MY FAMILY COUNSELING
Admin@MyFCinc.com 636-294-2694
Suite #2, 1137 North Main Street, O'Fallon, MO 63366

CLIENT INTAKE QUESTIONNAIRE

PLEASE NOTE, IF YOU ARE COMING IN AS A COUPLE OR FAMILY FILL OUT THIS FORM UNDER ONE PERSON

Date_____ Name_____ (◯)Male (◯) Female
Social Security Number_____ Date of Birth_____
Home Address_____
City_____State_____Zip_____
Contact Phone_____ May we: Leave Message (◯) YES (◯) NO
Text (◯) YES (◯) NO*Note* Appointment reminders are done by text only

Religion/Faith: Is spirituality important in your life? (◯) YES (◯) NO
If yes, what faith do you adhere to? _____ for how long?_____
Do you attend church? _____ How often? _____
Do you consent to counseling from a Biblical perspective? (◯) YES (◯) NO

Current Employer_____
Occupation_____

__
Emergency contact person_____
Phone_____Relationship_____

__
Whom may we thank for referring you?_____

Marital Status (Of Client):

(◯)Single, Never Married
(◯)Engaged, How Long_____
(◯)Married, How Long_____
(◯)Separated, How Long_____
(◯)Widowed
(◯)Divorce In Process, How Long_____
(◯)Divorced For, How Long_____
(◯) _____ Prior Marriages (Self)
(◯) _____ Prior Marriages (Partner)

IF NOT MARRIED, RELATIONSHIP STATUS:

(◯)Currently in a serious relationship (◯)Not currently in a serious relationship
(◯)never been in a serious relationship

RELATIONSHIP SATISFACTION:

(◯)Very satisfied with relationship
(◯)Satisfied with relationship
(◯)somewhat satisfied with relationship
(◯)Dissatisfied with relationship
(◯)Very dissatisfied with relationship

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RESPONSIBLE PARTY INFORMATION

PERSON RESPONSIBLE FOR ANY FEES WHICH MAY BE INCURRED

Person responsible for account_____

Relationship to client_____**Phone**_____

Home address_____**City**_____**State**____**Zip**_____

INSURANCE INFORMATION

PLEASE NOTE, IF YOU HAVE A DEDUCTIBLE THAT HAS NOT BEEN MET, FULL PAYMENT FOR THE VISIT IS DUE AT THE TIME OF YOUR APPOINTMENT

NAME OF POLICY HOLDER_____**RELATIONSHIP**_____

POLICY HOLDER'S SOCIAL SECURITY NUMBER_____**DATE OF BIRTH**_____

Policy Holders Home Address_____

City_____**State**_____**Zip**_____

NAME OF INSURANCE COMPANY_____

SPECIALIST CO-PAY AMOUNT $_____ **AUTHORIZATION #(IF APPLICABLE)**_____

HAS YOUR DEDUCTIBLE BEEN MET?_____ **DEDUCTIBLE AMOUNT $**_____

I AUTHORIZE RELEASE OF ANY INFORMATION CONCERNING MY (OR MY CHILD'S) HEALTH CARE, ADVICE AND TREATMENT PROVIDED, FOR THE PURPOSE OF EVALUATION AND ADMINISTERING CLAIMS FOR INSURANCE BENEFITS. I ALSO HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS, OTHERWISE PAYABLE TO ME, DIRECTLY TO THE PROVIDER OF SERVICES.

X_____**DATE**_____

***SIGNATURE OF CLIENT OR SIGNATURE OF PARENT/GUARDIAN IF CLIENT IS A MINOR**

PAYMENT POLICY

We expect payment for services at the time they are provided. Cash, check, Visa, MasterCard, and Discover are accepted. Due to the frequency of policy changes with insurance companies, we make no claim that your particular carrier provides coverage for our type of service. Delinquent accounts may be referred to a professional agency for collection and credit reporting. This may require us to disclose otherwise confidential information to identify your account status. If such action is necessary, the costs incurred in collections will be included in the balance due.

X_____

Date_____

Client Signature (Client's Parent/Guardian signature if client is a minor)

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Confidentiality Act Consent Notice Form
HIPPA National Notice of Psychotherapists and Psychologists Policies and Practices to Protect the Privacy of Your Patient's Health Information—April 14, 2003

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions—

PHI refers to information in your health record that could identify you.

Treatment, Payment and Health Care Operations

Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.

Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health care insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination including supervision of all practitioners.

Use applies only to activities within my office, clinic, practice group etc, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

Disclosure applies to activities outside of my office, clinic, practice group, etc, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when appropriate authorization is obtained. An *authorization* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *Psychotherapy notes* are notes I have made about our conversation during a private group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations of PHI or psychotherapy notes at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use of disclose PHI without your consent or authorization in the following circumstances:

Child Abuse—If I have reasonable cause to suspect that a child has been or may be subjected to abuse or neglect, or if I observe a child being subjected to conditions which would reasonable result in abuse or neglect, I must immediately report such information to the Missouri Division of Family Services. I must also report sexual abuse or molestation of a child under 18 years of age to Family Services. I may also report child abuse or neglect to a law enforcement agency or juvenile office.

Adult and Domestic Abuse—If I have reasonable cause to suspect that an eligible adult (defined below) presents a likelihood of suffering physical harm or is in need of protective services, I must report such information to the Missouri Department of Social Services.

Elligible adult means any person 60 years of age or older, or an adult with a handicap (substantially limiting mental or physical impairment) between the ages of 18 and 59 who is unable to protect his or her own interests or adequately perform or obtain services which are necessary to meet his or her essential human needs.

Health Oversight Activities—The Missouri Attorney General's Office may subpoena records from me relevant to disciplinary proceedings and investigations conducted by the Missouri State Committee for Professional Counselors.

Judicial and Administrative Proceedings—If your are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and I will not release information without written authorization from you or your personal or legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. I will inform you in advance if this is the case.

Serious Threat to Health or Safety--When I judge that disclosure is necessary to protect against a clear and substantial risk of imminent serious harm being inflicted by you on yourself or another person, I must disclose your relevant confidential information to the appropriate professional workers, public authorities, the potential victim, his or her family, or your family.

Worker's Compensation—If you file a worker's compensation claim, I must permit your record to be copied by the Missouri Labor and Industrial Commission or the Division of Worker's Compensation of the Missouri Department of Labor and Industrial Relations, your employer, you and any other party to the proceedings.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

Right to Request Restrictions—You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations—You have the right to request and receive confidential communications of PHI by alternative means and alternative locations (For example, you may not want a family member to know you are seeing me. On your request, I will send your bills to another address.)

Right to Inspect and Copy—You have the right to inspect and or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. There will be a fee for photocopying, time reviewing and accessing records, additional time spent on PHI, or psychotherapy reviews with a patient. On your request, I will discuss with you the additional fees, details of the request, and denial process.

Right to Amend—You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right To Accounting—You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy—You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's & Professional Counselor's Duties:

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the term currently in effect. If I revise my policies and procedures, I will notify you either by mail or in person if you are still my patient at that time.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision made about access to your records, or have other concerns about your privacy right, you may contact Jamie Morgan at 636-400-3311. You may also send a written complaint to the Secretary of US Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 14, 2003, in compliance with current HIPPA standards. Since HIPPA, State, and Federal Privacy guidelines may be modified in future months or years, I reserve the right to change the terms of this notice and to make new notice provisions effective for all PHI that I maintain. Current information about PHI or updates about the same can be received by contacting our office at the address above. Current and active patients will be notified via mail and/or in person of any changes in our privacy policy.

Signature or Attestation of Receipt Notice

I have received a copy of this HIPPA Privacy Notice regarding the above uses, disclosures, consents.

Signature of Client/Guardian_____

Date_____

HEALTH RATING:
Excellent ☐ Good ☐ Average ☐ Poor ☐ Very Poor ☐

Are you currently under a doctor's care? (○) YES (○) NO If yes, please explain.

_____

Physician's Name_____
Are you currently taking medications? (○) YES (○) NO
If yes, please list_____

_____

List any recent hospitalizations:

_____

List any current/past medical conditions:

_____

Have you ever experienced any trauma in your life? (○) YES (○) NO
Was it Physical? (○) YES (○) NO / Was it Emotional? (○) YES (○) NO / Was it Sexual? (○) YES (○) NO

Have you ever been to counseling before? (○) YES (○) NO What type of counseling?_____
Name of counselor_____

Have you ever received psychological testing? (○) YES (○) NO

If yes, briefly describe_____

_____

Alcohol use: Never _____Occasionally _____ Often _____
Have you ever used drugs recreationally? _____
What and when? _____

FAMILY HISTORY:

Mother's age_____ If deceased, how old were you when she died? _____
Father's age_____ If deceased, how old were you when he died? _____
If your mother and father separated, how old were you at the time? _____
If your mother and father divorced, how old were you at the time? _____
Total number of times mother divorced_____Total number of times father divorced _____
I was child number _____ in a family of _____ children.
How would you describe your relationship with your siblings?

_____

_____

Please list your children by age:

Name_____
Age_____**Sex**_____**Education**_____**Living at Home** _____
Special Concerns_____

Name_____
Age_____**Sex**_____**Education**_____**Living at Home** _____
Special Concerns_____

Name_____
Age_____**Sex**_____**Education**_____**Living at Home** _____
Special Concerns_____

Name_____
Age_____**Sex**_____**Education**_____**Living at Home** _____
Special Concerns_____

Name_____
Age_____**Sex**_____**Education**_____**Living at Home** _____
Special Concerns_____

Please list any other person (s) living in your home:

Name_____
Age_____**Sex**_____**Education**_____
Special Concerns_____

How would you describe your friends in regards to a healthy support system?

_____

_____

What is the highest education level completed by you? _____

How many jobs have you had in the past 15 years? _____

Have you, or any close relatives ever attempted suicide? Yes☐ No☐
If yes, please briefly explain:

_____

_____

SPECIFIC PROBLEM AREAS:
Please check any of the following that are currently troubling you:

- ☐ Abortion
- ☐ Addictions
- ☐ Adoption
- ☐ Alcoholism
- ☐ Anger
- ☐ Anxiety
- ☐ Apathy
- ☐ Bitterness/Resentment
- ☐ Burnout/Stress
- ☐ Change of Lifestyle
- ☐ Child Abuse
- ☐ Children/Discipline
- ☐ Children/School
- ☐ Children/Rebellion
- ☐ Communication
- ☐ Confusion
- ☐ Crisis/Conflict
- ☐ Death of Loved One
- ☐ Depressed Mood
- ☐ Divorce
- ☐ Eating Disorder
- ☐ Emotionality
- ☐ Envy/Jealousy
- ☐ Family Issues
- ☐ Fear
- ☐ Finances//Debt
- ☐ Forgiveness
- ☐ Frustration
- ☐ Grief
- ☐ Guilt
- ☐ Health/Medical
- ☐ Homosexuality
- ☐ Honesty
- ☐ Infidelity
- ☐ In-Laws
- ☐ Job Problems
- ☐ Legal Issues
- ☐ Loneliness
- ☐ Loss of Appetite
- ☐ Loss of Control
- ☐ Loss of Concentration
- ☐ Loss of Energy
- ☐ Loss of Memory
- ☐ Loss of Sleep
- ☐ Loss of Temper
- ☐ Loss of Trust
- ☐ Marriage
- ☐ Medication/Drug Issues
- ☐ Mood Swings
- ☐ Parenting Issues
- ☐ Panic Attacks
- ☐ Paranoia
- ☐ Parenting
- ☐ Phobias
- ☐ Physical Abuse
- ☐ Pornography
- ☐ Religion/Faith Issues
- ☐ Separation
- ☐ Sexual Abuse/Rape
- ☐ Sexual Addictions
- ☐ Sexual Issues
- ☐ Singleness
- ☐ Single Parent
- ☐ Spouse Abuse
- ☐ Substance Abuse
- ☐ Suicidal Thoughts
- ☐ Self-Esteem
- ☐ Rejection
- ☐ Unemployment
- ☐ Violence/Rage
- ☐ Withdrawal
- ☐ Worry
- ☐ Worthlessness

OTHER NOT LISTED_____

Have you ever been arrested? (◯) YES (◯) NO
If YES, what were you charged with? _____

Signature_____
Date_____

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CONSENT FOR RELEASE OF TREATMENT

I have come on a voluntary basis for counseling services for assessment and/or treatment at My Family Counseling

The limits of confidentiality have been explained to me. My counselor explained his/her qualifications and level of professional licensure.

I was informed that for quality assurance purposes, information is sometimes shared and corroborated with other doctors or practitioners. I have been offered a copy of the Missouri HIPPA Confidentiality Notice Form.

I understand that without written permission my counselor cannot discuss the fact that I am a client at My Family Counseling or any details of my counseling with any other person. I understand this includes, but is not limited to, my spouse, family members, pastor/priest, or physician.

Therefore, I hereby give my consent to my counselor to release psychological or therapy information gathered today to the following:

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

I understand and agree this consent for information will be good for as long as I am in counseling, or until I rescind this release in writing.

Signature_____Date_____

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NO SHOW FEE / LATE CANCELLATION FEE

PLEASE BE AWARE THAT WHEN WE SCHEDULE AN APPOINTMENT TIME FOR YOU, YOUR THERAPIST IS RESERVING A 45-60 MINUTE TIME SLOT **EXCLUSIVELY FOR YOUR SESSION**. UNLIKE YOUR PRIMARY CARE DOCTOR (WHO MAY SEE AS MANY AS 8 OR 10 PATIENTS DURING A CLOCK HOUR) YOUR THERAPIST WILL SCHEDULE ONLY **ONE PATIENT**, AS FAR IN ADVANCE AS TWO WEEKS, **FOR YOUR SPECIFIC APPOINTMENT TIME**.

WE ASK THAT YOU ACKNOWLEDGE THE FEE LISTED BELOW BY INITIALIZING IN THE APPROPRIATE SPACE.

LATE CANCELLATION FEE: THIS FEE IS ESTABLISHED BY THE RATE OF REIMBURSEMENT PRE-DETERMINED BY YOUR INSURANCE COMPANY; YOU WILL BE RESPONSIBLE FOR UP TO $120.00 PER THERAPEUTIC HOUR IF YOU MISS OR CANCEL WITHOUT **24 HOURS** NOTICE.

_____ _____

INITIAL PRINT NAME

CREDIT CARD CONSENT

I AUTHORIZE MY FAMILY COUNSELING, INC. TO KEEP MY SIGNATURE ON FILE AND CHARGE MY CREDIT OR DEBIT CARD ACCOUNT AS INDICATED BELOW:

- CO-PAY/CASH FEE FOR THERAPY SESSION
- MISSED APPOINTMENT WILL BE CHARGED UP TO $120
- LATE CANCELLATION FEE BASED ON RATE OF INSURANCE REIMBURSEMENT UP TO $120

I, THE UNDERSIGNED, UNDERSTAND THAT THIS FORM WILL BE VALID THROUGHOUT THE DURATION OF MY TREATMENT UNLESS I CANCEL THROUGH WRITTEN NOTICE.

_____ _____/_____/_____

SIGNATURE DATE