CLIENT INTAKE INFORMATION

Insurance / EAP Name: _____ Date:_____ Time: _____
Member Number: _____
Group Number:_____

Client Name:_____Sex:_____ Age:_____Birth Date:_____

Marital Status:_____

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

- Cell Phone: _____ May I call/leave a message on cell phone? Yes ____ No ____
  - Would you like a Text Message reminder for appointments? Yes___ No___
  - Cell Phone Carrier _____
- Home Phone_____ May I call/leave a message at home? Yes____ No____
- Work Phone_____ May I call/leave a message at work? Yes____ No____

Employer:_____

Name of Spouse/Partner/Parent: _____ Sex:____Age:___

Birth Date:_____

Address (if different):_____City: _____ State:_____Zip:_____

- Home/Cell Phone: _____May I call/leave a message at home? Yes ____ No ____
- Work Phone: _____ May I call/leave a message at work? Yes ____ No ____

Employer:_____

Name, Birth date, Age, and Sex of other s living in the home.

Name	Birth date	Age	Sex	Relationship to client
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Emergency Contact (Name and Phone #): _____

Client Rights, Responsibilities and Informed Consent

Counseling is a collaborative process with your therapist that involves:

- Exploring the issues that brought you to therapy.
- Building a trusting relationship with your therapist.
- Deciding upon specific goals and objectives.
- Working toward these goals and objectives.
- Evaluating your progress on a regular basis.

I understand:

- That I have chosen to receive treatment services and I may terminate my therapy at any time, unless ordered by the court.
- That there is no assurance that I will feel better.
- That during the course of my treatment, material may be discussed that is upsetting in nature. This is a part of the therapy process that may be necessary to resolve my concerns.
- That I may be contacted by my health plan to ensure continuity and quality of therapy or after the completion of treatment to assess the outcome of treatment.
- That records and information collected during my treatment will be held or released in accordance with federal and state laws regarding the confidentiality of such records and information.
- That state and local laws require that my therapist report all cases of suspected abuse or neglect of minors or vulnerable adults.
- That state and local laws require that my therapist report all cases where there exists a danger to self or others.
- That there may be other circumstances in which the law requires my therapist to disclose confidential information.

I have the right:

- To confidentiality under federal and state laws relating to the receipt of therapy.
- To be informed of and ask questions about my therapy including the qualifications of my therapist.
- To be a collaborative partner with my therapist in the development of treatment plans and goals.
- To select a therapist of my choice at my expense.
- To make an informed decision about whether to accept or refuse treatment.
- To contact and consult with counsel at my expense.

General Office Policies:

Missed or cancelled appointments without 24 hours notice, for any reason other than an emergency or illness, will be charged at $50. Messages may be left at 319-929-5668 at any time to change or cancel appointments. A pattern of No Shows or Late Cancellations may result in denial of services.

Emergency Situations: If you are experiencing a counseling emergency and are unable to reach me, please call your local 24 hour crisis line. If you are experiencing a life threatening emergency, go immediately to the nearest hospital emergency room or dial 911. For the Cedar Rapids area, the crisis line is through Foundation 2 at 319-362-2174.

I understand that my therapist, health plan representatives and my primary care physician may exchange any and all information pertaining to my therapy to the extent that such disclosure is necessary for claims processing, case management, coordination of care, quality assurance, and/or utilization review purposes. I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that the action has been taken in reliance on this consent. I understand that if I do not revoke this consent, it will expire automatically on year after all claims for treatment have been paid as provided in the benefit plan. I have read and understand the above.

_____ _____

Client Signature Date

CLIENT APPEALS/GRIEVANCES PROCEDURE

A client, who has a complaint about services, including fee issues, sexual harassment, or any other concern may request a review. The procedure for this is as follows:

1. The client is encouraged to discuss the concern/complaint with her/his counselor. If this does not satisfactorily resolve the concern/complaint, the client may undertake step 2. If a client is reluctant or unwilling to start with step 1, she/he may begin the appeals process with step 2.

2. The client shall send a written request for a review to the appropriate state licensing board or national certification association (LMHC, NCC, CADC).

Angela Lewis, LMHC, NCC, CADC
1450 Boyson Rd. Suite C-2B
Hiawatha, IA 52233

Date:

Dear Dr.

I am writing to inform you that your patient _____ (D.O.B.)_____, has begun psychotherapy with me to address personal concerns. If you have any questions or would like to share information that would be helpful to the care of this client, please contact me at 319-929-5668.

Enclosed is a signed copy of the Client Authorization to Release Protected Health Information.

Sincerely,

Angela Lewis, LMHC, NCC, CADC

Release of Information to Primary Care Physician

In order to provide you with the highest standard of care, we are requesting your permission to coordinate your treatment with your Primary Care Physician. To do this, we need you to complete and sign the attached Release of Information.

___ I have a Primary Care Physician and will sign the Release of Information.

___ I do not have a Primary Care Physician or do not want my Primary Care Physician contacted.

_____ _____

Client Signature Date

Authorization and Release

- I authorize/request my insurance company/EAP to pay directly to the provider of care insurance benefits otherwise payable to me.
- I authorize the release of necessary information to third party payers/insurance companies and/or other health practitioners.
- I have been informed of HIPAA guidelines and regulations related to confidentiality of medical records.
- I agree to be responsible for payment of all services (to include self pay) rendered on my behalf or for my dependents.

_____ Date:_____

Signature of Client or Responsible Party