Clearsight Counseling
4948 Kootenai St. Suite 207
Boise, ID 83705
208-258-5902

Client Information			
Full Name	**SSN**	**Date of Birth**	**Gender** Male Female
Marital Status Single Married Partnered Separated Divorced Widowed	**Employment Status** Full-Time Part-Time Self-Employed Minor Retired Active Military Other:	**Student Status** Full-Time Part-Time Minor None	
Address	**City, State, & ZIP**		
Home Phone	**Cell Phone**	**Preferred Method of Contact** **Home Cell Email**	
Email Address	**Okay to contact via Email?** Yes No **Okay to send receipts or statements by Email?** Yes No		
Employment			
Employer	**Work Phone**		
Emergency Contact			
Emergency Contact Name	**Emergency Contact Phone**	**Relationship to Client**	
EAP- You must call to start this process. If you have not, your sessions may not be covered.			
Do you have an EAP? **Yes No**	**Name of EAP Company**		
Authorization Number	**Number of Sessions Approved**		
Insurance Information (Your counselor will ask for a copy of your card when you meet)			
Primary Insurance Provider	**Secondary Insurance Provider**		
ID #	**ID#**		
Group #	**Group #**		
Phone # on card	**Policy Holder’s Name (If different than client)**		
Responsible Party (If Different Than Client)			
Full Name	**SSN**	**Relationship to Client** Legal Guardian Spouse Parent of Client over 18 Other:	
Billing Address	**City, State, and ZIP**		
Billing Phone	**Email Address**		

What kind of problem brings you to Clearsight Counseling?

____

____

How would you estimate the severity of your problem? (Check one)

Mild Moderate Serious Severe

Coping in the past, what has been helpful to you in dealing with this problem?

____

____

Have you ever intentionally inflicted harm upon yourself? (Check one) Yes____ No____ Unsure ____

Have you had suicidal thoughts recently? (Check one) Frequently _______ Sometimes _______ Rarely ______ Never_______

Have you had suicidal thoughts in the past? (Check one) Frequently ______ Sometimes ______ Rarely ______ Never _______

Has anyone related to you attempted/committed suicide? ______________ If yes, what is their relation to you? ____________

Have you personally experienced emotional abuse? Frequently _____ Sometimes _____ Rarely _____ Never _____

Have you personally experienced physical abuse? Frequently ___ Sometimes ___ Rarely ___ Never ___ As a child ___ As an adult ___

Who was this person to you? Family, friend, stranger etc.______________________________________

Medical History

Primary Care Physician:____

Current Medications Prescribed to You & the Prescribing Doctor's Name: ____

____

Current Health issues that effects emotional wellbeing: ____

____

List all therapists you have seen, and approximate date you saw them:____

____

List any inpatient psychiatric treatment you have had and the approximate dates: ______________________________________

____

Physical and Substance Information

Have you used the following in the past 6 months: (check all that apply)

Alcohol _____ Marijuana ____ Amphetamines _____ Meth _____ Heroin _____ Ecstasy _____

I use alcohol or drugs to (check all that apply): Manage Stress To relax For a better mood For Sleep

Have you been in an Inpatient treatment for substance abuse? __________ Date: __________

Yes No If I die or become incapacitated a representative of Clearsight Counseling can speak with law enforcement

Yes No If I die or become incapacitated a representative of Clearsight Counseling can speak with my family

Yes No A representative from Clearsight Counseling can text me. I understand that there is no way for this representative to know definitively if the person texting from my listed number is actually me. I understand the risk associated with marking yes on this block. Additionally, I agree to indemnify and hold harmless Clearsight Counseling for any breach of confidentiality due to text communication to any number that is either listed under my contact information or has been used previously to contact me.

CADIC Depression Questionnaire

For the questions below, select the option for each question that comes closest to your answer. *Over the past two weeks* how often have you:	None or little of the time	some of the time	most of the time	all of the time
1. Experienced sadness, weepiness, or crying spells?				
2. felt hopeless, pessimistic or discouraged about the future?				
3. not been able to enjoy things?				
4. felt tired, slowed down or had no energy?				
5. felt no interest in doing things?				
6. had difficulty falling asleep or sleeping too much?				
7. had difficulty with concentration, or making decisions?				
8. had no appetite, or found yourself eating when not hungry?				
9. felt guilty or worthless?				
10. felt like you wanted to die or wished you were dead?				
11. felt restless, worried, or nervous?				
12. Had physical problems such as headaches, stomachaches or chronic pain				

The GAM Assessment

In your lifetime have you *ever* had a week where you:	Yes	NO
1. felt excessive energy to the point of being hyper, overexcited or giddy?		
2. had such an unusually high or good mood that others thought you were not yourself?		
3. felt like your mind was flooded with ideas and your thoughts were racing?		
4. did not need as much sleep as you normally do?		
5. acted impulsively by participating in risky or irresponsible behavior (i.e. wild shopping, speeding)?		
6. felt more interest in exciting, pleasurable activities than you regularly do?		
7. felt more outgoing, rowdy, or socially open that you regularly do?		
8. found yourself easily distracted by the things going on around you?		
9. felt easily irritated or annoyed by regular everyday things?		
10. If you checked "yes" to more than one of the questions above, did they occur in combination?		
11. How big of a problem did these cause you? ___ none __ mild ___ moderate ___severe		
12. Have you ever had any direct blood relative with depression, manic depression, or who was psychiatrically hospitalized?		

CAAP Anxiety and Panic Questionnaire

During the past *six months for a majority of the days* have you:	Yes	NO
1. felt nervous and anxious about things at work, home or school?		
2. had difficulty controlling worries or fears?		
3. felt restless, nervous, or on edge?		
4. felt tired, exhausted or easily worn out?		
5. had difficulty concentrating?		
6. felt easily annoyed, irritated or frustrated?		
7. had difficulty with tense or tight muscles?		
8. had trouble falling asleep or with frequent waking during the night?		
9. worried excessively about the usual issues in your everyday life?		
10. had others notice that you worry or been told that you worry too much?		
11 had these worries cause noticeable problems in your daily life or caused a lot of distress for you?		
12. **additionally, have you ever had a distinct moment in time where you felt intense fear and		
distress, and experienced at least 3 of the following: shaking or trembling, sweating, loss of breath,		
feeling dizzy or out of control, chills or hot flashes, rapid heartbeat, or fear of dying?		

TASA Trauma and Stress Assessment	Yes	No
1. *Have you ever* had or seen a traumatic event where possible loss of life, severe injury or threat of physical well-being was involved?		
2. Did you feel fear or helpless during or after the event?		
If you answered "yes" to questions 1 & 2, please proceed to the next section		

During the past week for most days have you:	Yes	NO
1. experienced reoccurring and unwanted flashbacks, nightmares or reminders of the event?		
2. made efforts to avoid thinking or talking about this event, or doing things that remind you of it?		
3. felt less interest in people and things, a feeling numbness, or trouble experiencing emotions?		
4. felt nervous, jumpy, or had a sense of heightened alertness?		
5. had trouble with irritability, falling or staying asleep or with concentrating?		

Thank you for Filling out these forms.

Please give them to me at your appointment.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

Notice of Privacy Practices:
Privacy guidelines are determined by both ethical and legal standards. HIPAA rules and counseling ethics are very detailed and sometimes require professional interpretation. Please feel free to ask any questions you have.

When you see any health care provider information is collected about you and your physical and mental health. It may be information about medical condition, insurance information, or payment requirements. All of this information is categorized as Protected Health Information (PHI). This information goes into your medical or healthcare record or file. PHI is likely to include:

- Your medical history
- Your motivation for treatment
- Diagnoses and treatment plan
- Session notes
- Records from other providers
- Psychological test scores, school records, and other reports
- Medication information
- Legal documents
- Billing and insurance information

Although your health record is the physical property of the healthcare practitioner or facility that collected it, the information belongs to you. In most cases, you have access to all the information collected by this office. In some very rare situations, you cannot access your complete record. If you find anything in your record that you think is incorrect, or believe that something important is missing, you can request an amendment to your record. In most cases your therapist will write a letter for you instead of providing copies of everything contained within your record.

Privacy and the laws

I am legally and ethically bound to comply with all HIPAA guidelines. For additional information regarding HIPAA rules please email jordan@clearsightcounseling.com.

I understand HIPAA guidelines and am aware of the privacy policies applicable to my care at Clearsight Counseling.

Client Name: ____ DOB: ________________________________

Client/Guardian Signature: ____ Date: ________________________________

Welcome!

The purpose of this packet is to inform you about the therapy I provide at Clearsight Counseling. I am glad you are here and I am honored to have the opportunity to work with you. If at any time during your experience here you have questions, please don't hesitate to ask. Your questions are welcome and often useful to the therapeutic process. As you read through this document, please initial and date each section to indicate that you have read and understand its contents.

Services

I offer the following services:

- Individual counseling for adolescents and adults
- Family/Couples counseling

I serve clients who are dealing with a wide range of issues. These may include:

- Abuse/trauma/post-traumatic stress disorder
- Depression
- Anxiety & Stress
- Marriage/Relationship issues
- Parenting issues
- Life Transition issues
- School problems
- Obsessive Compulsive Disorder
- Attention Deficit Hyperactivity Disorder
- Career Issues
- Communication Issues
- Anger Management

If you are dealing with something that is not on the list above, don't worry. Let me know what you are dealing with and I will let you know if I can help. If I cannot, I will try to help you find someone who can help you with your particular challenge.

Generally, I have found that substance abuse and addiction issues are better addressed by specialists in that area. I also have found that eating disorders respond best to a team approach which may include a counselor, but which ***must*** include a physician and a nutritionist. I do not have a psychiatrist or a medical doctor on staff. I cannot prescribe medications or make recommendations about medications. On these issues, I will defer to your physician. I do not currently offer custody evaluations, psychological evaluations or testing. I do not currently offer mediation services or services as an expert witness in court proceedings. I currently do not offer forensic interviews for abused children. I will, however, try to help you find these resources if needed.

Most clients have two or three 45-minute sessions per-month until satisfactory progress has been made. After that, sessions can be less often for several more months if needed. Therapy then usually comes to an end. If you wish to stop therapy at any time, please schedule one last session to review your progress and provide feedback.

Office hours are Monday through Friday from 10:00 am to 6:00 pm. Other appointment times are available upon request. You can call the office phone, (208)258-5902, any time during the week to schedule appointments.

Clearsight Counseling does not currently provide telephone consultations or respond to emergency telephone calls. If you find yourself in an emergency situation, please call 911 or go to the nearest emergency room immediately. If you are concerned about this limitation, please discuss this with me so I can refer you to a clinic that will better meet your needs.

Initial________________

Counseling Approach

In accordance with IBOL rule 525, you are informed that I received my Master of Arts Degree in Counseling in 2013 from Boise State University in Boise, Idaho. My undergraduate degree is in Social Sciences, and was also received from Boise State University, in 2007. I am a Licensed Clinical Professional Counselor (LCPC), License number LCPC-6314. I am EMDR trained, and a board-approved supervisor. Additionally, this rule stipulates that you will be informed that the relationship between client and counselor will always be of a professional nature only and that any sexual or inappropriate nature will not be permitted at any time. Should you feel this rule has been violated you are encouraged to file a complaint with the licensing bureau at 208-334-3233.

Please be advised that these issues have been brought to your attention in compliance with Idaho Code 54-3410A. Additionally, Licensure by the State of Idaho does not imply endorsement of the counselor at Clearsight Counseling by the State. You may contact the Bureau of Occupational Licenses if you have any questions about me or wish to file a complaint against me. The Bureau can be reached by calling 208-334-3233.

Initial________________

Expectations & Outcomes

Counseling is best viewed as an individualized educational process. Like any educational process, I may give you homework to work on between sessions. Another thing to keep in mind is that counseling takes time. There are many factors that determine how much time counseling takes to be effective. You are likely to begin experiencing hope soon after counseling begins. However, be prepared that sometimes things will seem to get worse before they get better. Counseling is an overall positive experience for most clients. However, you may experience intense emotions and even distress while involved in the process of counseling. Though most people benefit greatly in their personal and professional lives from counseling, there is, unfortunately, no guarantee that this will be true for everyone.

You and I will plan your work together. Your treatment plan will list areas to work on, goals, methods, and commitments. We can re-evaluate and change your treatment plan when needed.

Initial________________

Fees & Insurance

The following services are available at Clearsight Counseling:
Initial Session: $150 (billed to insurance)
45-minute Session: $125 (billed to insurance)
60-minute Session: $150 (billed to insurance)
Family Session: $150 (billed to insurance)
Crisis Session: $180 (not billable to insurance)
No-Show fee: $30 (not billable to insurance)
Late Cancellation Fee within 24 hours: $30 (billed to insurance)

I understand payment is expected at the conclusion of each meeting unless other arrangements are made. I am responsible for payment of all services rendered. I understand that if I have a balance due, I will receive a statement and will be responsible for said balance no later than the last day of the month that the statement was rendered by Clearsight Counseling and/or Putman MH Billing. I also understand that if I suspend or terminate my care and treatment any outstanding balance will be immediately due and payable. If I default on any payment obligations as called for in this agreement Clearsight Counseling reserves the right to forward my information to collections. An additional 30% will be assessed to my account to cover the cost of collection. There will be no obligation to provide continuing services to any client who names Clearsight Counseling as a creditor in any bankruptcy filing.

If your health insurance includes mental health benefits, please consult with either myself and/or your insurance provider to work out if my services are covered and make payment arrangements. However, please understand that you are ultimately responsible for the payment for services rendered. If you need to cancel an appointment, please call and leave a message 24 hours in advance so I can contact clients on the waiting list. You will be charged $30 for sessions you miss without giving 24-hours prior notice, or if you arrive 20 minutes late or more (In which case you may not be seen). This fee cannot be billed to insurance, so it is your responsibility. If there are any problems with fees, billing, insurance, scheduling or any other issue, please bring it to my attention immediately so we can work out a solution.

You will be charged for any damage to, or theft of, property in this office and premises by you or anyone for whom you are legally responsible. Clearsight Counseling is not responsible for any personal property brought into the office or in the parking lot.

Initial________________

Litigation Limitation

Due to the nature of the therapeutic process, and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.) neither you (client) nor your attorney, nor anyone else acting on your behalf, will call on your therapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

Initial________________

Legal Proceedings
Clearsight Counseling does **NOT** provide disability determination, custody studies, or become voluntarily involved in legal matters.

- Providers will not willingly appear in court on behalf of individuals, children, or adults unless legally compelled to do so, or if it is critical to do so in order to provide proper patient care.
- Should we be called to court by a judge or court order, or our records court ordered or subpoenaed, we will charge the full amount applicable under the law for our services. Copies of records are available for $17.21 processing fee, plus $1.30 per page.
- In the event it is necessary, by court order or by subpoena, for the therapist to testify before any court, arbitrator, or other hearing officer to testify at a deposition, whether the testimony is factual or expert, or to present any or all records pertaining to the counseling relationship to a court official, the client agrees to pay the therapist for his or her services including but not limited to: travel, necessary expenditures, copies, parking, meals, time spent speaking with attorneys, reviewing records, preparation of reports, etc… Our fee is $250 per hour, rounded to the nearest hour.

- The client further agrees to pay a retainer fee of $2,000 two weeks prior to the appearance, presentation of records, or testimony requested. Checks will not be considered an acceptable form of payment for these services.

Initial________________

Confidentiality
I follow professional, ethical, and legal (federal and state) guidelines to keep your information private. Following are situations in which your information may be shared without your consent:

1. If therapy is mandated by a court or an employer, the court or employer requires a report. If this is your situation, please talk with me before revealing anything you do not want the court or your employer to know. You have the right to choose what you disclose.

2. Are you suing someone or being sued? Are you being charged with a crime? If so, I may be subpoenaed and ordered to testify and/or show the court your records. Please consult your lawyer about these issues.

3. If you make a serious threat to harm yourself or another person, the law requires me to try to protect you and/or the other person by seeking help from other sources.

4. If I believe a child or other vulnerable person has been or will be abused or neglected, I am legally required to report this to the authorities.

5. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

6. Counselors sometimes consult other therapists or helping professionals. These persons are also required to keep your information private. When discussing your case, your name is never included and identifying information is changed or omitted to protect your privacy. These professionals will be told only as much as they need to know to understand your situation in order to provide helpful feedback.

7. If the Department of Homeland Security contacts me and states they require your records as a matter of National security, I must comply.

There are also circumstances in which I may ask your permission to share your specific information with other professionals. In these cases you will be asked to sign a “Release of Information” form. This form states exactly what information is to be shared, with whom, and why. It also sets time limits. For example, it may be beneficial to confer with your primary care physician with regard to your counseling treatment or to discuss medical issues related to therapy. Also, in order to verify services rendered, insurance companies request information on symptoms, diagnoses, and treatment methods. You will be asked to sign a “Release of Information” form before this information is sent. This information may become part of your permanent medical record. My policy is to provide only as much information as the insurance company requires to pay your benefits.

I ask that you never disclose the name of another client being seen in this office to anyone.

Initial________________

Statement of Principles and Complaint Procedures

At Clearsight Counseling I will not discriminate against clients because of any of these factors: age, sex, marital/family status, race/ethnicity, religious beliefs, place of residence, veteran status, physical disability, health status, sexual orientation, or gender identity. I will always take

steps to advance and support the values of equal opportunity, human dignity, social justice, and racial/ethnic/cultural diversity. If you believe you have been discriminated against in my practice, please bring this matter to my attention immediately.

It is my intention to fully abide by all the rules of the American Counseling Association and by those of State of Idaho. At Clearsight Counseling, providing effective short-term counseling and long-term psychotherapeutic services is my highest priority. If you are not satisfied with any area of my work, please raise your concerns with me. I will make every effort to hear your complaint and seek a solution. If you continue to feel that your concern is not being addressed fairly, you can contact the Idaho Board of Counseling Licensure at (208) 334-3233, or the Idaho Division of Occupational and Professional Licenses at (208) 577-2591.

Mailing address:
Idaho Division of Occupational and Professional Licenses
P.O. Box 83720
Boise, ID 83720-0063

Physical address:
Idaho Division of Occupational and Professional Licenses
11351 W. Chinden Blvd. Bldg #6
Boise, ID 83714

Initial________________

Client Rights

1. You have the right to considerate and respectful treatment and recognition of your personal dignity.
2. You have the right to impartial access to treatment, regardless of race, religion, sex, age, ethnicity, sexual orientation, gender identity, handicap, medical condition, mental/physical disability, national origin, claims experience, medical history, evidence of insurability, or genetic information
3. You have the right to obtain information about your condition and prognosis from your physician.
4. You have the right to obtain information about treatment recommendations and alternatives.
5. You have the right to participate in treatment decisions.
6. You have the right to receive individual treatment.
7. You have the right to expect that all communications and records pertaining to your treatment shall be treated as confidential, except as otherwise required by law (according to the Notice of Privacy Practices).
8. You have the right to report any incidents of abuse or neglect, whether you are a victim or an observer.
9. You will be provided adequate and humane services, regardless of your source of financial support, within the least restrictive environment available for your safety and the community's.
10. You have the right to refuse any part or all of the services available to you.
11. You have the right to make a complaint.
12. You have the right to make suggestions. You are invited to suggest changes in any aspect of the services I provide.
13. You have the right to your civil rights. Your civil rights are protected by federal and state laws.
14. You have the right to obtain a copy and/or inspect your protected health information; however, I may deny access to certain records in which I will discuss this decision with you.
15. You have the right to request an amendment in your records; however, this request could be denied. If denied, your request will be kept in the records.
16. You have the right to receive an accounting of disclosures of your protected health information that you have not authorized.
17. Costs of services. I will provide a fee schedule for requested services.
18. Termination of services. You will be informed as to what behaviors or violations could lead to termination of services.
19. Confidentiality. You will be informed of the limits of confidentiality and how your protected health information will be used.
20. You have the right to be informed of any policy changes.

Client Responsibilities

1. You have the responsibility to respect others regardless of their race, religion, age, sex, ethnicity, sexual orientation, or handicap.
2. You have the responsibility to keep confidential all clinical information communicated to you personally or in groups.
3. You have the responsibility to keep individual appointments.
4. You have the responsibility to discuss differences of opinion regarding treatment.
5. You have the responsibility not to bring illicit drugs, alcohol, weapons, or other hazardous materials into the office.
6. You have the responsibility to engage in treatment you request. Not participating in services could result in a worsening in your condition resulting in the necessity for a higher level of care (such as hospitalization).
7. No firearms or weapons are allowed on premises (you will be asked to remove the weapon or to leave the premise).
8. Clients are not allowed to cause distress to others in the environment (yelling, unmanaged children, excessive phone conversations in lobby).
9. You are responsible for your financial obligations as outlined in the Informed Consent.
10. You are responsible for following the policies of the business.
11. You are responsible to treat your therapist in a respectful, cordial manner in which his rights are not violated.
12. You are responsible to provide accurate information about yourself.

Therapist Responsibilities

1. I dedicate myself to providing individualized treatment in serving the best interest of each client.
2. I will not discriminate between clients or professionals based on age, race, creed, disabilities, handicaps, preferences, or other personal concerns.
3. I maintain an objective and professional relationship with each client.
4. I respect the rights and views of other mental health professionals.
5. I will appropriately end services or refer clients to other programs when appropriate.
6. I will evaluate my personal limitations, strengths, biases, and effectiveness on an ongoing basis for the purpose of self-improvement. I will continually attain further education and training.
7. I hold respect for various institutional and managerial policies but will help improve such policies if the best interest of the client is served.

All patients using health insurance please sign below.

I hereby grant authorization to Clearsight Counseling Offices and/or Jordan Looze, LCPC for:

Protected Health Information (except psychotherapy notes), to my insurance company that is necessary for billing for the treatment or my insured family member's treatment, or to process my claim for payment of services.

I also authorized Clearsight Counseling Offices and/or Jordan Looze, LCPC and their chosen contracted billing agency/agent to exchange my PHI in order to process an insurance claim, provide me with a monthly statement of my account and facilitate reimbursement.

I authorize my insurance company to send payment directly to stated counselor at 4948 Kootenai St. Boise ID, 83705 for all services provided. I understand that stated counselor is a self-contracted, solo practitioner and therefore, responsible for the appropriate and legal handling of my PHI. I also agree that a photocopy of this document shall be as valid as the original.

Insured/Client Signature________________________________ Date: __________________

Quality of Care

All clients that receive services from Clearsight Counseling are entitled to the highest quality of services. If, for any reason, you are not satisfied with the quality of services you are receiving, there are several avenues available to make your needs known and seek solutions. I cannot retaliate for any use of the following grievance procedures:

1. Express your needs directly to the therapist. Seek to clarify your expectations and reach a mutually agreeable solution.
2. Participants in therapy at Clearsight Counseling may file a grievance with the therapist by completing a Grievance Form. This form can be obtained from the therapist. A grievance procedure may result in an appropriate referral within the community.
   If these steps do not produce the desired result, there are additional avenues open to you. You may contact the Idaho Division of Occupational and Professional Licenses: Information can be found online at https://dopl.idaho.gov

Initial________________

Informed Consent and Notice of Privacy Practices

I have read and understand the information in the paragraphs above. I give consent to receive counseling services at Clearsight Counseling. I also understand I have the right to request and receive a full copy of my HIPAA rights at any time.

____

Signature of client (or person acting for client) Date

____

Printed name

Relationship to client: ____ Self ____ Parent _____ Legal guardian

_____ Health care custodial parent of a minor (less than 14 years of age)

_____ Other person authorized to act on behalf of the client (please specify)

____ ________________________________

Signature of counselor Date