INTEGRITY COUNSELING

Please complete and sign the following forms to assist you in starting services as soon as possible.

Full Name:	
Email Address:	
Phone Number:	
Today's Date:	

INTEGRITY COUNSELING

CLIENTS RIGHTS

You have the right to ask questions about anything that happens in counseling. Your counselor is always willing to discuss any part of your therapy with you or engage in other therapeutic approaches you believe might be helpful to you. A treatment plan will be developed by your counselor based on the issues and goals that you have discussed. You are highly encouraged and urged to participate in formulating your treatment plan. You can and should have a very active voice in your treatment and counseling sessions. If you have concerns or you are unhappy with any aspect of your therapy, we hope you will discuss these concerns with your counselor; your counselor is open to any feedback you have for them.

You are also welcome to contact Integrity Counseling Executive Director, Lina Frazier for any issues, positive feedback or concerns.

You have the right to end therapy at any time without any moral or legal obligations. The only financial obligations in ending therapy will be those already accrued. Payment is received during the beginning or end of each session on that day. Unless we are billing your insurance.

It is also best practice to let your counselor know when you are considering discontinuing therapy so there is opportunity to gain good closure for the work you have done in counseling. Integrity Counseling will not keep inactive counseling cases in an open status if the client is no longer attending counseling.

Your file will be closed if you have not made any appointments or attended counseling after 45 days. The relationship between the counselor and client will automatically terminate at that time and the client fie will be considered closed. The client is free to reopen their case and return to counseling at any time. Depending on the length of time new intake forms may be required to be filled out and signed again. New forms to release information may be requested to be signed again and adding any new emergency contacts.

In order to provide the best services possible, counselors will compile written case notes which include diagnosis, treatment plans, all clinical notes, correspondence, and signed documents. All of the documents and records are subject to the strict confidentiality guidelines described in this document and in Chapter 400 of the Nevada Medicaid regulations if applicable. Case notes are required by State law to be kept for a period of five (5) years after a minor client turns 18, and audio or video recordings are destroyed immediately after supervision.

Therapy sessions are 50 minutes long.

_____ _____

Patient Name Patient Signature and Date

INTEGRITY COUNSELING

CONFIDENTIALITY

In general, he privacy of all communications between a client and a therapist is protected by laws. Your counselor can only release information about your sessions and communication with your written permission only. However, there are a few exceptions which are described below:

__Duty to Warn and Protect

If your therapist/staff have reason to believe or suspect that you will harm another person, your therapist must attempt to inform that individual or individuals of your intentions. Your therapist will also contact the appropriate authorities to ask them to protect your intended victim.

__Duty to Protect against Suicide

If your therapist/staff believe that you are in imminent danger of harming yourself or ending your life and you are unable to take steps to guarantee your safety (a written contract may be requested to be in place), your therapist is obligated to call the appropriate authorities.

__Abuse of Children and Vulnerable Adults

If your therapist/staff has reason to believe that you are currently or have previously abused or neglected a minor or a vulnerable adult, or if you give your therapist information that someone else is doing this, your therapist must inform the appropriate authorities. Mental healthcare professionals are also required to report admitted prenatal exposure to controlled substance that are potentially harmful.

__Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information they request regarding services to clients. Information that may be requested includes types of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

__Court Orders

Occasionally the court may, by power of subpoena, attempt to obtain the release of privileged information against the client's wishes. In such cases, your therapist/staff will attempt to protect your confidentiality. Therapist may be ordered to release information despite his/her efforts.

__Professional Consultation

Your counselor/staff may consult with other mental health professionals about your case in a confidential manner to gain additional insight and improve the services offered to you and if applicable your family members (if family therapy). If you are seeing an intern, the intern will be discussing your case with their approved supervisor in order to five you the best possible

treatment and services. The consultant and/or supervisor is also legally bound to confidentiality in these circumstances The intern will inform you of the names of their supervisors if requested.

__Quality Assurance

You may be contacted by the Executive Director or staff for questions concerning the services that you are receiving from your counselor or other staff from Integrity Counseling. We would like to obtain your opinion of the areas that your counselor excels or if any improvements are required. Our goal is for you to receive excellent services from Integrity Counseling. We will continuously strive to do our best with your feedback taken into account. Your feedback is always appreciated.

_____	_____
Client Name	Client Signature and Date
_____	_____
Name of Legal Guardian or parent (under 18)	Signature of Legal Guardian or parent-

Date : / /

INTEGRITY COUNSELING

INFORMED CONSENT

Welcome to Integrity Counseling. We appreciate you choosing us to sere you and your family. This document contains important information about our services and is designed to help you understand the professional relationship between you and your therapist/counselor.

Please discuss any questions that you may have with your counselor at the time that you sign this document.

Integrity Counseling services and counselors:

Integrity Counseling has different types of counselors with different backgrounds, experience and certification. Your therapist will discuss their background, licensure and educational background with you.

Integrity Counseling has amazing therapists, counselors and staff with many years of experience in the mental health field. We respect the diversity in all of our clients and offer services to all people regardless of differences in faith or background.

Integrity Counseling offers the following services:

- Individual and Family therapy
- Basic Skills Training
- Psychosocial Rehabilitation
- Case Management
- Life Coaching
- Parenting Classes
- Groups on different mental health diagnosis such as anxiety, depression and more

The Therapeutic Process:

Therapy is not easily described in general statements. It varies depending on the personalities of both the therapist and the client and the particular problems being addressed. Different counselors will use different approaches, counseling techniques, and interventions depending on the client and the counseling issues being presented. Therapy also calls for a very active effort on your part. It is imperative for you to be an active part of your therapy session.

The therapy process can have benefits and risks. Change is difficult and the process of change can sometimes feel uncomfortable. It is common that sometimes you may experience feelings

of sadness, guilt, anger, frustration, loneliness and helplessness due to discussing some unpleasant aspects of your life. Those painful and uncomfortable feelings are a normal part of the process on the way towards healing. Getting through the process can also give you a feeling of relief, improvement and happiness.

Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Being consistent with sessions and being dedicated to the process will help tremendously. However, there are no guarantees as to what you will experience as each person can be different. You can ask your counselors more questions in regards to the therapy process during some of your sessions and as treatment progresses.

Fees for Court Services:

Counselors from Integrity Counseling are not available to testify in court for you. Counselors will not agree to attend court with you but we recognize they may receive a subpoena to appear. If you, your attorney, a judge, or another attorney subpoenas your counselor to appear in court or take a deposition for your court case, you agree to pay for their time. Court can be unpredictable; therefore, our experience has shown that your counselor will need to block a full day in their schedule to appear in court. The counselor's fees for appearing in court is $150 per hour or $1,200 for the day. You agree to pay this fee in advance for this service if deemed necessary.

Contacting Your Therapist and Emergencies: Integrity Counseling is open Monday through Friday 9am-5pm including Saturday and Sunday but by appointment only. We are close on legal Holidays.

If you have an after-hours emergency, please call 911 or go to the nearest emergency room. You can reach your counselor during regular business hours. However, therapeutic services will normally only be discussed during a scheduled appointment. Phone and email communication should be used for scheduling or other questions you may have for your counselor. Please be aware that phone, email and other forms of electronic communications are not completely confidential forms of communications.

Weekend and Evening appointments:

Integrity Counseling does offer weekend and evening appointments to try and accommodate different schedules. While the office is closed during these times, advance appointments can be made for counseling. Weekend and evening appointments are paid in advance.

_____ _____

Client Name Client Signature and Date

INTEGRITY COUNSELING

COVID-19 QUESTIONNAIRE

DISCLAIMER OF LIABILITY: This document was prepared by the Society of Chemical Manufacturers and Affiliates (SOCMA) and is disseminated for information and educational purposes only. This information is not intended as legal guidance and does not create any legal relationship or responsibility between SOCMA and user. Nothing contained herein is intended to revoke or change the requirements of specifications of individual manufacturers or local state and federal officials that have jurisdiction in your area. The user is responsible for assuring compliance.

Safety is a core value of Integrity Counseling, LLC and as such the health and well-being of our employees, visitors and contractors fill out this voluntary survey before being granted access to any of our facilities.

Name: _____

Company: _____

Date: _____

1. Have you been out of the country in the past three weeks? If yes, which countries and airports did you travel through?

   Yes ☐ **NO** ☐

2. Have you experienced any of the following symptoms in the past three weeks? If yes, please check associated box.

   a. **Fever of 100.4 or higher** ☐
   b. **Cough** ☐
   c. **Shortness of Breath** ☐
   d. **Persistent Pain or Pressure in the chest** ☐

3. Have you been in close contact with anyone showing any of these symptoms or anyone who has been diagnosed with COVID-19 (Coronavirus).

   Yes ☐ **NO** ☐

Integrity Counseling
BILLING SHEET

PATIENT NAME	
Patient's Full Address	
Insurance Company Name:	**MEDICAID FFS / ANTHEM / SILVER SUMMIT**
If you are enrolled in Medicaid which plan?	
	MEDICAID ID# _____
Phone Number:	EMERGENCY CONTACT:
DATE OF BIRTH:	Emergency Contact Relationship:
PATIENTS SS #:	Emergency Contact Mobile Number:
ASSIGNMENT OF INSURANCE BENEFITS	
I hereby authorize direct payment of medical benefits ton Integrity Counseling for services rendered by him. I understand that I am financially responsible for any balance not covered by my insurance.	
AUTHORIZATION TO RELEASE INFORMATION	
I hereby authorize Integrity Counseling office and the medical billing office to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.	
MEDICAID	
I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payments of authorized benefit be made on my behalf.	
AUTHORIZATION FOR TREATMENT	
I hereby give my consent to treatment by Integrity Counseling and any/all providers working with Integrity Counseling.	

INSURANCE DISCLOSURE

I hereby certify that I do not have any other health insurance other than Medicaid.

HIPAA

I hereby certify that I did receive a copy of the HIPAA paperwork and understand my rights.

PATIENT SIGNATURE _____ DATE: _____

PARENT / GUARDIAN SIGNATURE _____ DATE:_____

A PHOTOCOPY OF THESE ASSIGNMENTS SHALL BE VALID AS THE ORIGINAL.

INTEGRITY COUNSELING

GRIEVANCE POLICY

1. Confidentiality: All Grievance procedures shall ensure the confidentiality of consumer records as define by State and Federal Laws.
2. Discrimination: Consumers shall not be subject to any discrimination, penalty, sanction, or for filling a grievance.
3. The concern will be addressed according to the Grievance policy of Integrity Counseling when a concern is turned in against any providers or staff members of Integrity Counseling.

The Grievance should include the following:

Date and Nature of the problem/complaint

Suggestion to resolving the complaint

Documentation of Grievance:

Grievance will be recorded in Integrity Counseling log for within 24 hours of receipt of grievance.

Information to be included in log:

Name of Client

Date of Receipt of the Grievance

Review of Grievance and follow up:

Review Grievances for resolution in a timely manner by Quality Assurance staff and Operations manager.

Contact person who submitted the Grievance within 48 hours and e-mail them as well

Document date of contact / letter sent to client for resolution

Integrity Counseling will provide a resolution of the client's grievance as quickly and as simply as possible

Monitor action taken to resolve the problem

Within 30 calendar days; every attempt will be made to resolve the Grievance

Verbal Grievances can also be made by calling: (702) 499-4922 or Fax: (702)476-4851

Grievances can also be mailed to: 11700 West Charleston Blvd #170-690 Las Vegas, Nevada 89135

INTEGRITY COUNSELING

DETAILED INSURANCE INFORMATION

Client Information

Full name: _____ DOB: _____

Address: _____

City: _____ State: _____Zip: _____

Social Security Number: _____

Insurance Information: _____

Insurance Company: _____ ID Number: _____

Group Number if applicable: _____ Employer: _____

Insured DOB: _____ Phone Number for Insurance: _____

Does Integrity Counseling have your permission to bill your Insurance company for services?

YES☐ NO☐

_____

Client Name

_____

Client Signature

Today's Date: / /

INTEGRITY COUNSELING

INTAKE - CLIENT INFORMATION

All of the following information is confidential. Please answer to the best of your knowledge.

Please Print

Name: _____Date: _____

Parent/Legal Guardian (if under 18): _____

Age: _____ DOB_____ ☐ Male ☐ Female Email: _____

***Please Note that e-mail correspondence may not be considered confidential medium of communication.**

Address:

_____

City _____ State _____ Zip Code _____

Preferred way of contact:

CELL _____ Home _____Work_____

Does Integrity Counseling have permission to leave a message on phone? Yes ☐ No ☐

Personal Information:

Occupation: _____ Employer: _____

How long at your job: _____ Annual Household Income: _____

Education: ☐ GED ☐ High School ☐ Bachelor ☐ Masters ☐ Doctorate

Faith Background? ☐ Christianity ☐ Judaism ☐ Islam ☐ Buddhism ☐ Hinduism

☐ None Other: _____

Marriage Information/ Marital Status:

☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed ☐ Domestic Partnership

Spouse Name: _____Date of Marriage: _____

Ave you ever been separated? ☐ Yes ☐ No If yes, How long? _____

Have either of you filed for Divorce? ☐ Yes ☐ No If yes, Date:_____

In a Relationship? ☐ Yes ☐ No Name of Partner (optional) : _____

Contact information of Partner (optional)

_____

Have you ever been in counseling for your marriage or relationship? _____ Yes _____ No

Number of Children? _____ Children's Ages: _____

Previous Marriages:

1. Year married _____ How Long: _____ Divorced _____ Yes _____ No
2. Year married _____ How Long: _____ Divorced _____ Yes _____ No
3. Year married _____ How Long: _____ Divorced _____Yes _____ No

Who can we thank for referring you to Integrity Counseling?

Name: _____Relationship: _____Phone Number: _____

Agency/ Doctor: _____ Phone Number: _____

☐ Yelp ☐ DFS ☐ Court Ordered ☐ Instagram Other: _____

Have you ever been in counseling, psychotherapy, life coaching, or a psychiatrist? ☐ Yes ☐ No

Have you ever been prescribed psychotropic medication in the past? ☐ Yes ☐ No

Reason for medication(s)?_____

Please list the names an the dates given?

_____

_____

Are you currently taking any medication: ☐ Yes ☐ No

List of Medications:

1. _____ Dosage: _____ Times per day: ____
2. _____ Dosage: _____ Times per day: ____
3. _____ Dosage: _____ Times per day: ____

What are the prescriptions for?

_____

_____

Questions:

Do you suffer from Insomnia? ☐ Yes ☐ No

How would you rate your current sleeping habits?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good

How many hours do you usually sleep per night? ____What time do you usually go to bed? ____

1. How would you rate your current medical health?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good

2. How many times per week do you exercise? _____
3. Please list any difficulties you experience with your appetite or eating habits:

_____

4. Are you currently experiencing overwhelming sadness, grief or depression? ☐ yes ☐ No
5. Are you currently experiencing anxiety, panic attacks or have any phobias? ☐ Yes ☐ No

If yes for approximately how long? _____

6. Have you been hospitalized recently? ☐ yes ☐ No If yes, Dates: _____
7. Do you drink alcohol? ☐ No ☐ Once a week ☐ Twice a week ☐ More
8. How do you engage in recreational drug use? ☐ Daily ☐ Weekly ☐ Monthly ☐ Never
9. Are you currently in a romantic relationship? ☐ Yes ☐ No IF yes, How long? _____

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

10. Do you have any pets at home? ☐ Yes ☐ No

Issues:

Alcohol/Substance Abuse	☐ Yes/No ☐	Anxiety	☐ Yes/No ☐
Depression	☐ Yes/No ☐	Chronic Pain	☐ Yes/No ☐
Eating Disorders	☐ Yes/No ☐	Sexual Identity	☐ Yes/No ☐
Obesity	☐ Yes/No ☐	Domestic Violence	☐ Yes/No ☐
Suicide Attempts	☐ Yes/No ☐		

If yes Dates and number of attempts:

_____

Do you have any medical Issues that we need to be aware of? ☐ Yes ☐ No

If yes, explain:

_____

Emergency Contact:

Name: _____ Relation: _____

Cell: _____ Home: _____

Address: _____City: _____ State: _____Zip: _____

INTEGRITY COUNSELING

CONCERNS QUESTIONNAIRE (INDIVIDUALS ONLY)

Name: _____

This questionnaire is to help your counselor get a better idea of your major concerns for your counseling sessions. This information can assist in developing part of your treatment plan. Please answer each question to the best of your ability and truthfully. Parents can complete this questionnaire for children under 12 years of age.

1. Please describe in your own words the problem/problems you are currently experiencing and would like to address in your counseling sessions.
2. What are some of your goals for your counseling and what are you looking to gain from these sessions?
3. Which of the followings best represents your most important concern and that you need counseling for?

   _____ Marital Problems

   _____ Problems with your children

   _____ Problems with Parents

   _____ Addiction

   _____ Mental Health (Be specific if already diagnosed)

   _____ Other

4. How bad is the problem?

   Not much of a Problem Average Severe

   ☐0 ☐1 ☐2 ☐3 ☐4 ☐5

5- How much does it affect your life ?

☐0 ☐1 ☐2 ☐3 ☐4 ☐5

6- How confident and willing are you to work to change that problem?

☐0 ☐1 ☐2 ☐3 ☐4 ☐5

INTEGRITY COUNSELING

Mental Health Services Referral Form

Referring Provider Name/Agency _____Person making referral _____

Phone Number _____ E-mail _____

Mailing Address: _____City _____ State_____ ZIP _____

PATIENT DEMOGRAPHIC INFORMATION

Patient's Name _____ DOB _____

Home Number _____ Cell Number _____

Address _____City _____State ____ Zip Code ____

Race _____ Sex _____ Religion _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Emergency Contact Name _____ Relationship to Client _____

Phone Contact Number _____

INSURANCE INFORMATION

Insurance Type ☐ Medicaid FFS ☐ Silver Summit ☐ Cash Pay ☐ Other

Insurance ID Number _____

CLINICAL INFORMATION

Referral Reason

_____

Services Requested: ☐ Therapy ☐ Assessment ☐ PSR ☐ BST

Psychiatric Diagnosis (Including Substance abuse)

_____

Relevant Medical Diagnosis

_____

Relevant Social Factors

_____

PAST PSYCHIATRIC HISTORY AND TREATMENT

History of Violence? ☐ No ☐ Yes, Details

History of Suicide Attempts? ☐ No ☐ Yes, Details

History of Psychiatric Hospitalization? ☐ No ☐ Yes, Details

CURRENT PSYCHIATRIC TREATMENT AND HISTORY

Current Symptoms

Current Suicidal/ Homicidal thoughts? ☐ No ☐ Yes, Details

Does client have a current outpatient mental health provider? ☐ No ☐ Yes, Details

Current Psychiatric Medications (name and dose, attach list if preferred)

Additional Information:

Please send previous Treatment Plan if there is one.

You are all done!

Please save this document and e-mail it to the following:
linaintegritycc@gmail.com

Or simply press here