Hope for Healthy Families Counseling Center

8788 Elk Grove Blvd, Bldg 1, Suite L Elk Grove, California 95624
Phone (916) 686-9209 Fax (916) 667-3239

INFORMATION FOR CLIENTS

Confidentiality

Information revealed in the course of therapy is protected by professional and ethical standards. All material is confidential and not released without your written consent except information related to suspected child abuse, elder or dependent adult abuse, and situations involving imminent harm to oneself or others.

Informed Consent

The process of therapy requires courage, commitment, and risk taking. There may be times when the information discussed in a therapy session will cause distressing feelings and/or thoughts. At times, you may experience physical symptoms as a result of processing distressing information. Please share this with me, so we may explore together ways in which you can manage these feelings and thoughts. Because every person is different, there is no way to predict how you will respond to the process of therapy, or how long the process will take for you. Your therapy session is 50 minutes. If your session goes longer there may be an additional charge.

HIPAA

Under the Health Insurance Portability and Accountability Act of 1996, we are required to provide a Notice of Privacy Practices regarding your Protected Health Information (PHI). This is posted on the wall in the office. Counselors Your therapist is a MFT Trainee, MFT Intern, Professional Clinical Counselor Trainee, a Mental Health Practitioner, or a Psychological Student Trainee earning hours toward graduation or licensure and is under the clinical supervision of Executive Director, Leina Hoyt, Licensed Marriage and Family Therapist.

Fees and Payment

Your fee will be discussed with you prior to the first session. We request that you pay your fee at the time of each session, unless other arrangements have been made ahead of time. If your fee was established using a sliding scale, and your financial situation changes significantly during the course of treatment, your fee will be renegotiated. We accept cash, personal checks, cashier checks, major credit cards, and PayPal. Returned checks will incur a $25 fee. Please keep in mind that if your therapy is court ordered, you may incur additional fees due to report writing, phone consultations, etc. Your fee is _____/session.

Cancellations

We have allocated your appointment time just for you. Cancellations or changes in session dates or times must be made 24-hours in advance. If an appointment is cancelled or missed without 24-hour notice, you will be charged for the session. If a third party is paying for your session, you will be responsible for any late cancelation or no show fees.

Your signature indicates that you have read and agree to abide by the above policies.

_____ _____

Signature Date

Counselor's Initials _____

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CLIENT INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please fill out this form and bring it to your first session or allow yourself thirty minutes prior to your appointment to complete the form in the office.

Name: _____

(Last) (First) (Middle Initial)

Local Address:

_____

(Street and Number)

_____

(City) (State) (Zip)

Home Phone: ( ) _____ May we leave a message? □ Yes □ No

Cell/Msg. Phone: ( ) _____ May we leave a message? □ Yes □ No

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status: □ Never Married □ Partnered □ Married □ Separated

□ Divorced □ Widowed

Number of Children: _____ ____ Girl(s) ____Boy(s)

E-mail: _____ May we email you? □ Yes □ No

*Please be aware that email might not be confidential.

Referred by: _____

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? □ Yes □ No

Have you had previous psychotherapy? □ No If Yes, previous therapist's name:

_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?

□ Yes □ No If yes, please list: _____ _____

_____ _____ _____

If no, have you been previously prescribed any medication? □ Yes □ No

If yes, please list: _____ _____ _____

_____ _____ _____ _____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): _____

_____

3. Are you having any problems with your sleep habits? □ No □ Yes

If yes, check where applicable: □ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Disturbing dreams □ Other _____

4. How many times per week do you exercise? _____ How long? _____

5. Are you having any difficulty with appetite or eating habits? □ No □ Yes

If yes, check where applicable: □ Eating less □ Eating more □ Binging □ Restricting

Have you experienced significant weight change in the last 2 months?

□ No □ Yes

6. Do you regularly use alcohol? □ No □ Yes

How often do you have 4 or more drinks in a 24-hour period? _____

7. How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Rarely □ Never

8. Have you had suicidal thoughts recently? □ Frequently □ Sometimes □ Rarely □ Never

Have you had them in the past? □ Frequently □ Sometimes □ Rarely □ Never

9. Are you currently in a romantic relationship? □ No □ Yes

If yes, how long have you been in this relationship? _____

On a scale of 1-10, how would you rate the quality of your current relationship? _____

10. In the last year, have you experienced any significant life changes or stressors:

_____

Have you ever experienced any of the following?

Extreme depressed mood: □ No □ Yes Extreme Mood Swings: □ No □ Yes

Rapid Speech: □ No □ Yes Extreme Anxiety: □ No □ Yes

Panic Attacks: □ No □ Yes Phobias: □ No □ Yes

Sleep Disturbances: □ No □ Yes Hallucinations: □ No □ Yes

Unexplained losses of time: □ No □ Yes Unexplained memory lapses: □ No □ Yes

Alcohol/Substance Abuse: □ No □ Yes Frequent Body Complaints: □ No □ Yes

Eating Disorder: □ No □ Yes Body Image Problems: □ No □ Yes

Homicidal Thoughts: □ No □ Yes Suicide Attempt: □ No □ Yes

Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing): □ No □ Yes

Repetitive Thoughts (e.g., Obsessions): □ No □ Yes

OCCUPATIONAL INFORMATION:

Are you currently employed? □ No □ Yes If yes, who is your current employer/position? _____

If yes, are you happy at your current position? _____

Please list any work-related stressors, if any: _____

_____

_____

_____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? □ No □ Yes

*Leave this question blank if you would rather not answer.

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? □ No □ Yes

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Circle any that applies and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty: **Family Member:**

Depression: □ No □ Yes _____

Bipolar Disorder: □ No □ Yes _____

Anxiety Disorders: □ No □ Yes _____

Panic Attacks: □ No □ Yes _____

Schizophrenia: □ No □ Yes _____

Alcohol/

Substance Abuse: □ No □ Yes_____

Eating Disorders: □ No □ Yes _____

Learning Disabilities: □ No □ Yes _____

Trauma History: □ No □ Yes _____

Suicide Attempts: □ No □ Yes _____

OTHER INFORMATION:

What do you consider to be your strengths?

_____

_____

What do you like most about yourself?

_____

_____

What are effective coping strategies that you've learned?

_____

_____

_____

What are your goals for therapy?

_____

_____

_____

_____

Your signature below indicates receipt of a copy of HIPAA:

_____ _____

Signature Date

Hope for Healthy Families Counseling Center

Credit Card Authorization Form

I _____ (name of card owner) authorize Hope for Healthy Families Counseling Center to charge my credit card for the counseling sessions at the rate of _____ per session. In addition, I authorize Hope for Healthy Families Counseling Center to charge my credit card for cancellation of sessions not honoring the 24-hour cancellation policy.

_____ _____

Authorized signature of cardholder **Date**

_____

Printed name of cardholder

Card Type: VISA
MasterCard
Discover

Card Number: _____

Expiration Date: _____ Security Code: _____

Name as it appears on card: _____

Billing Address: _____

Email: _____

Phone Number: _____

I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL I CANCEL IT IN WRITING AND AGREE TO NOTIFY HOPE FOR HEALTHY FAMILIES COUNSELING CENTER IN WIRTING OF ANY CHANGES IN MY ACCOUNT INFORMATION OR TERMINATION OF THIS AUTHORIZATION AT LEAST 15 DAYS PRIOR TO THE NEXT SESSION DATE. I UNDERSTAND THAT IN CASE OF A CHARGE DECLINE I WILL SUBMIT PAYMENT IN FULL BY ANOTHER NEGOTIABLE METHOD (CASH, CHECK, OR ANOTHER CREDIT/DEBIT CARD)

Notice of Privacy Practices Short Form

Our practice is committed to educating our patients about healthcare issues that affect them. As a result, we are providing you with general information about the Privacy Rules, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) along with a brief overview of our new Notice of Privacy. Our practice is complying with HIPPA's regulations.

What is HIPPA and how does the privacy rule affect you?

When the Health Insurance Portability and Accountability Act (HIPPA) was passed in August of 1996 this gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The Privacy Rule was created to protect your rights as a patient of our practice and we are required by law to be compliant with this regulation on April 14, 2003. Under the Privacy Rule you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

What is individually identifiable health information (IIHI)?

Any health information you provide, including your mailing address. Information that is created and retained by our practice or received by another healthcare provider that relates to treatment, payment and/or that identifies you as an individual. What is the Notice of Privacy Practice? Our practice has an official Notice of Privacy Practice posted in our treatment areas informing our patients about their rights surrounding the protection of your IIHI and our obligations concerning the use and disclosure of your IIHI. This notice applies to all records created or retained by our practice. We can update our Notice of Privacy Practices at any time. It will be posted in our treatment areas and you can ask for a copy of the current notice at any time.

The following categories describe the different ways in which we may use and disclose your IIHI:

- Treatment
- Appointment Reminders
- Release of information to family/friends
- Payment
- Treatment Options
- Disclosures Required by Law
- Healthcare Operations
- Health related benefits & services

The following categories describe unique situations in which we may use or disclose your identifiable health information:

- Public risks
- Health oversight activities
- Lawsuits
- Law enforcement
- Deceased patient's organ and tissue donation
- Serious health threats/safety
- Research

What are your rights concerning your individually Identifiable Health Information (IIHI)?

You have rights regarding the IIHI that we maintain about you. In our Notice of Privacy you can view the policies and procedures you will need to follow for the areas listed below:

1. Confidential communication
2. Requesting restrictions
3. Inspection and copies
4. Amendment
5. Accounting of Disclosures
6. Right to a paper copy of this notice
7. Right to file a complaint
8. Right to provide and authorization for other uses

If you have any questions regarding this notice or our health information privacy policies, please contact:

Leina Hoyt, LMFT
Executive Director
Hope for Healthy Families Counseling Center
916-686-9209