# INTAKE FORM

*Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.*

*Please fill out this form and bring it to your first session.*

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____/_____/_____ Age: _____ Gender: □ Male □ Female

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated
□ Divorced □ Widowed

Please list any children/age: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: (_____)_____ May we leave a message? □Yes □No

Cell/Other Phone: (_____)_____ May we leave a message? □Yes □No

E-mail: _____ May we email you? □Yes □No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No

□ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?

□ Yes

□ No

Please list: _____

_____

Have you ever been prescribed psychiatric medication?

□ Yes

□ No

Please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in: _____

4. Please list any difficulties you experience with your appetite or eating patterns.

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5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
□ No
□ Yes

If yes, please describe? _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

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FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

| | Please Circle | List Family Member |
|---|---|---|
| Alcohol/Substance Abuse | yes/no | |
| Anxiety | yes/no | |
| Depression | yes/no | |
| Domestic Violence | yes/no | |
| Eating Disorders | yes/no | |
| Obesity | yes/no | |
| Obsessive Compulsive Behavior | yes/no | |
| Schizophrenia | yes/no | |
| Suicide Attempts | yes/no | |

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation:

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

4. What do you consider to be some of your weakness?

5. What would you like to accomplish out of your time in therapy?

# New Beginning Christian Counseling

**5505 Foxridge Drive, Suite 102, Mission, KS 66202**

**INFORMED CONSENT & THERAPY CONTRACT**

We feel it is important that you are fully informed about the therapy services you will be receiving before deciding to begin therapy. Your signature below indicates that you have received, read, and understand the practice policies of this therapy site.

1. I understand that Sherrie Pucket is bound by the Code of Ethics set forth by the American Counseling Association (ACA), and I can request a copy of these ethics at any time.
2. I understand the confidentiality policies concerning case consultation. I also understand that, according to Kansas Law, Sherrie Pucket has an obligation 1) to warn others of life threatening concerns should it become necessary, 2) to notify appropriate state agencies of any suspicion of child or dependent adult abuse and, 3) to provide information in legal cases when under court order, and 4) to release information from my file when I request this using a written release.
3. I understand that there can be risks and benefits associated with therapy and have discussed those with Sherrie Pucket. I also understand that no promises have been made to me as to the results of treatment or of any procedures provided by Sherrie Pucket.
4. I understand that I may leave therapy at any time and agree to discuss the termination of therapy with Sherrie Pucket at a regular therapy session rather than by phone.
5. I understand that, under Kansas Law, Sherrie Pucket is required to consult with my primary care physician or psychiatrist to determine if there may be a medical condition or medication that is contributing to any observed symptoms of a mental disorder. In order to complete such a consultation, Sherrie Pucket will request that I complete a Release of Information form. I also understand that I may waive this consultation, in writing, and that my therapist will discuss this process with me at any time if I so request.
6. I understand the financial policies of this therapy site and agree to pay $_____ for therapy at the beginning of each session. I understand that if I miss a scheduled session for any reason except an emergency I am still responsible for the fee.
7. I have received the client information sheet which informs me of my rights and other pertinent information. This information has been explained to me and any questions answered by Sherrie Pucket. _____ (Client Initials)

My signature below indicates that I give my full informed consent to receive therapy services from Sherrie Pucket.

Signature _____ Date ____ Signature _____ Date _____

Signature _____ Date _____ Signature _____ Date _____

# New Beginning Christian Counseling

**CONFIDENTIALITY**

The information clients share in therapy and all documents relating to therapy services are kept confidential, unless the client requests in writing that the records be released. Some specific confidential information may be disclosed for the purpose of professional consultation/supervision and guidance in treatment, or when mandated by law. Your Therapist, Sherrie Pucket, is under the direct supervision of Craig Waddle, LCPC, of CrossPointe Counseling Center. Kansas law mandates that confidentiality be broken if you are found to be a clear and imminent danger to self or others, if you report current abuse of a child or dependent adult, or if your therapist receives a court order to release your records.
Please allow Craig Waddle full access to your client file for the purpose of guiding your counseling.

Client Signature _____ Date _____

# New Beginning Christian Counseling

5505 Foxridge Drive, Suite 102, Mission, KS 66202

## WAIVER OF MEDICAL/PSYCHIATRIC CONSULTATION

***I understand that under the provisions of KSA 65-6404 (b) (3) my therapist(s) is/are required to consult with my primary care physician or a psychiatrist to determine if there may be a medical condition or medication that is causing or contributing to any observed symptoms of a mental disorder in either myself or my minor child(ren) listed below:***

| | |
|---|---|
| *Name of Minor child* | *Name of Minor child* |
| *Name of Minor child* | *Name of Minor child* |

In the event that I or my minor child(ren) do not have a primary care physician or psychiatrist, I acknowledge that my student counselor(s) has/have recommended that *I seek medical consultation.*

By signing below I am indicating that I waive my right to such consultation and that I do not wish for my student counselor to contact my(our) physician(s). I am also aware that this waiver will become part of my client record.

| | | | |
|---|---|---|---|
| X Client Signature | Date | Client Signature | Date |
| Client Signature | Date | Client Signature | Date |
| Client Signature | Date | *Client Signature* | Date |

# Consent for Treatment
## and Limits of Liability

**Limits of Services and Assumption of Risks**:

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

**Limits of Confidentiality**:

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

**Duty to Warn and Protect**
If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

**Abuse of Children and Vulnerable Adults**
If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

**Prenatal Exposure to Controlled Substances**
Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

**Minors/Guardianship**
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

**Insurance Providers**
Insurance companies and other third-party payers are given information that they request regarding services to the clients.

The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

*By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.*

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

# Cancellation Policy

If you are unable to attend an appointment, we request that you provide at least 24 hours advanced notice to our office. Since we are unable to use this time for another client, please note that you will be billed for the entire cost of your scheduled appointment if it is not timely cancelled, unless such cancellation is due to illness or an emergency.

For cancellations made with less than 24 hour notice (unless due to illness or an emergency) or a scheduled appointment that is completely missed, you will be mailed a bill directly for the full session fee.

We appreciate your help in keeping the office schedule running timely and efficiently.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

# Authorization for Use or Disclosure of Protected Health Information

**Client Information**

Client Last Name_____ First Name _____MI ___
DOB:___/___/____
Client Address

_____
Client Home Phone: _____ Cell/Work Phone:

_____
Client Email Address: _____

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**Recipient Information**

I, _____, do hereby authorize _____ to release a copy of my mental health information to the person or facility below.

Name of person/facility to receive medical information: _____
Phone: _____
Address: _____

Date of Authorization: ___/___/_____
Authorization to expire on ___/___/_____ or upon the happening of the following event: _____

_____

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**Information to be Released** (*Note: Requests for release of psychotherapy notes cannot be combined with any other type of request.*)

□ My entire mental health record

□ Only those portions pertaining to: _____
(Specific provider name and/or dates of treatment)

□ Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

□ Other: _____

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**Purpose of Information Release:**

□ Further mental health care
□ Applying for insurance
□ At the request of the individual
□ Payment of insurance claim
□ Vocational rehab, evaluation
□ Other (specify): _____
□ Legal investigation
□ Disability determination

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.

5. If this office initiated this authorization, you must receive a copy of the signed authorization.

6. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.*** HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

   In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.

**Authorization and Signature**

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

_____ _____

Signature Date

If signed by a personal representative:

(a) Print your name: _____

(b) Indicate your relationship to the client and/or reason and legal authority for signing:

Patient is: □ minor □ incompetent □ disabled □ deceased

Legal authority: □ parent □ legal guardian □ representative of deceased