Daytona Beach
Christian Counseling

CLIENT INTAKE FORM

PLEASE FILL OUT THE FOLLOWING INFORMATION AS COMPLETELY AS POSSIBLE.

Client's Full Legal Name:_____ Date:_____/____/ _____

Address: _____

City: _____ State:_____ Zip: _____

Phone: (H)_____ (C) _____ If child, second parent phone: _____

Date of Birth: _____/_____/_____ Email: _____

Family Member Names	Date of Birth	Relationship	Phone Number and/or Email Address

How were you referred to SI Christian Counseling? ○ Insurance Co. ○ Physician ○ School ○ Church

○ Friend ○ Advertising ○ Google ○ Other: _____

Birth Sex: _____ Gender Identity: _____

Sexual Orientation: _____

Race: _____ Ethnicity: _____

Place of Employment: _____

Job Title: _____ Number of years at current job: _____

Highest education completed: ○ High school/GED ○ Some college ○ College ○ Graduate/other

Marital Status: ○ Single ○ Engaged ○ Married ○ Separated ○ Divorced ○ Widowed

If married, spouse's name: _____ Date of Birth ___/____/_____

Spouse's occupation and place of employment:_____

Number of years married: _____

Is there a racial or ethnic group you identify with (or your parents) that you'd like me to be aware of?

_____

Do you consider your spiritual life a resource? ○ Yes ○ No

What is your religious affiliation (optional)_____

Attendance: ○ Regularly ○ Sometimes ○ Never

THE FOLLOWING QUESTIONS ARE DESIGNED TO HELP ME UNDERSTAND YOUR BACKGROUND. PLEASE COMPLETE THEM AS THEY APPLY TO YOU. THANK YOU.

Parent's names: (F) _____ Age_____ Deceased_____

(M) _____ Age_____ Deceased_____

○ Married ○ Separated ○ Divorced ○ Widowed

Number of brothers _____ sisters _____

Has anyone in your family of origin had counseling? ○ Yes ○ No

If so, for what? _____ Is

Is there any history of substance abuse or mental illness your parent's families? ○ Yes ○ No

If yes, please describe _____

Was there any physical, sexual, or emotional abuse done to you? ○ Yes ○ No

If yes, please describe _____

Are you in any way fearful of your current partner? ○ Yes ○ No

Does your partner have angry outburst or temper tantrums? ○ Yes ○ No

Has your partner ever pushed, grabbed, slapped, or hit you? ○ Yes ○ No

Please list any specific medical conditions that you have _____

_____

Are you taking any prescription medications at this time? ○ Yes ○ No

If yes, what are they? _____

_____

How long have you been taking this? _____ Who prescribed it for you? _____

What is your daily or weekly alcohol intake? _____

Do you have a past or current history of other drug abuse? ○ Yes, current ○ Yes, past ○ No

If yes, please list _____

_____

Have you been in therapy in the past? ○ Yes ○ No

If yes, when, for what, how long, and with whom? _____

_____

Was the therapy helpful? _____

What is your reason for contacting Daytona Beach Christian Counseling and seeking therapy? What are your goals?

_____

_____

_____

Is there anything else that you feel is important to this therapy process?

_____

_____

_____

Please complete the following checklist, initial and sign the Informed Consent, initial and sign the Notice of Private Practices. Return the completed packet to your therapist with your insurance card.

We look forward to working with you.

Daytona Beach Christian Counseling

Name: _____ Date: _____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU AT PRESENT:

- ○ Suicidal thoughts
- ○ Always tired
- ○ Poor appetite
- ○ Trouble sleeping
- ○ Loss of weight
- ○ Weight gain
- ○ Fast heartbeat
- ○ Frequent sweating
- ○ Dizziness
- ○ Shaky hands
- ○ Stomach trouble
- ○ Feeling tense
- ○ Cold feet and/or hands
- ○ Diarrhea
- ○ Constipation
- ○ Muscles twitching or jumping
- ○ Nausea or Vomiting
- ○ Headaches
- ○ Fainting spells
- ○ Chronic illness
- ○ Full of energy
- ○ Financial problems
- ○ Marital problems
- ○ Difficulties at work
- ○ Excessive drinking
- ○ Excessive use of drugs
- ○ Excessive spending of money
- ○ Pornography use
- ○ Problems with children
- ○ Problems with parents
- ○ Fighting and quarreling often
- ○ Overly ambitious
- ○ Difficulties at school
- ○ Confused about personal religious practice
- ○ Recent loss of someone close to me
- ○ Crying spells
- ○ Unable to have fun
- ○ Feeling easily hurt
- ○ Lacking confidence
- ○ Feeling grouchy
- ○ Depressed
- ○ Feeling lonely
- ○ Not enjoying usual activities
- ○ Feeling inferior
- ○ No one understands me
- ○ Worried about health
- ○ Can't concentrate
- ○ Can't get going
- ○ Feeling angry
- ○ Don't like being alone
- ○ Always worried
- ○ Nightmares
- ○ Feeling panicky
- ○ Can't make decisions
- ○ Can't make friends
- ○ Unable to relax
- ○ Feeling fearful
- ○ Overly sensitive
- ○ Anxious inside
- ○ Panic/Anxiety attacks
- ○ Sexual problems
- ○ Easily excited
- ○ Quick tempered / lose temper
- ○ Impatient with people
- ○ Very restless
- ○ Feel like hurting someone
- ○ Feel like smashing things
- ○ Shy with people
- ○ Loss of meaning of life
- ○ Feelings of guilt
- ○ Unable to pray
- ○ Unable to forgive
- ○ Unable to feel forgiven
- ○ Loss/Disappointment
- ○ Binging/Purging
- ○ Restricting food intake
- ○ Self-harm
- ○ Bullied
- ○ Purposefully isolating
- ○ Loss of friendships
- ○ Other

_____

Daytona Beach Christian Counseling

INFORMED CONSENT

We would like you to have a clear understanding of the services we provide and our expectations of you, our client. If you have questions or need clarification, please ask your therapist for assistance before you sign.

SERVICES OFFERED

Daytona Beach Christian Counseling provides outpatient counseling services. We work with persons 14 years and up. Licensed practitioners provide individual counseling.

We strive to return all messages as quickly as possible Monday through Friday. Routine messages left on the weekend may be returned Monday. We do not offer 24 hour crisis coverage and if your therapist is not available when you feel you are in crisis, proceed to your local hospital emergency room or call 911.

INITIAL ASSESSMENT, DIAGNOSIS, AND COUNSELING PROCESS

Initial assessments take place at the first appointment. This appointment is used to gather data, complete intake information, and to determine the best course of care. A diagnosis will be given for each client being seen, just as with a visit to a medical doctor.

If ongoing counseling is recommended, we will diligently work to provide the best therapeutic methods and tools available. For counseling to be successful, your commitment to the process is absolutely essential. This includes regular attendance and active participation, homework between sessions to enhance or speed your growth, and completion of the process through planned termination of counseling services. You may begin to find some relief of symptoms initially, and it may be tempting to terminate. However, this initial relief is often temporary if counseling is stopped abruptly. Because all therapists want to see you have the greatest growth possible during the time you are here, we will work with you to plan a successful wrap-up. This is an important part of the counseling process, and we highly encourage you to honor your own effort by not neglecting this phase.

FEES AND INSURANCE

Session fees are $175. Telephone consults less than 10 minutes are complementary if not overused. Phone sessions that last more than 10 minutes will be charged to the client directly, as phone sessions are not covered by insurance. Phone sessions are the same cost as office sessions. Payment is due at the time of service. Any checks returned by the bank will incur a fee. Any balances unpaid after 90 days will be forwarded to collections. All accounts forwarded to collections will incur a 25% Collection Fee. Continued non-payment will result in a report to the credit bureau and remain until the balance has been paid in full. We bill most insurance as a courtesy to you. If we are unable to bill your insurance company, you will be considered a Self-Pay client and must pay in full at the time of session. You will be given a receipt for your session, which you may use to request reimbursement from your insurance company. If you receive an insurance payment meant for us we ask that you send payment to us immediately.

CANCELLED OR MISSED APPOINTMENTS

Due to the nature of counseling services, we never overbook our schedules. We require 24-hours notification of cancellation. We charge an **$75 Cancellation Fee** for any appointment not canceled 24-hours in advance. If you are more than 15 minutes late for your scheduled appointment you may be asked to reschedule for another day and you will be charged the **$75 Cancellation Fee**. Insurance companies WILL NOT COVER missed appointment fees. These fees are immediately due by you. Please note that two or more instances of missed appointments without notifying your therapist may result in termination of services. In the event of inclement weather, as determined by the local school district, the cancellation fee may be waived. In order to have your fee waived you must contact the office prior to your appointment to notify the therapist that you will not arrive due to inclement weather. You are financially responsible for the time you have reserved with your therapist. You will be billed for any services not covered by insurance.

CONFIDENTIALITY

Legal and ethical standards require us to maintain confidentiality. Information cannot be divulged to any outside parties without your written consent with the following exceptions: if you are or become a danger to yourself or others, we become aware of any real or alleged abuse to children, elderly, or vulnerable peoples (in which case we are mandated reporters to the State of Florida), and if we receive a properly issued subpoena accompanied by a court order to produce records.

If your therapist receives clinical supervision, s/he will inform you of that process. If you are here with family members, your therapist will discuss expectations and limitations of confidentiality.

TRANSFER PLAN

In the event of the incapacitation, death, or termination of a therapist's practice at Daytona Beach Christian Cousneling during the course of your care, your records will remain in our possession and a new therapist will be made available to you. If you desire to transfer care outside of our practice, you may sign a release of records and we will release a standard extract from your file of the initial intake and the most recent progress notes. It is our standard policy to release records directly to another provider. Any variance will be arranged with the Director/designee.

AGREEMENT

I have read and understand the above statement on services, policies, and procedures. My signature below indicates that I give my full consent to receive services at Daytona Beach Christian Counseling.

Client (age 17 and over) _____ Date: _____

Client (spouse) _____ Date: _____

Client (age 12-16) _____ Date: _____

Client guardian (for minors) _____ Date: _____

Daytona Beach Christian Counseling

NOTICE OF PRIVACY PRACTICES

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

Daytona Beach Christan Counseling

Daytona Beach Christian Counseling only releases information in accordance with state and federal laws and the ethics of the counseling profession. This notice describes our policies related to the use and disclosure of our client's healthcare information.

"Use and disclosure of protected health information for the purpose of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes."

TREATMENT

We use and disclose health information to:

- Provide, manage or coordinate care
- Consultants
- Referral sources

PAYMENT

We use and disclose health information to:

- Verify insurance and coverage
- Process claims and collect fees

HEALTHCARE OPERATIONS

We use and disclose health information to:

- Review of treatment procedures
- Review of business activities
- Certification
- Staff training
- Compliance and licensing activities

OTHER USES AND DISCLOSURES WITHOUT YOUR CONSENT

- Mandated reporting
- Emergencies
- Criminal damage
- Appointment scheduling
- Treatment alternatives
- As required by law

CLIENT RIGHTS

In the Notice of Privacy Practices counselors are required to inform clients as to their rights under state and federal law.

Right to inspect and copy your medical billing records

- Right to inspect and copy records
- Counselor may deny this request
- Charges for copying, mailing, etc.

Right to add information or amend your medical records

- May request to amend records
- Number of days to decide
- May deny the request
- If denied, right to file disagreement statement
- Disagreement state and your response will be filled in the record
- Amendment request must be in writing

Initials: _____ Date: _____

CLIENT RIGHTS (continued)

Right to Accounting of disclosures

- For a six year period beginning with date the counselor came in to compliance
- Exceptions:
  - Disclosure for treatment, payment or healthcare operations
  - Disclosure pursuant to a signed release
  - Disclosure made to client
  - Disclosures for national security or law enforcement

Right to request restrictions on uses and disclosures of your healthcare information

- Must be in writing
- You are not obligated to agree

Right to complain

- Please contact us first
- If not satisfied, right to complain to the U.S. Dept. of Health and Human Services
- No retaliation

Right to receive changes in policy

- May request any future changes
- Request to privacy officer

Right to release your medical records

- Written authorization to release records to others
- Right to revoke release in writing
- Revocation is not valid to the extent that you have acted in reliance on such previous authorization

Right to request where we contact you

- Home ○ yes ○ no Leave message? ○ yes ○ no
- Text ○ yes ○ no Leave message? ○ yes ○ no
- Voicemail ○ yes ○ no Leave message? ○ yes ○ no
- Email ○ yes ○ no Email: _____
- If not, how may we contact you: _____

RELEASE OF ACCOUNT INFORMATION

This is not an authorization to release any medical information, this is simply an authorization for who we may speak with regarding your account balance and insurance claims.

○ I authorize the release of information including account and claims information. This information may be released to:

○ Spouse _____ Phone_____

○ Other _____ Phone_____

○ Information is not to be released to anyone

This document will remain in effect until terminated by me in writing.

I have read and received a copy of this document outlying notice of privacy practices

Signature: _____ Date: _____

Signature: _____ Date: _____
(any other family member included in therapy)