Gina West, MA, CIT

Supervised by Carpenter Counseling Service, LLC

Client Information Form

CONFIDENTIAL

Please complete the below items, as applicable to you. You may use the back of the sheet as necessary.

DEMOGRAPHIC INFORMATION:

Client Name (s):_____ Male/Female (please circle)

Parent Name (s):_____ (Complete only if client is a minor.)

Birthdate (s) of Client (s):_____

Address:_____ Home Phone:_____

City, State and Zip:_____ Work Phone:_____

Referred By:_____ Cell Phone:_____

E-mail (parent's email if client is a minor):_____

Gina West can leave messages at these phone numbers (circle any that apply):

Home Work Cell

EMPLOYMENT AND INSURANCE (FOR PRIMARY CLIENT, OR FOR PARENT, IF CLIENT IS A MINOR):

Employer Name:_____ Phone:_____

Employer Address:_____

Position Held:_____ How Long:_____

Name of Policy Holder:_____ Relationship to Client:_____

Insurance Company:_____

Policy#:_____ Group #:_____

Address:_____

MEDICAL HISTORY: *Mental health goes "hand-in-hand" with physical health. Completion of the below as thoroughly as possible will greatly assist this office in working with you. The below questions all pertain to the client.*

Name and address of your primary care physician:_____

_____

When was your last physical exam?_____

What was the outcome?_____

Have your family members suffered from a major medical illness? ❒ Yes ❒ No Please specify:_____

Have you had any major medical operations? ❒ Yes ❒ No Please specify:

_____

Have you had your thyroid checked and/or do you know of any thyroid issues/disease? Does this apply to members of your family?_____

_____

Circle any physical concerns you are having at present:

Headaches	Stomach (and or Bowel) Trouble	Skin problems
Dizziness	Tics	Dry Mouth
Palpitations	Fatigue	Burning or Itchy Skin
Muscle Spasms	Twitches	Chest Pains
Tension	Back Pain	Rapid Heart Beat
Sexual Disturbance	Fainting Spells	Blackouts
Hearing Things	Seeing Things	Excessive Sweating
Tingling	Watery eyes	Visual Disturbances
Numbness	Flushes	Hearing Problems

Other (please describe):_____

Are you currently being treated for the above? ❒ Yes ❒ No Please specify:_____

On average, how many hours of sleep do you get nightly?_____

Do you have trouble falling or staying asleep? ❒ Yes ❒ No If yes, please describe:_____

_____

Have you gained or lost over ten pounds this last year? ❒ Yes ❒ No ❒ Gained ❒ Lost

If yes, was this on purpose? ❒ Yes ❒ No To what do you attribute the change?_____

_____

Current Medications/Doses/Purpose*:

Medication	Dose	Purpose

***PLEASE INCLUDE ANY MEDICATIONS YOU ARE CURRENTLY TAKING. INCLUDE ASPIRIN, BIRTH CONTROL, PRESCRIPTION, *OVER THE COUNTER AND HERBAL MEDICATIONS.* PLEASE INFORM THIS OFFICE SHOULD THESE CHANGE.**

For female clients only:
Do you have a regular period? ❒ Yes ❒ No

Do your periods affect your mood? ❒ Yes ❒ No

Are you pre-menopausal or post-menopausal? ❒ Yes ❒ No

Any relevant information about your cycle, hormones, abortions, or miscarriages? ❒ Yes ❒ No If yes, please describe:_____

_____

FAMILY INFORMATION:

Present Marital Status:

❒ N/A (Client is a minor.) ❒ Never Married ❒Engaged to be Married ❒Married Now for the First Time ❒Married Now, after the First Time ❒Separated ❒Divorced and not Remarried ❒Widowed and not Remarried ❒Other: _____ (please specify)

Are you currently (or have ever been) in an abusive relationship? ❒ Yes ❒ No

If you are married, are you currently living with your spouse? ❒ Yes ❒ No*

*If no, how long have you been separated? _____

How long have you been married?_____

How long did you know one another before becoming engaged?_____

Name of your spouse (current)_____

Will your spouse be attending counseling with you? ❒ Yes ❒ No

May this office share information with your spouse?* ❒ Yes ❒ No

*Please note that this office is mandated to report child abuse, sexual misconduct, and the potential of harm to self or others.

Children (If client is a minor, please list their brothers and sisters, including step-siblings.):

Male/ Female	Name	Age	In the home? Yes or No*	Living/Deceased	If deceased, date of death and cause

*If no, child/ren currently reside/s with:_____

Names and Ages of Others in Household:_____

_____

MENTAL HEALTH/COUNSELING HISTORY:

Are you currently receiving counseling services? ❒ Yes* ❒ No Provider:_____

*If yes, please briefly describe:_____

Have you received counseling services in the past? ❒ Yes* ❒ No Provider:_____

*If yes, please briefly describe:_____

Have you ever been hospitalized for psychological problems? ❒ Yes* ❒ No Provider:_____

*If yes, please briefly describe:_____

Have you received any mental health diagnoses? ❒ Yes ❒ No Diagnosis:_____

What is (are) your main reason(s) for this visit?_____

_____

On the scale below, please estimate the severity of your problem(s):

❒ Mildly Upsetting ❒Moderately Upsetting ❒Very Upsetting ❒Extremely Upsetting ❒Totally Upsetting

When did your problem(s) begin?_____

Under what conditions does your problem(s) seem to get *worse*?_____

_____

Under what conditions does your problem(s) seem to get *better* (and what solutions have you found most helpful)?_____

_____

Circle any psychological concerns you are having at present:

Aggression
Alcohol Dependence
Anger
Antisocial Behavior
Anxiety
Avoiding People
Chest Pain
Depression
Disorientation
Distractibility
Dizziness
Drug Dependence
Eating Disorder
Elevated Mood
Fatigue
Hallucinations
Heart Palpitations
High Blood Pressure
Hopelessness
Impulsivity
Irritability
Judgment Errors
Loneliness
Memory Impairment
Mood Shifts
Panic Attacks
Phobias/Fears
Recurring Thoughts
Sexual Difficulties
Sick Often
Sleeping Problems
Speech Problems
Suicidal Thoughts
Thoughts Disorganized
Trembling
Withdrawing
Worrying

Other (please describe):_____

_____

How do each of the symptoms that you checked impair your ability to function (i.e. socially, emotionally, at work, physically, etc.) Use the back of this sheet if necessary.

_____

_____

Have you ever attempted suicide? ❒ Yes ❒ No

Does any member of your family suffer from Alcoholism, Drug Abuse, Epilepsy, Depression, or Mental Disorders? ❒ Yes ❒ No If yes, please describe:_____

_____

Has any relative attempted or committed suicide? ❒ Yes ❒ No

Have you had any serious problems with the law? ❒ Yes ❒ No

Check any of the following that apply to you:

	NEVER	RARELY	FREQUENTLY	OFTEN
Aspirin				
Tylenol, Aleve, etc. (non prescription pain relievers)				
Pain killers (prescription, please specify)				
Herbal Drugs or Medications (please specify)				
Marijuana				
Tranquilizers				
Sedatives				
Alcohol				
Cocaine				
Narcotics				
Stimulants				
Hallucinogens, LSD				
Coffee				
“Energy” Drinks				
Cigarettes				
Diarrhea				
Constipation				
Nausea				
Vomiting				
Allergies				
High Blood Pressure				
Headaches				
Backaches				
Fitful Sleep				

Early Awakening from Nightly Sleep				
Overeat				
Poor Appetite				
Eat "Junk Foods"				

RELIGION (NOT REQUIRED, BUT GENERALLY HELPFUL):

What is your present religious affiliation?

❒ Catholic
❒ Jewish
❒ Protestant (specify denomination if any)
❒ None, but I believe in God
❒ Atheist or Agnostic
❒ Other (please specify) _____

How important is your religious commitment to you?

❒ Unimportant ❒Average Importance ❒Extremely Important

Do you desire to have your religious beliefs and values incorporated into the counseling process?

❒ Yes ❒ No ❒ Not Sure If yes, please explain:_____

_____

FEE AND RELEASE AGREEMENT: Please take a few minutes to read this to avoid misunderstandings about payment.

I understand that fees are due and payable when services are rendered. In signing this fee agreement, I authorize the release of information required to process this and future claims to the Referral Source; I also hereby authorize payment of benefits to the service provider. ***I agree to pay in full for any schedule appointment for which I fail to appear or do not cancel at least 24 hours in advance.*** I agree to pay for telephone contacts of a therapeutic nature.

Signed:_____ Date:_____

Signed:_____ Date:_____

Today's Date:_____

Financial Policy and Fee Agreement

I am committed to providing you with the best possible service. Your clear understanding of my Financial Policy is important to our professional relationship. Please ask if you have any questions about my fees, Financial Policy, or your responsibility for payment.

- All Clients must complete the information form and financial policy before seeing the therapist.
- Full payment is due at the time of service.
- I will accept cash, check, or money order for payment.

Regarding Insurance:

Full payment is due by the client(s) at the time of service. I provide services at a reduced fee, and at this time do not accept insurance.

Insufficient Funds:

I do require reimbursement for all bank fees charged in the event of check received with insufficient funds.

Missed Appointments:

Your appointment time is especially reserved for you. Policies regarding charging for missed appointments appear on the next page. Please help me serve you better by keeping your scheduled appointments; let me know if you have questions or concerns.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I have read all of the information on this sheet, and have also completed the "Client Information" form. I certify that this information is true and correct to the best of my knowledge; I will notify you of any changes regarding the above information.

Responsible Party Signature:_____ Date:_____

Gina M. West, MA, CIT Today's Date:_____
Supervised by Carpenter Counseling Service, LLC

Disclosure Statement/Informed Consent

Welcome! I am very glad to meet you.

Please read the following Disclosure Statement/Informed Consent carefully, since it provides you with very important information regarding counseling.

Regarding Confidentiality:
In this office, I strive to create an environment where my clients feel safe, comfortable, and free to discuss difficult topics. Generally speaking, information provided by a client during counseling sessions is legally confidential, and the counselor cannot disclose the information without the client's consent. However, I may be required to disclose information if:

- Requested by your insurance company (typically this information includes general diagnosis and dates of service).
- There is a threat to your own or other's safety/lives.
- I am subpoenaed.
- You or your children report about physical, sexual abuse, or elder abuse. By Missouri law, this must be reported to the Missouri Department of Social Services.
- Information is necessary for case supervision or consultation.
- You sign a release of information, and ask me to contact another provider (e.g. a physician).

Please note that I do not engage with my clients on social networking sites (such as Facebook or LinkedIn). This is to ensure your confidentiality. Although my clients do utilize mechanisms such as texting or e-mail, be aware that these modes of communication may or may not be confidential, and I may not be able to respond.

When working with couples, it is my practice to not keep secrets from either party, whether meeting privately or together.

When working with minors, it is my practice to primarily give general information to the parent, as needed for treatment plans and goals. This ensures that your minor is free to speak with me. Exceptions to this policy are: 1) if I feel the minor will be of harm to his/herself, and 2) if I feel there is a potential of harm to others. When this is the case, I will discuss the situation with the minor and the parent. I always review this practice with minors and parents in the first counseling session. Please ask me if you have any questions. This may apply to family counseling as well.

Occasionally, this office may record sessions.

The Missouri Licensing Board:
The Licensing Board of Missouri, Division of Professional Registration, located in Jefferson City, MO, has the general responsibility of regulating the practice of licensed and unlicensed counselors. This agency can be contacted by phone at 573-751-0018. Information about this board is available at the following website: http://www.pr.mo.gov/counselors.asp. In accordance with their policies, I must inform all

clients that I am under supervision for licensure. Tracy Carpenter, MA, LPC 2007034798 provides this supervision.

Please note that sexual contact between a counselor and client is never appropriate, and should always be reported to the licensing board.

ACA Code of Ethics:

This office follows the American Counseling Association Code of Ethics (2005). You may obtain a copy of this code on the web at: http://www.ncblpc.org/Laws_and_Codes/ACA_Code_of_Ethics.pdf

Client Rights:

1. To be treated with consideration and respect.
2. To expect quality services provided by concerned, competent staff.
3. To a clear statement or purposes, goals techniques, rules of procedure and limitations, as well as potential dangers of the services to be performed, plus all other information related to or likely to effect the on-going counseling relationship.
4. To obtain information about the case record, and too have the information explained clearly and directly.
5. To full knowledgeable and responsible participation in the on-going treatment plan.
6. To expect complete confidentiality and that no information will be released without written consent.
7. To see and discuss charges and payment record.
8. To refuse any recommended services and be advised of the consequences of this action.
9. You are entitled to receive information from me about my methods of counseling, the techniques I use, the length of time counseling should take (if I can determine it), and my fee structure.
10. You can seek a second opinion from another counselor, or terminate counseling at any time.

You should be aware that no one can guarantee that counseling will produce certain results. There are some inherent benefits and risks associated with counseling. During the hour you spend in counseling, you will get to know yourself better. Knowing who you are, what you believe in, and why you do the things you do often helps people bring about positive changes in their life. However, you may discover things about yourself that are uncomfortable; sometimes relationships change as a result of counseling; if you are discussing a traumatic event with me, sometimes the feelings get more intense. I can assure you that I will use my professional skills to the best of my ability to address your concerns and help manage possible risks.

Client and Counselor Responsibilities:

Counseling is a mutual endeavor. You and I will work together to develop personal goals and treatment plans. I act as a catalyst for the changes you wish to implement; however, each person can only change themselves. You are responsible for making the effort to work on the problems or issues that concern you. I am devoted to helping you with this process.

When you are working with a counselor, it is important to honor the commitment you have made to meet with your counselor, and to take an active role. For example, it is helpful if you:

- Attend your regularly schedule appointments

- Spend time between scheduled sessions thinking about what you and your counselor have been discussing, or complete any homework assignments given during the counseling session
- Follow through on any actions you agreed to take
- Take the initiative to bring up issues or topics to talk about with your counselor

Coordination of Treatment:

It is important that all health care providers work together. As such, I would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. **Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization**. If you prefer to decline consent no information will be shared.

____**You may inform my physician(s) ____I decline to inform my physician**

PHYSICIAN NAME:_____

CLINIC:_____

ADDRESS:_____

PHONE:_____

Signature(s)_____Date_____

In Case of Emergency:

This office understands that counseling issues do not always arise during normal business hours. If you have a non-life threatening emergency, please contact my cell at 816-694-5955. General questions (of non-emergent nature) will be answered the same business day.

If you have a life threatening emergency, please report to the nearest emergency room, or dial 911 immediately.

If you have any questions, or would like additional information, please feel free to ask.

HIPAA:

This office complies with HIPAA, and a copy has been enclosed in this document for your information.

My signature certifies that I have read this disclosure and have received the HIPAA document.

Signed:_____ Date:_____

Signed:_____ Date:_____

If client is a minor: I _____ give consent that _____ may be treated by Gina West MA, CIT.

Signed:_____ Date:_____

April 14, 2003

NOTICE OF POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION (HIPAA NOTICE FORM)

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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 psychotherapist.
  - Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health 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.
- "Use" applies only to activities within my office (clinic, practice), such as releasing, transferring, or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your 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 and health care operations, I will obtain an authorization from you before releasing this information.

You may revoke all such authorizations (of PHI) 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, and the law provides the insurer the right to contest the claim under the policy.

Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances (please see prior section entitled "Regarding Confidentiality:"

- **Child Abuse**
- **Adult and Domestic Abuse**
- **Health Oversight:** If I receive a request from the Missouri Attorney General's office with respect to an inquiry or complaint about my professional conduct related to disciplinary proceedings and/or investigations conducted by the Missouri State Committee of Psychologists/or Licensed Professional Counselors, I must make available any record relevant to such inquiry.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release this information without written authorization from you or your 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. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** I may disclose confidential information from your record if I believe such disclosure is necessary to protect you or another person from a clear and substantial risk of imminent, serious harm. I may only disclose such information and to such persons as are consistent with the standards of my profession in addressing such problems.
- **Worker's Compensation:** If you file a worker's compensation claim, and if I provide treatment to you relevant to that claim, then I must submit to your employer's insurer or a third party administrator, a report on services rendered.

II. Patient's Rights and Duties of Therapist

Patient's Right

- Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. 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 at alternative locations. For example, you may not want a family member to know that you are seeing me. Upon your request, I will send bills to another address.
- Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing record 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. On your request, I will discuss with you the 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 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.

Therapist'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 terms currently in effect.
- If I revise my policies and procedures, I will provide you with a copy of the revised notice, in person, or via mail.

III. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your record, you may send a written complaint to the Secretary of the U.S. Department of Health and Human Services. You will be given the appropriate address upon request.

IV. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14th, 2003. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail or in person.