Welcome to L.O.L. Counseling and Consulting Services, LLC! Thank you for taking a few minutes to fill out this form. The information you provide is confidential, and will be helpful for you and your counselor when you meet for the first time. If you have any questions, please contact us at (205) 775-6037 or email us at lolcounselingservices@gmail.com

Client Intake Application

Patient Name:	Social Security #:
Street Address:	Date of Birth:
City, State, Zip Code:	Home Phone:
Gender:	Work Phone:
Email Address:	Mobile Phone:
Primary Physician:	Psychiatrist (if any):
Emergency Contact Person:	Emergency Contact Phone:
How did you hear about us?	Marital Status:

Responsible Party is the person who will be paying the per-session fee for services (leave blank if same as patient)

Responsible Party:	Home Phone:
Street Address:	Work Phone:
City, State, Zip Code:	Mobile Phone:
Relationship to Patient:	Responsible Party SSN:

Insurance Information (If Applicable)

Primary Insurance:	Policy Holder Name:
Company Address:	Policy Holder Date of Birth:
City, State, Zip Code:	Identification Number:

Company Phone:	Policy/Group Number:
Employer:	Policy Holder SSN:
Secondary Insurance:	**Policy Holder Name:**
Company Address:	Policy Holder Date of Birth:
City, State, Zip Code:	Identification Number:
Company Phone:	Policy/Group Number:
Employer:	Policy Holder SSN:

Crisis Information:

- Are you having any current suicidal thoughts, feelings or actions? Y______ N______
- If yes, explain ____
- Any current homicidal or violent thoughts or feelings, or anger-control problems? Y_____ N_____
- If yes, explain ____
- Any issues, hospitalizations, or imprisonments for suicidal or assault behavior? Y______ N_____
- If yes, describe ____
- Any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)? Y__ N___
- If yes, describe ____
- Who referred you to us? ____

Are you on any medications? Y___N___ If so, what and why? ____________________

How can we help? Please tell us in your own words what brings you here today____

____

____

What are your 2 most important goals for therapy?

1.

____

2.

____

Have you participated in any therapy before? Y___N___
If yes, when? ________ Reason ________________________

Are you, currently seeing a psychiatrist, or therapist? Y____ N___

Have you or a family member ever been hospitalized for mental or emotional illness? Y_____ N_____
If yes, please explain—dates, where, reason: ____

Common problem/symptom checklist. Fill in: 0 - none, 1 - mild, 2 - moderate, 3 - severe. ___marriage

___divorce/separation ___alcohol/drugs ___God/faith ___pre-marital
___other addictions ___church/ministry ___being single ___disabled
___past hurts ___sexual issues ___work/career ___depression
___family ___school/learning ___fear/anxiety ___intimacy
___money/budgeting ___anger control ___communication ___parents
___loneliness ___self-esteem ___in-laws ___weight control
___mood swings ___stress control ___child custody ___grief/loss
___aging/dependency ___codependency ___children

THANK YOU *for taking the time to fill out this information sheet. This will be reviewed with you during your first counseling session.*

______________________________________ ____________________
Signature of Client Date

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to it. Please review carefully.

1. Your medical records are used to provide treatment, bill and receive payments, and conduct healthcare operations. Examples of these activities include but not limited to review of treatment records to ensure appropriate care, electronic or mail delivery of billing for treatment to you or other authorized payers, appointment reminder telephone calls, and records review to ensure completeness and quality of care. Use and disclosure of medical records is limited to the internal used outlined above except required by law or authorized by the patient or legal

2. Federal and State laws require abuse, neglect, domestic violence and threats to be reported to social services or other protective agencies. If such reports are made they will be disclosed to you or your legal representative unless disclosure increases risk of further

3. Disclosed information will be limited to the minimum necessary. You may request an account for any uses or disclosures other than those described in Sections 1 and Sections 2.

4. You, or your legal representative, may request your records to be disclosed to yourself or any other entity. Your request must be made in writing, clearly identify the person authorized to request the release, specify the information you want disclosed, the name and address of the entity you want the information released to, purpose and the expiration date of the authorization. Any authorization provided may be revoked in writing at anytime. Psychotherapy notes are part of your medical records. We have 30 days to respond to a disclosure request and 60 days if the records is stored off site.

5. A request for disclosure may be denied under the following circumstances: disclosure would likely endanger the life or physical safety of you or another person, requested information references other persons, except another healthcare provider, or if released to a legal representative would likely result in harm.

6. If a request for disclosure is denied for reasons outlined in Section 5, you or your legal representative may request review of the denial. A review will be conducted by another licensed healthcare provider appointed by the original reviewer, who was not involved in the original decision to deny access. A review will be concluded within 30 days.

7. You may request that we restrict uses and disclosures outlined in Section 1. However, we are not required to agree to the restrictions. If an agreement is made to restrict use or disclosure, we will be bound by such restriction until revoked by you or your legal representative orally or in writing except when disclosure is required by law or in an emergency. We may also revoke such restrictions but information gathered while required by law or in an emergency. We may also revoke such restrictions but information gathered while the restriction was in place will remain restricted by such an agreement.

8. This agreement may be modified or amended as required by law or in the course of health care operations.

I HAVE READ AND UNDERSTOOD THIS PRIVACY NOTICE AND MY RIGHTS CONCERNING USE AND DISCLOSURE OF PROTECTED HEATLH CARE INFORMATION.

______________________________ ________________

Client (please print) Date

______________________________ ________________

Signature of Client Date

No Show, Late Cancellation and Co-payment Policy

1. I understand that I will be charged a LATE CANCELLATION fee of **$25** if I fail to give at least 24 hour notice prior to cancelling my appointment.

2. I understand that I will be charged a NO-SHOW fee of **$25** if I fail to show for my appointment.

3. I understand that I am responsible for knowing my co-payment amount and deductible amount. My co-payment amount per session is ______; my deductible amount per year is ___________. Have you met your deductible for this year? □YES □ NO If no, how much more do you have to pay towards your deductible?__________________

4. I understand that I will be charged a **$10** service charge if I fail to make my payment and/or co-payment at the time of my appointment.

5. I understand that these charges are an out of pocket expense and that my insurance carrier will not cover these charges.

6. I understand that the therapy session will last **60** minutes. I understand that if I am late to the appointment, I will still have to end the session at the allotted time. By signing this, I am agreeing to the above stated terms and stipulations regarding the services I receive from this therapist.

____

Signature of Responsible Party

____

Date