



# Peculiar One Counseling & Consulting

*Where the Mind Matters*

## Intake Form for Counseling Services

Please complete all of the information on this form and bring it to first appointment.

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Address \_\_\_\_\_

Apt. # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Home Phone ( ) - \_\_\_\_\_ Cell Phone ( ) - \_\_\_\_\_ Work ( ) - \_\_\_\_\_

Employer: \_\_\_\_\_ Phone ( ) - \_\_\_\_\_

### Emergency Contact:

Name \_\_\_\_\_ Phone ( ) - \_\_\_\_\_ Relationship \_\_\_\_\_

May we leave a message on your phone concerning your counseling appointment?

(Check to give permission. Leave blank if no): Home \_\_\_\_ Cell \_\_\_\_ Work \_\_\_\_

### Educational History

Highest Grade Completed? \_\_\_\_\_ Where? \_\_\_\_\_

Did you attend college? \_\_\_\_\_ Where? \_\_\_\_\_ Major? \_\_\_\_\_

What is your highest educational level or degree attained? \_\_\_\_\_

### Military History

Have you ever served in the military? \_\_\_\_\_ If so, what branch and when? \_\_\_\_\_

### Current Symptoms

Checklist: (check once for any symptoms present, twice for major symptoms)

( ) Depressed mood ( ) Racing thoughts ( ) Excessive worry ( ) Unable to enjoy activities

( ) Impulsivity ( ) Anxiety attacks ( ) Sleep pattern disturbance ( ) Increase risky behavior

( ) Avoidance ( ) Loss of interest ( ) Increased libido ( ) Hallucinations

( ) Concentration/forgetfulness ( ) Decrease need for sleep ( ) Suspiciousness ( ) Fatigue

( ) Crying spells ( ) Decreased libido ( ) Change in appetite ( ) Excessive energy ( )

\_\_\_\_\_ ( ) Excessive guilt ( ) Increased irritability ( ) \_\_\_\_\_



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**List ALL current prescription medications** and how often you take them: (if none, write none)

Medication Name Total Daily Dosage

Medication	Dosage	Medication	Dosage

## Past Psychiatric History

**Outpatient treatment** ( ) Yes ( ) No If yes, Please describe when, by whom, and nature of treatment.

Reason Dates Treated By Whom

Therapist	Location	Dates	Reason

## Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No.

If YES, please answer the following. If NO, please skip to the next section.

Do you **currently** feel that you don't want to live? ( ) Yes ( ) No

How often do you have these thoughts? \_\_\_\_\_

When was the last time you had thoughts of dying? \_\_\_\_\_

Has anything happened recently to make you feel this way? \_\_\_\_\_

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? \_\_\_\_\_

Would anything make it better? \_\_\_\_\_

Have you ever thought about how you would kill yourself? \_\_\_\_\_

Is the method you would use readily available? \_\_\_\_\_

Have you planned a time for this? \_\_\_\_\_

Is there anything that would stop you from killing yourself? \_\_\_\_\_

Do you feel hopeless and/or worthless? \_\_\_\_\_

Have you ever tried to kill or harm yourself before? \_\_\_\_\_

Do you have access to guns? If yes, please explain. \_\_\_\_\_



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**Psychiatric Hospitalization** ( ) Yes ( ) No If yes, describe for what reason, when and where.

Reason Date Hospitalized Where

Hospital	Dates	Location	Reason

### **Family Psychiatric History:**

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder ( ) Yes ( ) No Schizophrenia ( ) Yes ( ) No

Depression ( ) Yes ( ) No Post-traumatic stress ( ) Yes ( ) No

Anxiety ( ) Yes ( ) No Alcohol abuse ( ) Yes ( ) No

Anger ( ) Yes ( ) No Other substance abuse ( ) Yes ( ) No

Suicide ( ) Yes ( ) No Violence ( ) Yes ( ) No

If yes, list each family member and their diagnosis

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### **Substance Use:**

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substances? \_\_\_\_\_

If yes, where were you treated and when? \_\_\_\_\_

How many days per week do you drink any alcohol? \_\_\_\_\_

What is the least number of drinks you will drink in a day? \_\_\_\_\_

What is the most number of drinks you will drink in a day? \_\_\_\_\_

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? \_\_\_\_\_

Have you ever felt you should cut down on your drinking or drug use? ( ) Yes ( ) No

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you used any street drugs in the past 3 months? ( ) Yes ( ) No

If yes, which ones? \_\_\_\_\_

Have you ever abused prescription medication? ( ) Yes ( ) No

If yes, which ones and for how long? \_\_\_\_\_

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### **Trauma History**

Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No.

Please describe when, where and by whom: \_\_\_\_\_

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## **Relationship History and Current Family:**

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( ) Widowed How long? \_\_\_\_

If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? \_\_\_\_

Describe your relationship with your spouse or significant other: \_\_\_\_\_

Have you had any prior marriages? ( ) Yes ( ) No. If so, how many? \_\_\_\_\_

Do you have children? ( ) Yes ( ) No If yes, list ages and gender: \_\_\_\_\_

List everyone who currently lives with you \_\_\_\_\_

## **Insurance**

Insurance Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Claims Address: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Authorization Code (if required): \_\_\_\_\_ Copay: \_\_\_\_\_

IF EAP: EAP Company: \_\_\_\_\_ EAP Authorization # \_\_\_\_\_

No. of visits \_\_\_\_\_



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## AGREEMENT FOR THERAPY

1. Therapy sessions are scheduled, as much as possible, for your convenience. Therefore, cancellations must be made at least 24 hours in advance; or you will be billed the full private pay fee for the session.
2. No additional appointments will be made after three consecutive no-shows or five consecutive late cancellations. Appointments will be suspended, if your account reaches an unpaid balance of \$150 or more, until the balance is paid. We are willing, at any point, to give you a referral.
3. Therapy sessions will be 45 minutes in length unless otherwise agreed upon by you and your therapist.
4. Payment for services is due at the time they are rendered unless prior arrangements are agreed upon with your therapist. If you have insurance coverage that will apply to the cost of your therapy, your therapist will cooperate in providing any appropriate information and signatures required.
5. There is a \$45 fee for any returned checks.
6. If we are unable to collect payment from you (or your insurance company), the bill will be forwarded to a collection agency.

By signing this form, I acknowledge that I have read, understand, and agree to the above.

_____	_____
<i>Signature</i>	<i>Date</i>
<i>Guardian Signature (if under age 18)</i> _____	<i>Date</i> _____
_____	_____
<i>Therapist Signature</i>	<i>Date</i>



**INFORMED CONSENT**  
(INTERACTION WITH THE LEGAL SYSTEM)

I understand that I will not involve or engage my therapist in any legal issues or litigation in which I am a party to at any time either during my counseling or after counseling terminates. This would include any interaction with the Court system, attorneys, Guardian ad Litem, psychological evaluators, alcohol and drug evaluators, or any other contact with the legal system. In the event that I wish to have a copy of my file, and I execute a proper release, my therapist will provide me with a copy of my record, and I will be responsible for charges in producing that record.

If I believe it necessary to subpoena my therapist to testify at a deposition or a hearing, I would be responsible for his or her expert witness fees in the amount of \$1,500.00 for one-half (1/2) day to be paid five (5) days in advance of any court appearance or deposition. Any additional time that my therapist spends over one-half (1/2) day would be billed at the rate of \$375.00 per hour including travel time. I understand that if I subpoena my therapist, he or she may elect not to speak with my attorney, and a subpoena may result in my therapist withdrawing as my counselor.

\_\_\_\_\_  
Signature of Patient or his/her Personal Representative      Date

\_\_\_\_\_  
Printed Name of Patient or Personal Representative      Relationship to Patient

\_\_\_\_\_  
Signature of Therapist      Date      Printed Name of Therapist



# Peculiar One Counseling & Consulting

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## **CONFIDENTIALITY (Health Insurance Portability and Accountability Act)**

### **NOTICE OF POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION**

Peculiar One Counseling & Consulting (Marcia Blane, APC) recognizes our responsibility for safeguarding the privacy of your health information. This notice provides information regarding use and disclosure of protected health information by Peculiar One Counseling & Consulting (Marcia Blane) and our affiliated mental health counselors. This notice also describes your rights and our obligations for using your health information and informs you about laws that provide special protections for your health information. It also explains how your protected health information is used and how, under certain circumstances, it may be disclosed.

#### **Understanding Your Mental Health Record Information**

Each time that you visit a hospital, a physician, or another health care provider, the provider makes a record of your visit. Typically, this record contains your health history, current symptoms, examination and test results, diagnoses, treatment, and plan for future care or treatment. This information, often referred to as your medical record, serves as the following:

- ❖ Basis for planning your care and treatment.
- ❖ Means of communication among the many health professionals who contribute to your care.
- ❖ Legal document describing the care that you received.
- ❖ Means by which you or a third-party payer can verify that you actually received the services billed for.
- ❖ Tool in medical education.
- ❖ Source of information for public health officials charged with improving the health of the regions they serve.
- ❖ Tool to assess the appropriateness and quality of care that you received.
- ❖ Tool to improve the quality of health care and achieve better patient outcomes.

**Understanding what is in your health records and how your health information is used helps you to:**

- ❖ Ensure its accuracy and completeness.
- ❖ Understand who, what, where, why and how others may access your health information.
- ❖ Make informed decisions about authorizing disclosure to others.
- ❖ Better understand the health information rights detailed below.

#### **Your rights under the Federal Privacy Standard**

Although your health records are the physical property of the health care provider who completed the records, you have the following rights with regard to the information contained therein:



## Peculiar One Counseling & Consulting

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I have received HIPAA notification from P1CC (Ms. Blane). Date: \_\_\_\_\_ Client Initials: \_\_\_\_\_

- ❖ Request restriction on uses and disclosures of your health information for treatment, payment, and health care operations. “Health care operations” consists of activities that are necessary to carry out the operations of the provider, such as quality assurance and peer review. The right to request restriction does not extend to uses or disclosures permitted or required under the following section of the federal privacy regulations: §164.502(a)(2)(i) (disclosures to you), § 164.510(a) (for facility directories, but note that you have the right to object to such uses), or § 164.512 (uses and disclosures not requiring a consent or an authorization). The latter uses and disclosures include for example, those required by law, such as mandatory communicable disease reporting. In those cases, you do not have a right to request restriction. The consent to use and disclose your individually identifiable health information provides the ability to request restriction. We do not, however, have to agree to the restriction, except in the situation explained below. If we do, we will adhere to it unless you request otherwise, or we give you advance notice. You may also ask us to communicate with you by alternate means, and if the method of communication is reasonable, we must grant the alternate communication request. You may request restriction or alternate communications on the consent form for treatment, payment, and health care operations. If, however, you request restriction on a disclosure to a health plan for purposes of payment or health care operations (not for treatment), we must grant the request if the health information pertains solely to an item or a service for which we have been paid in full.
- ❖ Obtain a copy of this notice of information practices. Although we have posted a copy in prominent locations throughout the facility and our website, you have a right to a hard copy upon request.
- ❖ Inspect and copy your health information upon request. Again, this right is not absolute. In certain situation, such as if access would cause harm, we can deny access. You do not have a right of access to the following:
  - Psychotherapy notes. Such notes consist of those notes that are recorded in any medium by a health care provider who is a mental health professional documenting or analyzing a conversation during a private, group, joint, or family counseling session and that are separated from the rest of your medical record.
  - Information compiled in a reasonable anticipation of or for use in civil, criminal, or administrative actions or proceedings.
  - Protected health information (“PHI”) that is subject to the Clinical Laboratory Improvement Amendments of 1988 (“CLIA”), 42 U.S.C. § 263a, to the extent that giving you access would be prohibited by law.
  - Information that was obtained from someone other than a health care provider under a promise of confidentiality and the requested access would be reasonably likely to reveal the source of the information.

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In other situations, we may deny you access, but if we do, we must provide you a review of our decision denying access. These “reviewable” grounds for denial include the following:

- A licensed health care professional, such as your attending physician, has determined, in the exercise of professional judgment, that the access is reasonably likely to endanger the life or physical safety of yourself or another person.
- PHI makes reference to another person (other than a health care provider) and a licensed health care provider has determined, in the exercise of professional judgment, that the access is reasonably likely to cause substantial harm to such other person.
- The request is made by your personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that giving access to such personal representative is reasonably likely to cause substantial harm to you or another person.

For these reviewable grounds, another licensed professional must review the decision of the provider denying access within 60 days. If we deny you access, we will explain why and what your rights are, including how to seek review. If we grant access, we will tell you what, if anything, you have to do to get access. We reserve the right to charge a reasonable, cost-based fee for making copies.

- ❖ Request amendment/correction of your health information. We do not have to grant the request if the following conditions exist:
  - We did not create the record. If, as in the case of a consultation report from another provider, we did not create the record, we cannot know whether it is accurate or not. Thus, in such cases, you must seek amendment/correction from the party creating the record. If the party amends or corrects the record, we will put the corrected record into our records.
  - The records are not available to you as discussed immediately above.
  - The record is accurate and complete.

If we deny your request for amendment/correction we will notify you why, how you can attach a statement of disagreement to your records (which you may rebut), and how you can complain. If we grant the request, we will make the correction and distribute the correction to those who need it and those whom you identify to us that you want to receive the corrected information.

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- ❖ Obtain an accounting of non-routine uses and disclosures, those other than for treatment, payment, and health care operations until a date that the federal Department of Health and Human Services will set after January 1, 2011. After that date, we will have to provide an accounting to you upon request for uses and disclosure for treatment, payment, and health care operations. We do not need to provide an accounting for the following disclosures:
  - To you for disclosures of protected health information to you.
  - For the facility directory or to persons involved in your care or for other notification purposes as provided in § 164.510 of the federal privacy regulations (uses and disclosures requiring an opportunity for the individual to agree or to object, including notification to family members, personal representatives, or other persons responsible for your care, or your location, general condition or death).
  - For national security or intelligence purposes under § 164.512(k)(2) of the federal privacy regulations (disclosures not requiring consent, authorization, or an opportunity to object).
  - To correctional institutions or law enforcement official under § 164.512(k)(5) of the federal privacy regulations (disclosures not requiring consent, authorization, or an opportunity to object).
  - That occurred before April 14, 2003.

We must provide the accounting within 60 days. The accounting must include the following information:

- Date of each disclosure.
- Name and address of the organization or person who received the protected health information.
- Brief description of the information disclosed. ○ Brief statement of the purpose of the disclosure that reasonably informs you of the basis for the disclosure or, in lieu of such statement, a copy of your written authorization or a copy of the written request for disclosure.

The first accounting in any 12-month period is free. Thereafter, we reserve the right to charge a reasonable, cost based fee.

- ❖ Revoke your consent or authorization to use or disclosure health information except to the extent that we have taken action in reliance on the consent or authorization.

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## Peculiar One Counseling & Consulting

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### **Our Responsibilities under the Federal Privacy Standard**

In addition to providing you your rights, as detailed above, the federal privacy standard requires us to take the following measures:

- ❖ Maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative and technical safeguards to protect the information. ☐
- ❖ Provide you this notice as to our legal duties and privacy practices with respect to individually identifiable health information that we collect and maintain about you.
- ❖ Abide by the terms of this notice.
- ❖ Train our personnel concerning privacy and confidentiality.
- ❖ Implement a sanction policy to discipline those who breach privacy/confidentiality or our policies with regard thereto.
- ❖ Mitigate (lessen the harm to) any breach of privacy/confidentiality.

We will not use or disclose your health information without your consent or authorization, except as described in this notice or otherwise required by law.

How to Get More Information or to Report a Problem If you have questions and/or would like additional information, you may contact Marcia Blane at 679-379-8450.

I have received HIPAA notification from P1CC (Ms. Blane). Date: \_\_\_\_\_ Client Initials: \_\_\_\_\_



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# Credit / Debit Card Payment Consent Form

**Client Name:** \_\_\_\_\_

**Name on Card if different than client:** \_\_\_\_\_

**Number on Card** \_\_\_\_\_

**Expiration Date:** \_\_\_\_\_

**Security Code:** \_\_\_\_\_ **Zip Code of Card:** \_\_\_\_\_

I authorize Marcia Blane Peculiar One Counseling & Consultant to charge my credit/debit/health account card for professional services. If I do not cancel before 24 hours, I recognize that Ms. Blane will charge my card as a late cancel or no show if I do not show up for the appointment. I will be billed for the full session charge:

- ❖ \$95.00 for Individual Sessions
- ❖ \$120 for Family and Couples Sessions

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

**Signature:** \_\_\_\_\_

**Printed Signature:** \_\_\_\_\_

**Initials:** \_\_\_\_\_

**Date:** \_\_\_\_\_



## No Show, Late Cancellation and Copayment Policy

1. I understand that I will be charged a LATE CANCELLATION fee of \$95 for Individual sessions and \$120 for families/couple sessions 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 \$45 for Individual sessions and \$120 for families/couple sessions 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 copayment 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 copayment 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 45 to 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.

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Signature of Responsible Party

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Date



## Peculiar One Counseling & Consulting

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### **Fragrance Free Policy**

Due to severe fragrance allergies clients and personnel are restricted from wearing perfume, oils, and scented lotions. Research indicates that fragrant sensitivity has surpassed secondhand cigarette smoke and the damaging impact on individuals with noted allergens. POCC recognizes that Marcia Blane, MS MHC is chronically diagnosed with fragrant sensitive and chronic asthma and fragrant policies must be adhered to. As client at P1CC, I agree to adhere to the fragrance-free policy by limiting fragrance use 1 hour prior to the appointment.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date