COUNSELING CONNECTIONS & ASSOCIATES, LLC
CLIENT INTAKE FORM

Legal Last Name ______________________________ First Name ____________________________ Middle _________________

Preferred Name ______________________________ Preferred Pronouns: She ____ He ____ Other: _________________

Client's Social Security Number ___________________________ Age _______ Date of Birth ___________________

Gender ______________ Relationship Status: Married ___ Partnered ___ Divorced ____ Single ___ Widowed ____

Home Telephone ___________________ Cell Phone _________________ Email Address ______________________________

Street Address ____ City ____________ State ______ Zip Code ______________

May we contact you at Home **Yes No**? Work **Yes No?** Cell Phone **Yes No?** Email **Yes No?**

Name of Spouse [if applicable]______________________________________ Spouse's Date of Birth _________________

Name(s) of Children and Date of Birth(s) [if applicable] ____

Emergency Contact Name and Telephone Number:____

Employer Information

Are you (please choose one) [ ] Employed [ ] Unemployed [ ] Student [ ] Disabled [ ] Retired

Client's Employer Name: ____ Telephone Number ____________________

Street Address: ______________________________ City:________________ State: ________ Zip Code ___________________

Primary Insurance Information/Employee Assistance Program Information

Primary Insured Name _____________________ Address ______________________ Home Telephone _________________

Name of Insurance Company/EAP _________________________ Insurance/EAP (800) Phone _______________________

Insurance Member # ___________________ Plan # ______________ Date of Birth of Insured ________________________

Insured's Employer _______________________ Address _______________________________ Phone __________________

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Referred By/How Did You Hear About Us?

___ I am a former client returning ___ Relative ___ Friend/Family ___ Court/Legal
___ Employee Assistance Program ___ Minister/Priest/Rabbi ___ Insurance Company ___ School
___ Physician, Dr.____________ ___ Another Therapist ___ Website ___ Internet
___ Yellow Pages ___ Other __________________________________

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As a courtesy, we offer appointment reminders. Please choose one of the following options:

[ ] Please call me for my appointment reminder at ______________________
[ ] Please email my appointment reminder to ___________________________
[ ] Please do not give me any appointment reminders

Print Authorized Person or Patient's Name:____

Authorized Person or Patient's Signature: ____

Name: _____ _____ Intake Date
ID: _____ _____ Therapist Initials
DOB: _____

COUNSELING CONNECTIONS & ASSOCIATES, LLC
HIPPA 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 INFORMATIION. PLEASE REVIEW IT CAREFULLY.

Effective date: August 1, 2011

Counseling Connections & Associates, LLC has been and always will be committed to maintaining our clients' confidentiality. We will only release your health care information in accordance with federal and state laws and the code of ethics for the counseling profession.

This notice describes our policies related to the use and disclosure of your health care information.

Uses and disclosures of your health information for the purposes of: Providing treatment services, collecting payment and conducting healthcare operations. These are necessary activities for provided our client's quality care. State and federal laws allow us to use and disclose your health information for these purposes.

TREATMENT: We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. This may include include consultants and potential referral sources.

PAYMENT: Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims, as well as information needed for billing and collection purposes. We may also bill the person in your family who is identified as the primary insurance holder or responsibility party.

HEALTHCARE OPERATIONS: We may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance and licensing activities.

Other uses or disclosures of your information, which does not require your consent: There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse. In this circumstance, in accordance with Nebraska State Law, we are obligated to report this to Child Protective Services. If you provide information that informs us that you are in danger of harming yourself or others. Information shared with law enforcement if a crime is committed on our premises or against one of our staff. Any other instances as required by law such as a subpoena or court order. Information to remind you of /or to reschedule appointments or other treatment alternatives.

Clinical records, psychotherapy notes, and other disclosures require a separate signed release of information. You have a right to or will receive notification of a breach of any unsecured personal health information. You have a right to restrict any disclosure of personal health information where you have paid for services out-of-pocket and in full.

Name: _____ _____ Intake Date
ID: _____ _____ Therapist Initials
DOB: _____

COUNSELING CONNECTIONS & ASSOCIATES, LLC
CLIENT RIGHTS

Right to request how we contact you.
It is our normal practice to communicate with you at your home address and via the daytime phone number you provided us when you scheduled your appointment, about health matters, billing information, and appointment reminders (if requested). If permitted by you, we may sometimes leave messages on your voicemail. You also reserve the right to request that our office communicate with you in a different way.

Right to release your medical records.
You may consent in writing to release your records to others that you identify. You have the right to revoke this authorization, in writing, at any time. However, please note that a revocation is not valid to the extent that we acted in reliance on such authorization.

Right to inspect and copy your medical and billing records.
You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, please contact the office manager. Under limited circumstance we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and supplies.

Right to add information or amend your medical records.
If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request within 60 days, or in some cases within 90 days. Under certain circumstances, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

Right to an accounting of disclosures.
You may request an accounting of any disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment, health care operational purposes, information that was shared with you or your family, or information that you gave us specific consent to release. This also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than seven years, please submit your request in writing to Counseling Connections & Associates, LLC Privacy Officer. We will notify you of the cost involved in preparing this list.

Right to request restrictions on uses and disclosures of your health information.
You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our office manager. However, please note that we are not required to agree to such a request.

Right to complain.
If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

Right to receive changes in policy.
You have the right to receive any future policy changes secondary to changes in state and federal laws.

Name: _____ _____ Intake Date
ID: _____ _____ Therapist Initials
DOB: _____

COUNSELING CONNECTIONS & ASSOCIATES
Sarah Scott, LCSW, LIMHP
INFORMED CONSENT

Thank you for choosing Sarah Scott, LCSW, LIMHP. Today's appointment will take approximately 60 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws, and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need. Sarah Scott, LCSW, LIMHP has earned a Bachelor of Arts Degree in Psychology and a Master's Degree in Social Work. She is licensed by the State of Nebraska as a Clinical Social Worker and Independent Mental Health Practitioner. She has experience in treating adolescents, adults, and families using individual, couples, and family therapy modalities. Sarah practices standard Cognitive Behavioral Therapy, Solution-Focused Therapy, and Insight-Oriented Therapy for most conditions. Other treatment approaches may be used depending on the person or condition. Treatment philosophy and practices will be discussed with you today.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for the following situations: a) information (diagnosis and dates of service) shared with your insurance company to process your claims; b) information you and/or your child or children report about physical, sexual, or elder abuse; then, by Nebraska State Law, this information must be reported to the Department of Children and Family Services; c) where you sign a release of information to have specific information shared; d) if you provide information that you are in danger of harming yourself or others; or e) when required by law. If an emergency situation for which you feel immediate attention is necessary, please call the office to have a counselor paged. If no call is received within 15 minutes, you as the client or guardian understand that you are to contact the emergency services in the community (911) for those services. Sarah Scott, LCSW, LIMHP will follow those emergency services with standard counseling and support as needed.

HOURS: Our front desk is open to take telephone calls from 8:00 am until 8:00 pm, Monday through Thursday, 8:00 am until 6:00 pm on Fridays, and 9:00 am until 3:00 pm on Saturdays. These hours may vary. Furthermore, your provider may offer different and/or additional appointment times. Voicemail is available to leave a message when the office is closed, as well as, when all lines are busy during the day. Messages left overnight or on the weekend will be attended to the next business day. In the case of an emergency, please contact 911 or go directly to the nearest hospital emergency room.

COORDINATION OF TREAMENT: It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or other mental health providers. Your consent is valid for six months. **Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice.** If you prefer to decline consent no information will be shared.

If consent is granted, you will be provided a release of information form to be completed for each treatment provider.

_____ You may inform my physician(s) **_____ I decline to inform my physician**

Name: _____ _____ Intake Date
ID: _____ _____ Therapist Initials
DOB: _____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: I/We have read and received a copy of the 'Notice of Privacy Practices' and the 'Client Rights' document.

Initials _____ Date_____

FINANCIAL/INSURANCE ISSUES: As a courtesy we will bill your insurance company, HMO, responsible party or third party payer for you if you wish. We ask that at each session you pay your co-payment or coinsurance amount. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. **If your balance exceeds $200.00 we will need to ask that you pay for services when rendered.** In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to Sarah Scott, LCSW, LIMHP. You may put a credit card on file to pay for charges not covered by your insurance.

Following this meeting we ask you to notify us immediately as to any change in your health insurance, place of employment, home address or other information pertinent to our records. (Failure to do this may result in our no longer being able to process insurance claims for you and you would be held responsible for full payment of each session not covered by your insurance). The financial responsibility for your treatment is ultimately yours.

Policy on Non-Covered Services: In order to offer you consistent quality care and to coordinate this care with other providers or organizations, we may need to charge for services that are not typically covered or reimbursed by your insurance company. A list of these services is provided below. When we provide these services, we will bill you directly. These services are billed at the standard hourly rate for your therapist or doctor. If you have any questions regarding this policy, please ask our staff. The following are a list of some of the services not covered by insurance companies. These services are billed at the standard hourly rate:

- Court ordered and legal related services
- Preparing reports or letters for other providers or organizations
- Completing documents (for disability claims, insurance reviews, workers' compensation, etc.)
- Consultations by telephone or e-mail
- Duplication of your medical records
- Evaluating, testing or treatment services not covered by your insurance

We sincerely appreciate your cooperation and at any time you have questions regarding insurance, fees, balances or payments please feel free to ask one of our billing staff.

Missed Appointment Cancellation Policy: We consider it an honor and privilege to be of service & hope for a long and mutually satisfying relationship. We do understand that there may be extenuating circumstances; however, we request that any cancellation or rescheduling of your appointment be made at least **24 hours in advance**. We value your time and hope that you value ours. Missed appointments or appointments cancelled less than 24 hours in advance affect us all and prevent us from being able to serve others in need. Because of this, we have created a cancellation and missed appointment policy outlined here.

Name: _____ _____ Intake Date
ID: _____ _____ Therapist Initials
DOB: _____

You will be charged a **$100.00** fee for missed appointments or appointments not cancelled at least 24 hours in advance of the scheduled visit. If you are new to our practice and cancel or are a no-show within 24 hours of your first visit and wish to reschedule, a cancelation fee of **$35.00** will be applied to your bill at the time of your rescheduled appointment.

We provide reminder calls before your appointment as a courtesy. You are still responsible for remembering your scheduled appointments. Stating that you did not receive a reminder call or that the call was made after the 24-hour deadline, does not make your missed or cancelled

appointment an exception. Furthermore, we have a **3 late cancel/no show policy**. If you late cancel or no show for 3 appointments, you will not be rescheduled. We appreciate your consideration of our time and will express the same consideration for yours.

We realize that there may be emergency situations where a 24-hour cancellation notice is not possible, and those situations will be dealt with individually. Questions? Please ask your therapist.

I, the undersigned, agree and consent to participate in the mental health care offered and provided by Sarah Scott, LCSW, LIMHP as defined by Nebraska Law.

I understand that I am consenting and agreeing only to those mental health services that the above-named professional is qualified to provide within the scope of the professional's license, certifications, and training.

Please Print Patient's Name: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Counseling Connections & Associates, LLC

Mental and Physical Health Questionnaire

Current Symptoms (Check Symptoms You Have Recently Experienced)

____ Depressed Mood	____ Loss of Interest	____ Sleep Disturbances
____ Appetite Changes	____ Avoidance	____ Crying Spells
____ Feelings of Guilt	____ Unable to Enjoy Activities	____ Fatigue
____ Feelings of Helplessness	____ Feelings of Worthlessness	____ Low Self-Esteem
____ Feelings of Hopelessness	____ Thoughts of Death	____ Suicidal Thoughts
____ Racing Thoughts	____ Excessive Worry	____ Self-Harm Behaviors
____ Concentration Problems	____ Impulsivity	____ Homicidal Thoughts
____ Feelings of Panic	____ Frequent Mood Swings	____ Increased Risky Behavior
____ Hallucinations	____ Excessive Energy	____ Increased Irritability
____ Feeling Keyed Up or On Edge	____ Gastrointestinal Upset	____ Headaches

Have you ever participated in outpatient therapy? _____ Yes _____ No If Yes please provide names & approximate treatment dates for each provider seen in the space provided below.

Provider:_____ Dates:_____

Provider:_____ Dates:_____

Provider:_____ Dates:_____

Have you ever had inpatient treatment for psychiatric purposes? _____ Yes _____ No If Yes please provide the name(s) of the treatment facilities & the approximate dates for each stay.

Facility:_____ Dates:_____

Facility:_____ Dates:_____

Facility:_____ Dates:_____

Have you ever been diagnosed with any mental health conditions? _____ Yes _____ No If Yes please list all diagnoses below:

_____ _____ _____

_____ _____ _____

Please list all psychotropic medications (with dosages) that you are currently being prescribed.

_____ _____ _____

_____ _____ _____

Allergies: Please list any food, medication, or other allergies you have.

_____ _____ _____

_____ _____ _____

Are you currently being treated by a psychiatrist? _____ Yes _____ No If Yes who are you currently seeing?

Provider: _____ Dates: _____

Have you ever attempted suicide? _____ Yes _____ No - If Yes when? _____

Physical Health Information

Please list any past health conditions including major illnesses, broken bones, and surgeries which required medical treatment. Please also list any hospitalizations for medical conditions.

_____ _____ _____

_____ _____ _____

Please list all medications (with dosages) for physical health reasons that you are currently being prescribed.

_____ _____ _____

_____ _____ _____

Is there any additional family medical history? ____ Yes ____ No If Yes, please explain _____

_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

____ Yes ____ No If Yes, please explain: _____

Have you participated in regular exercise/sports/recreation (about 3 times a week) to keep fit _____ Yes _____ No

Have you been dieting to lose weight? ____ Yes ____ No

Use of Caffeine: Indicate how often in a day you drink beverages containing caffeine including pop, coffee, tea, or energy drinks. _____ _____ Daily _____ Weekly _____ Monthly

Substance Use History

Have you smoked cigarettes on a daily basis? ____ Yes ____ No If yes, # per day: _____

How often in the past month did you drink alcohol? (please circle your answer)

A. I do not drink at all B. About once a month C. 2 to 3 times a month D. 2 to 3 times a week E. Once a day or more

On days that you drink, how many servings of beer/wine/spirits/ do you consume? _____

How often in the past month have you used illicit drugs? (please circle your answer)

A. I do not use drugs at all B. About once a month C. 2 to 3 times a month D. 2 to 3 times a week E. Once a day or more

Please list the names of any illicit drugs and the quantity consumed.

_____ _____

_____ _____

Have you ever been hospitalized for chemical dependency treatment? _____ Yes _____ No If Yes please provide the name(s) of the treatment facilities & the approximate dates for each stay.

Facility:_____ Dates:_____

Facility:_____ Dates:_____

Facility:_____ Dates:_____

Family Background

Where were you born? _____ Where did you grow up? _____

Were you adopted? _____ Yes _____ No

Father's Name: _____ Age: _____ Occupation: _____

Mother's Name: _____Age: _____ Occupation: _____

List your sibling's names and ages: _____

Did your parents divorce?_____Yes _____ No If Yes, how old were you when they divorced? _____

If your parents divorced, whom did you live with? _____

Are you currently: ____ Married ____ Partnered ____ Divorced ____ Divorced ____ Single ____ Widowed

How long? _____

If not married, are you currently in a relationship? ____ Yes ____ No If Yes, How long? _____

How would you identify your sexual orientation? _____

What is our spouse or significant other's occupation? _____

Describe the relationship with your spouse or significant other: _____

Do you have any children? ____ Yes ____ No If Yes, list names and ages: _____

_____

Describe the relationship with your children: _____

_____

Educational/Occupational/Legal Background

Education – Years completed or highest degree earned _____

Military Service: ___Yes ___No If Yes, ____ Present ____ Past How long? _____ Rank_____

Employer Name:_____ Length of employment:_____

Recent/Current Legal Issues: ____ Yes ____ No If Yes please provide a description of current legal issues.

_____

_____

Financial Problems: _____ Yes _____ No

Are there any other concerns that you wish to share with your therapist? _____

_____

_____

_____

_____

_____

C& ASSOCIATES

PARENTAL CONSENT FOR MENTAL HEALTH TREATMENT OF A MINOR

Child's Name: _____

Date of Birth: _____

As the parent or legal guardian with the authority to consent on behalf of the minor child named above, I hereby give my consent for the minor to seek counseling services and/or mental health assessment by Sarah Scott, LCSW, LIMHP.

This consent will be valid until the minor reaches the age of 18, but can be revoked at any time by written notification.

Any questions relating to this form or the proposed treatment can be directed to Sarah Scott at 402-932-2296.

_____ _____

(Print Name of Parent/Guardian) (Signature of Parent/Guardian)

_____

(Date)

_____

(Therapist Signature) (Date)