EMMAUS COUNSELING CENTER

MINOR/CLIENT INTAKE INFORMATION FORM

The information requested in this form will be kept confidential, and will help your counselor to assist you. Please fill out the form as completely as you can. Use a "√" or an "x" to indicate your choices. Write in words or numbers where asked.

CLIENT GENERAL INFORMATION

Last Name _____ First Name _____ Middle Initial ___
Birth Date ___/___/_____ Age ____ Social Security # _____ -____ - _____ ❑ Male ❑ Female
Mailing Address _____ Apt # _____
City _____ State _____ Zip _____
Okay to leave message on: ❑ Home Telephone ( ) _____
❑ Work Telephone ( ) _____ ❑ Cell # ( ) _____
❑ Email address of Parent/Guardian _____
**Guardian/Parent Name(s) You Live With: _____
Emergency Contact: _____ Phone # _____
Name(s) of people who have permission to pick up child after counseling _____
_____
Primary Care Physician: _____
Referred by: _____ Reason for Referral: _____
Reason for choosing this Center: _____
Religious/denominational preference: _____
Your congregation/church/temple: _____
Your racial/ethnic identity: ❑ African-American ❑ Native-American ❑ Asian-American
❑ White/Caucasian ❑ Hispanic ❑ Other

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*__CLIENT__ EDUCATION INFORMATION

School Attending: _____ Current Grade _____

** __CLIENT__ FAMILY INFORMATION (if parents are separated or divorced, please provide copy of Parenting Plan)

Mother's Name: _____ ❑ living ❑ Deceased - Date _____
Father's Name: _____ ❑ living ❑ Deceased - Date _____
Number of *Brothers* [ ] Number of *Sisters* [ ] ❑ Only Child
Names & Ages of *Brothers* [, , , ,]
Names & Ages of *Sisters* [, , , ,]
Have any of your brothers or sisters died? _____ Date(s) _____
If living with Stepfamily:
Stepmother's Name _____ Stepfather's Name _____
Step-Siblings Names & Ages [, , , , ,]

**__PAYMENT METHOD:__ *Party(s) responsible for payment:*

(*Primary Ins.*) Insurance Company: _____
Subscriber Name: _____ DOB _____
Address: _____ Telephone: _____
(*Secondary Ins.*) Insurance Company: _____
Subscriber Name: _____ DOB _____
Address: _____ Telephone: _____
Do you plan to file insurance for these services? ❑ Yes ❑ No ❑ Don't Know
Are you covered by an Employee Assistance Program? ❑ Yes ❑ No ❑ Don't Know
Do you wish to apply for fee assistance? ❑ Yes ❑ No

MINOR/CLIENT INTAKE INFORMATION FORM (page 2)

PROBLEM DEFINITION

What is your reason for seeking help now? _____

_____

Are any of the following conditions a problem at this time? (Check the ones that apply)

___Anxiety	___Substance abuse	___Religious doubts
___Grief	___Chronic fear	___School Problems:
___Depression	___Guilt feelings	___Grades
___Irrational fears	___Suicidal feelings	___Peers
___Nervousness	___Loss of hope	___Teachers
___Loneliness	___Rage	___Truancy
___Anger	___Relationship to parents	___Other (list)
___Sexual problems	___Relationship to siblings	_____
___Self Esteem	___Loss of meaning in Life	_____
___Stress	___Loss of faith in God	_____

What would you like to see happen as a result of psychotherapy or counseling?

_____

MEDICAL/PSYCHOLOGICAL HISTORY

Name and address of your physician: _____

_____

When was your last medical examination? _____

Are you suffering any physical illnesses or symptoms at this time? _____

_____

List major surgeries or illnesses in the last five years: _____

_____

_____

List current medications: _____

_____

Have you or any member of your family received help for drug or alcohol dependency? ❑ Yes ❑ No

When? _____ Name of helping agency _____

Have you received psychotherapy or counseling in the past? ❑ Yes ❑ No. When? _____

Name of treating therapist: _____

Make a check mark if any of these statements are true:

- ❑ Do you have thoughts of harming yourself or others?
- ❑ Are thoughts of harming yourself or others a frequent occurrence?
- ❑ Do you dwell on these thoughts and wonder if you can control them?
- ❑ Have you sought professional help because of these thoughts or feelings?

ACKNOWLEDGEMENT Please sign and date this document attesting that the information you have written on this form is accurate to the best of your knowledge.

_____ _____

CLIENT'S NAME **DATE**

_____ _____

GUARDIAN/PARENT SIGNATURE **DATE**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Emmaus Counseling Center

1124 Stevens Drive
Richland, WA 99354
(509) 946-1430 Fax (509) 946-1432

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Client Name: _____

Relationship to Client: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

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EMMAUS COUNSELING CENTER

THERAPY INFORMATION AND DISCLOSURE FORM

Welcome Emmaus Counseling Center welcomes you as a potential client. We believe it is important for you to be informed about the nature of counseling or psychotherapy, the policies and procedures governing the help you will receive here, the fees charged for our services, and your rights as a client. At the end of this statement there is a place for you to sign, signifying your general consent to therapy.

Counseling and Psychotherapy In This Center The words counseling and psychotherapy (referred to below as "therapy") are often used interchangeably to indicate forms of psychological help that address various kinds of personal and family distress such as depression, anxiety, adjustment difficulties at work and with other people, and marital and family conflicts. The goals of therapy range from the relief of symptoms to significant life change based on acquiring a better understanding of one's personal, interpersonal, and social circumstances. _____**(initial here)**

Emmaus Counseling Center's methods of treatment are based on standard practices common to the training and experience of psychotherapists, marriage and family therapists, psychologists, social workers, and pastoral counselors. Practitioners in this Center work within the standards and ethical guidelines of state licensing laws, of professional associations, and of the Samaritan Institute. [A statement of Professional and Clinical Standards is available on request.] Emmaus Counseling Center therapists also respond to the spiritual and theological needs of clients who recognize that values, beliefs, and religious affiliations make a difference in the process of changing and growing, and who want these factors to be considered in their therapy. _____**(initial here)**

Therapy Process Therapy begins with an *intake process* designed to evaluate your needs and difficulties and to help you and the therapist make a decision about engaging in therapy. This may take one interview or a series of interviews. If becoming a client here does not seem feasible, you will be helped to select a more appropriate place for the help you need. The *therapy process* itself may take many forms, depending on the issues that need to be addressed and how far you wish to go in dealing with them. Treatment is guided by a *treatment plan* that you and your therapist both agree to pursue. Therapy ends when the work is done, or at the point you decide to end it. _____**(initial here)**

Clients are entitled to receive information from therapists about their credentials, education, methods of therapy, the possible duration of therapy, and fees. Your therapist will disclose these facts and opinions in the initial interview/s. _____**(initial here)**

Therapy Policies and Procedures

Your Rights as a Client. You have all of the rights established by the state of Washington governing clinical practices. These include the rights of consent to treatment, of seeking disclosure from your therapist about his or her qualifications, of requesting a different therapist, of ending treatment at any time, of accessing the client grievance procedures, and of having the records of your treatment kept in confidence (see confidentiality statement below). _____**(initial here)**

Confidentiality. What you tell your therapist will be kept strictly confidential and will not be revealed to other persons or agencies without your written permission, except when mandated by state and federal statutes, and as part of the professional practice of this Center. By law, there are circumstances when the therapist must report information to the appropriate persons or agencies, for example: a) if you threaten grave bodily harm or death to yourself or someone else; b) if you reveal information about child or parental abuse; and c) if ordered by a court of law. If your therapy is court ordered, the results of treatment or tests must be revealed to the court. Also, in keeping with standard professional practice, your case records may be viewed by Emmaus Counseling Center staff, consultants, and accreditation reviewers for purposes of diagnosis, treatment, and quality control. In all other instances, your written permission is required before your therapist or the Center can reveal information about your treatment. _____**(initial here)**

Fees & Payments. The therapy Fee Agreement that you will complete in the intake interview will state your fee and payment requirements. We request payment at the time of your therapy appointment. You may pay by cash, check, or credit card. Any check returned because of insufficient funds will result in a charge to you of $15 plus bank charges. If your bill becomes 30 days overdue, you will be assessed a monthly compounded interest of 1.5% in addition to the bill. The director of the Center has the right to seek assistance from the Samaritan Fund on a financial need basis. In the event your bill becomes larger than $250 without payment, therapy will be discontinued until a reasonable effort to pay has been made. A payment plan can be established that will require monthly payments over no longer than a 6 month period. If there have been no payments made or payment plan established after 60 days, we reserve the right to turn your account over to a collection agency. You specifically waive any right to confidentiality regarding financial information given to Emmaus Counseling Center in the event your account is turned over to a collection agency. _____**(initial here)**

Appointments and Cancellations. All appointments are made with your counselor unless the counselor specifically asks the office to make the appointment. If you are unable to keep a scheduled appointment, please notify your counselor or leave a message with the Center's voice messaging system 24 hours in advance. Failure to give 24 hour notification to the counselor or the Center may result in a charge up to the amount of your fee. This charge is not covered by insurance. _____**(initial here)**

Insurance and Other Third-Party Payments. If you have insurance or some other third-party coverage (e.g., a managed care organization or employee assistance program) that pays for therapy, you are responsible for giving the Center this information on the Insurance Information Form. The Center will file your claims if the information you give us is accurate and complete. The Center does not guarantee that your insurance or other coverage will pay your claim. You are responsible for the account balance and for deductibles and co-payments required by the insurance or third-party company. _____**(initial here)**

Ending Therapy. Although you may end therapy at any time, it is preferred that you have at least one face-to-face concluding appointment with your therapist rather than terminating by telephone, mail, or by not showing up. At the time of discharge, clients are given or sent a Client Satisfaction Form that is used to elicit feedback on the therapy process. This is a valuable tool to increase the Center's awareness of the strengths and weaknesses of our services. _____**(initial here)**

General Consent to Therapy

You will be asked to sign this consent when you meet with your therapist.

- ❑ I have seen and read the information contained in this Therapy Information and Disclosure Form
- ❑ I consent to treatment as described in the Therapy Information and Disclosure Form, and will pay for my therapy expenses as prescribed in the Fee Agreement.

Client Signature/s

_____

_____

_____

Witness signature

_____

Date _____

Parent or Legal Guardian of a Minor

_____

Date _____

EMMAUS COUNSELING CENTER

INSURANCE INFORMATION FORM

This form is required for all clients who are covered by insurance, EAP, or managed care benefits.

1. Client's Name: _____
2. Name of Insured: _____
3. Insured's Employer (if group policy): _____
4. Insured's Date of Birth: _____
5. Address of Employer: _____
6. Insurance Card ID/SSN of Insured: _____
7. Relationship of Client to Insured: _____
8. Check one of the following: ❑ Insurance ❑ Managed Care ❑ EAP
9. Managed Care/ Insurance Company: _____
   Address: _____
   Telephone: _____ Group Number: _____
10. Is there another health benefit plan or insurance company providing coverage? ❑ Yes ❑ No
    If Yes, complete the following:
    Name of Insured: _____
    Other Insured's Policy or Group Number: _____ Other Insured's D.O.B. _____
    Other Insured's Employer: _____
    Other Insurance Plan Name: _____

RELEASE OF INFORMATION FOR CLAIM BENEFITS

I hereby authorize Emmaus Counseling Center and any member of the clinical staff of the Center to provide summary of care and assessment information regarding evaluation and /or treatment of (client's name) _____ for the purpose of evaluating and processing claims for benefits.

Signed: _____ Date signed: _____

Client or Parent/Legal Guardian

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO CENTER
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

I hereby instruct and direct the _____Insurance Company to: Pay by check made out and mailed directly to

Emmaus Counseling Center
1124 Stevens Drive
Richland, WA 99354

OR – if my current policy prohibits direct payment to the Center, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

c/o Emmaus Counseling Center
1124 Stevens Drive
Richland, WA 99354

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered by Emmaus Counseling Center. This payment will not exceed my indebtedness to above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize Emmaus Counseling Center to release any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Dated at _____ this _____day of _____, 20___.
(CITY & STATE) (MONTH)

_____
(SIGNATURE OF POLICYHOLDER)

_____
(SIGNATURE OF CLAIMANT IF OTHER THAN POLICYHOLDER)