

Associated Counseling Professionals
CLIENT INTAKE FORM

_____ Intake Date
_____ Therapist

Client Information – Please, only one name per form

Last Name _____ First Name _____ Middle _____
Client's Social Security Number _____ Age _____ Date of Birth _____
Sex - Male / Female Married _____ Single _____ Other _____ E-Mail Address _____
Home Telephone _____ Cell Telephone _____ Work Telephone _____
Street Address _____ City _____ State _____ Zip Code _____

Primary Care Provider _____ Office Telephone _____
Name of Spouse _____ Date of Birth _____ Employer _____
Emergency Contact Name and Telephone Number _____
Name(s) of Children and Date of Birth(s) [if applicable] _____

Employer Information

Client's Employer Name _____ Telephone Number _____
Street Address _____ City _____ State _____ Zip Code _____

Primary Insurance Information/Employee Assistance Program Information

Primary Insured Name _____ Address _____ Home Telephone # _____
Name of Insurance Company/EAP _____ Insurance/EAP (800) Phone # _____
ID#/Social Security # _____ Plan # _____ Date of Birth of Insured _____
Insured's Employer _____ Address _____ Phone _____

- Have you ever been treated by a psychiatrist? ___ Yes ___ No
- Have you ever been hospitalized for mental health or chemical dependency treatment? ___ Yes ___ No
- Have you seen another therapist in the past twelve months? ___ Yes ___ No
If yes, who did you see? _____
- Have you ever attempted suicide? If yes, when _____

Briefly describe your reasons for seeking counseling services –

Healthy Habit Information (please base your answers on the past month):

- Have you participated in regular exercise/sports/recreation (about 3 times/week) to keep fit ___ Yes ___ No
- Have you been dieting to lose weight? ___ Yes ___ No
- Have you smoked cigarettes on a daily basis? ___ Yes ___ No If yes, # per day: _____

How often in the past month did you drink alcohol? (circle your answer)

A. I do not drink at all B. About once a month C. 2 to 3 times a month D. 2 to 3 times a week E. Once a day or more

On days that you drink, how many servings of beer/wine/spirits do you consume?

Education – Years completed or degree earned _____ Recent/Current Legal Issues: ___ Yes ___ No

Financial Problems: ___ Yes ___ No

Military Service: ___ Yes ___ No If yes, Present ___ Past ___ How Long? _____ Rank _____

Any other health issues or concerns that you want your therapist to know about? _____

I am having trouble with:	Yes	No	Describe:
Work, school, daily activities			
My emotions			
A relationship			
Controlling my choices			
Making a decision			
Using alcohol or drugs			
Thoughts of hurting myself or someone else			
A medical problem or pain			
Adjusting to abuse, neglect, or other hurts earlier in my life			
Someone else's behavior			
Other			

Medications	Taking Now (check if yes)	Name	Have Taken in the Past (check if yes)	Name
For anxiety				
For depression				
For mood swings				
To help with sleep				
For pain				
Other				

Overall, how serious is your current situation for you?

On a scale from 1-10 (with 1 being not very serious and 10 being serious) - _____

What do you hope to accomplish by coming here? Anything else you want to mention?

Patient Authorization - Please review each Statement Below. Your signature acknowledges Your Understanding That:

- I request payment be made directly to the provider
- As the authorizing person, my signature acknowledges that I assume sole financial responsibility for services rendered
- I am personally responsible for payment of all appointments **NOT CANCELLED 24 HOURS IN ADVANCE OR IF I FAIL TO ARRIVE FOR A SCHEDULED APPOINTMENT**
- If this account is forwarded to a collection agency due to lack of payment, I will be responsible for all fees associated with this transaction including any legal fees
- Associated Counseling Professionals may call my home, cell phone or work to confirm or schedule appointments unless I notify Associated Counseling Professionals of my objections **in writing**
- Voicemail is available to leave messages when the office is closed or if lines are busy. In the case of an emergency please contact 911 or go to the nearest emergency room.

Authorized Person or Patient's Signature: _____

Print Authorized Person or Patient's Name: _____

Consent For Mental Health Care

I, the undersigned, agree and consent to participate in the mental health care offered and provided by

_____, a mental health professional as defined by
(Name of Treating Therapist)

Nebraska law.

I understand that I am consenting and agreeing only to those mental health services that the above-named professional is qualified to provide within the scope of the professional's license, certifications and training.

Please print patient's name: _____

I have read and understand
all of the above (Please sign) _____ Date _____

Witness Signature: _____ Date _____

Referred By/How Did You Hear About Us?

- | | | |
|---|--|---|
| <input type="checkbox"/> I am a former client returning | <input type="checkbox"/> Relative | <input type="checkbox"/> Friend |
| <input type="checkbox"/> Employee Assistance Program | <input type="checkbox"/> Minister/Priest/Rabbi | <input type="checkbox"/> Court/Legal |
| <input type="checkbox"/> Insurance Company | <input type="checkbox"/> Another Therapist | <input type="checkbox"/> School |
| <input type="checkbox"/> Dex Yellow Pages | <input type="checkbox"/> Internet | <input type="checkbox"/> Dex – hypnosis |
| <input type="checkbox"/> Yellow Book | <input type="checkbox"/> Physician: Dr. _____ | |
| <input type="checkbox"/> Other _____ | | |

FOR OFFICE USE ONLY

Benefits - EAP _____	Managed Care _____
# Sessions _____	Copay \$ _____
Self Pay \$ _____	Deductible \$ _____
	Number of Sessions - _____/Year
	Authorization - YES _____ NO _____

THERAPIST: _____ DSM CODE: _____ ACCOUNT NUMBER: _____

Welcome to Associated Counseling Professionals

We are pleased that you have placed your confidence for your mental health care in us and want you to know that we are, as a practice, committed to developing a working and therapeutic relationship with you that reflects our strong belief in respect and openness. We hope and aim to demonstrate these values in all we do, from your first telephone contact through your final visit. We welcome feedback from you as to the quality of your experiences with us in this regard. We believe that open communication clears up confusion, prevents disappointment and enhances your experience and care. Feel free to ask questions or offer input regarding your treatment or any aspect of your experience with us.

We look forward to working with you and would like to familiarize you with several of our office policies:

Your contact with your therapist and/or doctor is confidential. No one may have access to your records or information shared in therapy sessions without your specific permission. Federal and state laws, however, provide for several exceptions to this rule which we ask you to discuss with your therapist. (Please refer to "Notice of Privacy Practices".)

Financial Responsibility

- Payment is expected each time you come to an appointment whether it be payment in full or your co-pay. Due to the increased complexity of health insurance in recent years if you need any clarity in regard to your copayments or deductibles, please feel free to ask one of our billing specialists. Following this meeting we ask you to notify us immediately as to any change in your health insurance, place of employment, home address or other information pertinent to our records. (Failure to do this may result in our no longer being able to process insurance claims for you and could disrupt your treatment.)
- The financial responsibility for your treatment is ultimately yours. If required, we will file claims for insurance reimbursement as allowed by your policy. We file your insurance as a courtesy and, therefore, we will file only two times for any given date of service. Any monies remaining owed beyond this will be due from you (this does not apply to certain managed care insurance companies and federal/state funded agencies).

Policy on Non-Covered Services

In order to offer you consistent quality care and to coordinate this care with other providers or organizations, we may need to charge for services that are not typically covered or reimbursed by your insurance company. A list of many of these services is provided below. When we provide these services, we will bill you directly. These services are billed at the standard hourly rate for your therapist or doctor. If you have any questions regarding this policy, please ask our staff.

- The following are a list of some of the services not covered by insurance companies. These services are billed at the standard hourly rate:
 - a. Court ordered and legal related services
 - b. Preparing reports or letters for other providers or organizations
 - c. Completing documents (for disability claims, insurance reviews, workers' compensation, etc.)

- d. Consultations by telephone or e-mail
- e. Duplication of your medical records
- f. Evaluating, testing or treatment services not covered by your insurance
- g. *Your therapist will discuss these fees with you, and answer your questions.*

Cancellation Policy

- It is our policy to require a 24 hour cancellation notice. We realize that bona fide emergencies do occur, but when we reserve an appointment for you, that time is designated exclusively for you. Accordingly, we will charge for appointments not cancelled 24 hours in advance of the scheduled appointment time and insurance companies will not reimburse for this fee. Each therapist at ACP implements this for his or her clients – all questions about this policy are best discussed with your therapist.
- We realize that there may be emergency situations where a 24 hour cancellation notice is not possible, and those situations will be dealt with individually. Questions? Please ask your therapist.

Childcare

- Our goal is to provide a safe, quiet and welcoming office environment. Without a parent present, children often find it difficult to be alone. It is likely best to find a sitter, or other trusted caregiver, to provide care for your child while you visit ACP for your session. We value your cooperation with this.

Cell Phones

- We request that you please silence or turn off your cell phone while at our office. Cell phone use in the waiting room can be disruptive for the therapy sessions in progress, and those around you.

HOURS – Our front desk is open to take telephone calls from 9:00am until 6:00pm, Monday through Thursday; 9:00am until 5:00pm on Friday; and 9:00am until 12:00pm on Saturday. The office is open at 8:00am to see clients for appointments Monday through Saturday. Your therapist and/or doctor may offer different and/or additional appointment times, as well. Voicemail is available to leave a message when the office is closed or until the telephone lines are open at 9:00am. Messages left over night or on the weekend will be attended to the next business day. In the case of an emergency, please contact 911 or go directly to the nearest hospital emergency room.

Reviewed and Accepted

Patient’s Name (please print): _____ Date _____

Therapist or Doctor’s Signature _____ Date _____

**NOTICE OF PRIVACY PRACTICES
OVERVIEW OF KEY ISSUES**

This notice provides an overview of privacy practices followed by Associated Counseling Professionals' employees, staff, other office personnel, and business associates. For more information on our privacy practices, please ask the front desk personnel for a complete Notice of Privacy Practices form or you can go online to www.acpcounseling.com.

Uses and Disclosures

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. We may use or disclose identifiable health information about you without your consent in specific situations described in the Notice of Privacy Practices. Beyond these situations, however, we will ask for your written authorization before using or disclosing any identifiable health information about you. Neither this overview nor the full Notice of Privacy Practices covers every possible use or disclosure.

Your Rights

In most cases, you have the right to look at or get a copy of health information about you (this excludes therapy notes). If you request copies, we will charge you the usual and customary fees for copying, mailing or other services required to fulfill the request. You also have the right to receive a list of certain types of disclosures of your information that we may have made other than for the purposes of treatment, payment, and health care operations. If you believe that information in your record is incorrect, you have the right to request an amendment.

Our Legal Duty

We are required by law to protect the privacy of your information, provide the Notice of Privacy Practices, follow the practices described in the notice, and seek your acknowledgement of receipt of the notes. Before we make a significant change in our policies, we will change our Notice of Privacy Practices and post the new notice. You can also request a copy of our notice at any time.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact us at any time. You may also send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

I HEREBY ACKNOWLEDGE: I have reviewed the information above of the Notice of Privacy Practices.

Please sign and print your name, and note the date on which you signed this acknowledgement form and return it to the front office personnel.

Signature:

Printed Name:

Date:

DISTRESSING EVENT QUESTIONNAIRE

Developed by Leslie K. Pielack, MA

Please answer the questions below as they apply to you. Check all that apply or put a question mark next to an item about which you are uncertain –

Have you experienced any of the following distressing events during any part of your life?

- Long separation from one or both parents
- Abandonment by caretaker(s) for periods of time
- Death of parent(s)
- Diagnosis of severe life-threatening illness
- Severe/serious injury to self
- Severe/serious injury to others
- Severe physical discipline or abuse at home
- Other violent personal attack (robbery, assault, etc.)
- Rape by stranger
- Sexual molestation by known person
- Witnessed violence toward others
- Witnessed physical abuse of others
- Witnessed sexual abuse of others
- Hostage/kidnapping
- Victim of war/military conflict
- Military combat/prisoner of war
- Political prisoner/torture
- Natural or man-made disaster
- Unexpectedly witnessing a serious injury, dead body or body parts
- Learning of sudden death/serious injury/illness/violent attack of loved one
- Experiencing an event which made you feel intensely afraid/helpless/horrified
- Other distressing event(s) _____

Please indicate which of the following problems you have had:

- Recurrent or intrusive recollections/memories of event (images/thoughts/perceptions)
- Recurrent distressing dreams of the event or night terrors
- Flashbacks: Acting/feeling as if part or all of the event was happening again (reliving the experience illusions, hallucination-type experiences); can occur on awakening or when intoxicated
- Intense psychological distress when exposed to internal/external reminders or symbols of the event
- Intense physical reaction when exposed to internal/external reminders of the event
- Efforts to avoid thoughts, feelings or conversations associated with the event
- Efforts to avoid activities, places or people that arouse recollections of the event
- Inability to recall an important aspect of the event; blanks in your memory
- Loss of interest or participation in significant activities
- Feeling numb, having a sense of no feelings or unable to have certain feelings (i.e. loving feelings)
- Feeling detachment or estrangement from others
- No sense of or hope for future (not expecting to have a career/marriage/children/normal life span)
- Reduction in awareness of your surroundings (feeling in a daze)
- Feeling like your surroundings are not real or that you are not real or are detached from your body
- Difficulty falling or staying asleep
- Irritability or outbursts of anger
- Difficulty concentrating
- Hyper-vigilant (always feeling a sense of alarm, not being able to relax, not feeling safe)
- Exaggerated startle response
- Other _____

Length of time you have been experiencing these problems _____

Overall, how much have these problems affected your personal/social/occupations well-being? (Circle one)

1. Very Little 2. Somewhat 3. Significantly 4. Quite a Lot 5. Excessively