

Elements of Motivation
 7040 Laredo Street Suite K
 Las Vegas, NV 89117
 Ph: 702-331-4874 Fax: 702-446-8034

CLIENT INTAKE FORM
 (Please Print)

Today's Date ____/____/____

CLIENT INFORMATION

Client's Last Name		First	Middle	<input type="checkbox"/> Mr.	<input type="checkbox"/> Ms.	Marital Status (Circle One) Single / Married / Other	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name? (Former Name)		Birth Date / /	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F		
Street Address		City	State	ZIP Code	Social Security - -	Home Phone No. ()	
P.O. Box		City	State	ZIP Code	Cell Phone No. ()		
Occupation	Employer				Work Phone No. ()		
Referred to Provider by (Please check one box & list) <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to Home/Work <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other _____				<input type="checkbox"/> Dr. _____	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Website	
Email Address:				Alternative Email Address:			

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE OFFICE MANAGER)

Person Responsible for Bill	Birth Date / /	Address (if different)		Home Phone No. ()	
Email Address:				Cell Phone No. ()	
Occupation	Employer	Employer Address		Work Phone No. ()	
Is this client covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this an EAP visit? <input type="checkbox"/> Yes <input type="checkbox"/> No		Total Annual EAPs allowed? _____	
Please Select Your Primary Insurance Provider		<input type="checkbox"/> Medicaid <input type="checkbox"/> Other _____			
What is the authorization number?				<input type="checkbox"/> Self Pay	

Insured's Name	Insured's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment \$
Client's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					
Name of Secondary Insurance (if any)			Insured's Name	Group #	Policy #
Client's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.

Elements of Motivation

IMPORTANT INFORMATION AND CLIENT CONSENT: Please read and sign at the end stating you have fully read and understand the information below.

CLIENT/THERAPIST RELATIONSHIP: You and your Therapist have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your Therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship. Gifts are not appropriate, nor is any sort of trade of service for service.

AVAILABLE SERVICES: Elements of Motivation offers a wide array of services, including individual therapy, family therapy, couples therapy, group services, Psychosocial Rehabilitation and Basic Skills Training. We are staffed by skilled and experienced licensed therapists, counselors and psychologists, licensed intern therapists and counselors and rehabilitative support staff. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. It is our intent to convey the policies and procedures used in our practice, and we will be pleased to discuss any questions or concerns you may have.

RISKS AND BENEFITS: Counseling, psychotherapy and support services are beneficial, but as with any treatment, there are inherent risks. You will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. We cannot guarantee these benefits, of course. It is our desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

SERVICES: We provide short-term mental health services designed to address many of the issues our clients are dealing with. Your first visit will be an intake session in which you and your Therapist will determine your concerns, and if both agree that he/she can meet your therapeutic needs, develop a plan of treatment. Should you choose not to follow the plan of treatment provided to you by your Therapist, services to you may be terminated.

The goal of Elements of Motivation is to provide the most effective therapeutic experience available to you. If at any time you feel that you and your current Therapist are not a good fit, please discuss this matter with your Therapist to determine if transferring to a more suitable Therapist is right for you. If you and your Therapist decide that other services would be more appropriate, we will assist you in finding a provider to meet your needs.

Wellness is more than the absence of disease; it is a state of optimal well-being. It goes beyond the curing of illness to achieving health. Through the ongoing integration of our physical, emotional, mental, and spiritual self, each person has the opportunity to create and preserve a whole and happy life. Our services are designed to provide our clients an integrated solution for their mind, body, spirit, and life to enhance their lives and resolve issues.

APPOINTMENTS: Appointments are typically scheduled on a weekly basis and are approximately 50 – 120 minutes long. More frequent sessions or an intensive outpatient schedule are available if determined appropriate by your Therapist. If you must cancel or reschedule your appointment, we ask that you call our office at least 24 hours in advance, whenever possible. This will free your appointment time for another client.

PAYMENT/INSURANCE FILING: Payment of fees, including any required co-pays, is expected at the time of each appointment. We request that payment be made before your session begins. If you are using insurance benefits, Elements of Motivation will file insurance claims for you, and we will honor any contractual agreements with managed health care companies that have specific reimbursement restrictions and claim requirements. If you are not using a Managed Care/PPO/HMO insurance plan and wish to file your own claim, we expect full payment at the time of service, and we will provide you with a statement for services rendered. Monthly payment arrangements are available, if needed, for clients who have established a payment record for three months. **You are responsible for any fees not covered by insurance.**

EMERGENCIES: You may encounter a personal emergency which will require prompt attention. In this event, please contact our office regarding the nature and urgency of the circumstances. We will make every attempt to schedule you as soon as possible or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, we will make every effort to respond to your emergency in a timely manner. If you are experiencing a life-threatening emergency, call 911 or have someone take you to the nearest emergency room for help. When your Therapist is out of town, you will be advised and given the name of the on-call therapist.

CONFIDENTIALITY: Elements of Motivation follows all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your services. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a Therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of the Therapist when you and the Therapist discuss this matter further. By signing this Information and Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result.

When conducting therapeutic services in locations other than the office (e.g. client homes, medical/rehab facilities, et al), there exists potential for limitations to confidentiality. These limitations occur due to aspects of the environment which are outside of either the clinician's or client's control, and may include, but are not limited to:

- Family members/medical staff/others entering or passing through the area where therapeutic services are conducted
- Individuals in close proximity (e.g. neighbors, family, roommates, medical staff, et al) overhearing dialogue and concepts which arise or are presented during session via open windows, doors, ect.

Both the clinician and client will work to explore and utilize the most private location available within reason to conduct therapeutic services in accordance with state and federal laws, however even in light of these considerations, there are situations where confidentiality cannot be reliably guaranteed.

DUTY TO WARN/DUTY TO PROTECT: If my Therapist believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my Therapist to contact the any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my Therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name

Telephone Number

INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of the undersigned Therapist, it will be necessary to assign my case to another Therapist and for that Therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned Therapist, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such treatment or services at any time. **NOTE:** If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, Elements of Motivation will not render services to your child until the Therapist has received and reviewed a copy of the most recent applicable court order.

Name of Client or Parent/Guardian (Print)

Signature of Client or Parent/Guardian

Date _____

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

Signature of Client or Parent/Guardian

Date _____

I hereby authorize the payment of medical benefits to the provider of services.

Signature of Client/Parent

Date _____

Elements of Motivation

CONSENT FOR TREATMENT OF A MINOR

We/I, the undersigned _____, parent(s) and/or guardian(s) of a minor child _____, give you full and unconditional authority to proceed with a clinical evaluation and treatment as your judgment indicates. This consent is given by me/us as parent(s) and/or guardian(s) of said child. We/I have legal power to consent to medical, psychological, and mental health assessment and treatment of said minor child. It is clearly understood that you are hereby fully released from any claims and demands that might arise, or be incident to the evaluation and/or treatment, provided that your duties are performed with standard care and responsibility to the best of your professional ability.

Signed this ____ day of _____, 20__

Mother or Guardian

Father or Guardian

The above explained to: (circle all that apply) Mother / Father / Guardian

By _____ on the ____ day of _____, 20__

Witness

Date

Elements of Motivation

Consent to Use PHI for Treatment, Payment, and Healthcare Operations

With my consent, Elements of Motivation may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Elements of Motivation Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Elements of Motivation reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Elements of Motivation at 6877 West Charleston Blvd, Las Vegas, NV 89117.

With my consent, Elements of Motivation may call my cell phone or designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care. With my consent, Elements of Motivation may mail to my home or other designated location any items that assist in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked Personal and Confidential.

With my consent, Elements of Motivation may e-mail to me my appointment reminder cards and patient statements. I have the right to request that Elements of Motivation restrict how it uses or discloses my PHI to carry out TPO. However, the practice is required by state statutes to agree to my requested restrictions, unless in extenuating circumstances allowed by law.

By signing this form, I consent for Elements of Motivation to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Elements of Motivation may decline to provide treatment to me.

Name of Client or Parent/Guardian (Print)

Signature of Client or Parent/Guardian

Date _____

Staff Member Signature

Elements of Motivation

Phone: (702) 331-4874

www.elementslv.com

Fax: (702) 446-8034

HIPAA RELEASE OF INFORMATION

I, _____, whose date of birth is _____, authorize _____ to disclose to and/or obtain from _____ the following information:

Description of Information to be Disclosed

(Patient/Client should initial each item to be disclosed.)

- | | |
|--|--|
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Testing Information |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Educational Information |
| <input type="checkbox"/> Psychosocial Evaluation | <input type="checkbox"/> Presence/Participation in Treatment |
| <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Continuing Care Plan |
| <input type="checkbox"/> Treatment Plan or Summary | <input type="checkbox"/> Progress in Treatment |
| <input type="checkbox"/> Current Treatment Update | <input type="checkbox"/> Other _____ |

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify: _____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to _____ at the above address. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on _____, or as otherwise indicated: _____

Conditions

I further understand that _____ will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: _____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information (PHI) that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections. Other types of information may be re-disclosed by the recipient of the information in the following circumstances: _____

I will be given a copy of this authorization for my records.

Signature of Client

Date

Signature of Parent, Guardian or Personal Representative

Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual. Attach appropriate document (power of attorney, temporary orders, healthcare surrogate, etc.)

_____ Check here if client refuses to sign authorization.

Signature of Staff Witness

Date

Elements of Motivation

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information (“PHI”). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

**Abuse and Neglect
Emergencies
National Security**

**Judicial and Administrative Proceedings
Law Enforcement
Public Safety (Duty to Warn)**

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to our Privacy Officer at 702-331-4874

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** . You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Breach Notification.** If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer, at 702-331-4874 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is 7/24/2013

Elements of Motivation

Notice of Privacy Practices Receipt and Acknowledgment of Notice

Patient/Client Name: _____

DOB: _____ SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Elements of Motivation Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Officer at 702.331.4874.

Signature of Patient/Client

Signature or Parent, Guardian or
Personal Representative*

Date

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Patient/Client Refuses to Acknowledge Receipt:

Signature of Staff Member

Date