE OF
Life Christian Counseling Network, LLC

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE GIVES YOU INFORMATION REQUIRED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) that prescribes legal duties and privacy practices to protect the privacy of your individual identifiable health information; this is, *Protected Health Information (PHI)*, as that term is defined in the HIPAA under *Information*.

THE EFFECTIVE DATE OF THIS NOTICE IS APRIL 14, 2003. LCCN is required to follow the terms of this Notice until it is replaced. LCCN may make changes to the terms of this Notice at any time. **Upon your request**, we will provide you with a copy of the current Notice. LCCN reserves the right to make the changes apply to your *Information* maintained in LCCN files before and after the effective date of the new Notice. The following is a general description of how Federal and State law permits me to use and disclose your *Information*.

Purposes for which LCCN May Use or Disclose Your Mental Health Information with your Consent

LCCN may request your consent for the use and/or disclosure of your *Information* for *treatment, payment or health care operations* as described below:

- Treatment. LCCN will use and disclose your *Information* to provide, coordinate, or manage your mental health care and any related services. LCCN may disclose your *Information* to physicians, therapists, other mental health providers, or other health care providers who are treating you or assisting in your diagnosis, treatment, or recovery.
- Payment. Your *Information* will be used and disclosed, as needed, to obtain payment for your mental health care services. This may include certain activities that your health insurance plan undertakes before it approves or pays for the mental health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and utilization review activities. If more than one, third party payer is responsible for payment for your health care, LCCN may disclose your *Information* to more than one health plan and those health plans may share your *Information* with each other. Your *Information* may also be used and disclosed as needed to obtain payment for mental health care services rendered to you by other providers.
- Mental Health Care Operations. LCCN may use or disclose, as needed, your *Information* in order to support my delivery of mental health care services. LCCN may call you by name in the waiting room area. LCCN may use or disclose your *Information*, as necessary, to contact you to schedule an appointment or remind you of your appointment.

LCCN may share your *Information* with third party Business Associates who perform various administrative services. For example, those within LCCN, or with whom LCCN contracts, who perform billing services, transcription services, record retention, or other professional consultants. Whenever an arrangement between a Business Associate and me involves the use or disclosure of your *Information*, we will have a written contract that contains terms that will protect the privacy of your *Information*.

- Health Care Services. Your *Information* may be used and disclosed to contact you and to give you information about treatment alternatives or other health benefits and services that may be of interest to you.

Uses and Disclosures With Your Verbal Consent

Your *Information* may be disclosed to a family member, friend, or other person designated by you or as designated by the law, if you verbally agree.

Uses and Disclosures with Your Written Authorization

Except as provided below, your *Information* will not be used for any non-routine purposes unless you give your written authorization to do so. If you give written authorization to use or disclose your *Information* for a purpose that is not

Described in this Notice, then, with certain exception, you may revoke it in writing at any time. Your revocation will be effective for the *Information* LCCN maintains, unless LCCN has taken action in reliance on your authorization.

Uses and Disclosures without Your Consent

- As required by law;
- To comply with legal proceedings, such as a court or administrative order or subpoena;
- To law enforcement officials for limited law enforcement purposes;
- To a coroner, medical examiner, or funeral director about a deceased person;
- To avert a serious threat to your health or safety or the health or safety of others;
- To a governmental agency authorized to oversee the mental health care system or government programs;
- To federal officials for lawful intelligence, counterintelligence, and other national security purposes; and
- To public mental health authorities for public health purposes.

Your Rights

You may make a written request to me to do one or more of the following concerning your *Information*:

- Put additional restrictions on use and disclosure of your *Information*.
- Communicate with you in confidence about your *Information* by a different means than LCCN is currently doing.
- See and get a summary of your *Information*.
- Receive a list of disclosures of your *Information* that LCCN has made for certain purposes for four (4) years prior to your request (after April 14, 2003), with certain exceptions permitted by law, which includes exceptions for disclosure made directly to you or made pursuant to your authorization.

If you want to exercise any of these rights or require further information about privacy practices, please contact me at the address below. In certain instances, LCCN is not required to agree to your request. LCCN will give you the necessary information and forms for you to complete and return to request your *Information*. LCCN is permitted, by law, to charge you a fee for copying any documents requested in accordance with your rights as listed above. (Fee \$1.00 per page.)

Complaints

If you believe that LCCN violated your privacy rights, you have the right to complain to me or to the Secretary of the U.S. Department of Health and Human Services (DHHS). You may file a written complaint with me at the address below. An individual must file a complaint within 180 days of when he/she knew or should have known that the act or omission occurred, unless the time limit is waived by the Secretary of DHHS. LCCN will not retaliate against you if you choose to file a complaint.

Contact Address:

Life Christian Counseling Network, LLC
3102 Floral Park Road
Clinton, MD 20735

Phone: 301-292-2778

PRIVACY NOTICE ACKNOWLEDGEMENT

As a client of Life Christian Counseling Network, I acknowledge that I have been given the Privacy Notice required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that prescribes legal duties and privacy practices to protect the privacy of my individually identifiable health information, by Life Christian Counseling Network

Client Name _____

Client or Guardian Signature _____ Date _____



Life Christian Counseling Network, LLC
Clinical Excellence from a Christian Foundation

CREDIT CARD AUTHORIZATION FORM

Name on Card (client or family member): _____

Credit Card #: _____ - _____ - _____ - _____

Expiration Date: ____ / ____

3 digit verification number on the back of card: ____ ____ ____

Street # for Card: _____

Zip Code: _____

Charge Amount: _____

Date of Service: _____

Please keep my number on file for multiple uses.

Type of Credit Card: Master Card VISA Discover

I, _____, authorize Life Christian Counseling Network to bill my credit card for the amount indicated above.

I authorize Life Christian Counseling Network, LLC to bill my credit card for the amount indicated above. Charges that are declined will incur an **administration fee of \$ 25.00**. I further understand and agree that if I fail to cancel my scheduled appointment as agreed in this contract, Life Christian Counseling Network, LLC has my express permission to charge to this credit card the **cancellation fee**.

Signature: _____ Date: _____