Kelcy Eckels
COUNSELING & PSYCHOTHERAPY

Date of Intake: ____/____/_____ Name:_____
Mailing Address: _____
Telephone:_____
Birth Date: ___/___/_____ Age: ___ Gender : M/F; Ethnicity:_____

EMERGENCY CONTACT:

_____
Last Name First Name Relation Age
Mailing Address: _____
Telephone:_____

How did you learn about Kelcy Eckels Counseling & Psychotherapy?

Psychology Today Site Google My Health Insurance Another
Counselor:_____ A Friend/Family Member:_____ A Doctor:_____

What are your expectations, by choosing Kelcy Eckels specifically?

_____
Urgent Needs:_____

Please fill out whatever is applicable to you.
Presenting Problem
Please state in your own words the main reason for seeking counseling.

_____
_____

On the scale below, please estimate the severity of your problems:
< None-----Mild------Extreme>
<0----------5----------10>

When did your problems begin? Please give dates.

_____

Please describe significant events occurring at the time, or since then, which may relate to the development or maintenance of your problems.

_____
_____

So far, what solutions to your problems have been most helpful?

_____
_____

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Have you been in counseling before? Y/N If so, please give, professional titles, dates of treatment and results. _____
Have you ever been hospitalized for psychological problems? Y/N If yes, when and where?

_____

Current Living Situation: Please list all that applies at your current residence.
Name Age Gender Relationship Quality of Relationship (poor, fair, good, abusive)

_____

_____

Personal and Social History: Siblings: If not already listed, please list all of your siblings.
Name Age Gender Relationship Quality of Relationship (poor, fair, good, abusive)

_____

_____

Living y/n (if not include date of death)

_____

Parental/Guardian History
If your father is living, what is his age? _____ His occupation?_____
State of his health? (Good, fair, poor) If deceased, what was his age at the time of death?_____
Cause of death?_____How old were you then?_____
If your mother is living, what is her age? _____ Her occupation_____
State of her health? (Good, fair, poor) If deceased, what was her age at the time of death? _____
Cause of death?_____How old were you at the time_____

If applicable, please provide the following information:
Marital Status: (circle one) *Single- Engaged- Married/Committed- Separated- Divorced- Widowed*
Marriage date: _____ Spouse's Age: _____ Spouse's Occupation: _____
How long did you know one another before your engagement? _____
Former Spouse's Age: _____ Former Spouse's occupation? _____ When were you married? _____
When did the marriage end? _____
How long did you know one another before your engagement? _____ How did the marriage end?
Divorced_____ Deceased_____

CHILDREN: Please list all of your children by order of birth, Name Age Gender Quality of Relationship (poor, fair, good, abusive)

_____

_____

Living y/n (if not include date of death)

_____

FRIENDS: Do you have one or more friends with whom you feel comfortable sharing your most private thoughts and feelings? Y/N

RELIGION: As a child? _____ As an adult? _____ Is religion important to you? _____

OCCUPATION/EDUCATION INFORMATION
Employed? Y/N, Full Time/Part time, Position: _____ Duties:_____
How long have you been employed at this location?_____ Employer:_____
Employer's Address:_____
Are you a student? Y/N Where?_____
Studying what? _____
Last grade/level/degree completed? _____
How would you describe your academic performance:

Excellent- Above Average- Average- Low Average- Poor

What were scholastic strengths and weakness?
Did you date much in high school? Y/N Did you date much in college? Y/N
Circle any of the following that applied during your childhood and/or adolescence:

Happy Childhood *School Problems* *Medical Problems* *Treated as an Adult*

Unhappy Childhood *Family Problems* *Alcohol Abuse* *Emotionally Unattended To*

Emotional/Behavior Problems *Strong Religious Convictions* *Detached Family/Parents*

Drug Abuse *Legal Problems* *Strictness* *Latch Key* *High Standards*

Other _____

Have you ever attempted suicide? Y/N Most recent date:
Does any member of your family suffer from, Alcoholism, Epilepsy, Depression, Mental Disorders? Y/N. If yes, please describe:
_____
_____
Has any relative attempted or committed suicide? Y/N If yes, who? _____
Has any relative had serious problems with the law? Y/N

MENSTRUAL FACTORS: Do your periods affect your mood? Y/N
Any relevant information about abortions or miscarriages? If yes, please describe:
_____
_____
BIOLOGICAL FACTORS: Do you have any current concerns about your physical health? Y/N .
Describe: _____
_____ Please list any medications you are currently taking, or have taken during the past six months. (include aspirin, birth control, prescription or over the counter medicines.)

_____
_____ Have you had accidents, injuries or traumas that have not been previously describe ? Y/N If yes, please provide details and dates: _____

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CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU: (*include last approximate date, and how many times a week/day*)

	Never	Sometimes	Often	Frequently
Marijuana				
Sedatives				
Aspirin				
Cocaine				
Painkillers				
Alcohol				
Coffee				
Tobacco				
Narcotics				
Stimulants				
Hallucinogens				
LSD				
Diarrhea				
Constipation				
Allergies				
High Blood Pressure				
Nausea				
Vomiting				
Insomnia				
Headaches				
Backaches				
Early Morning Awakening				
Difficulty Falling Asleep				
Difficulty Staying Asleep				
Overeating				
Poor Appetite				
Eating a lot of Junk Food				
Dizziness				
Dry Mouth				
Fatigue				
Burning or Itchy Skin				
Muscle Spasms				
Other				

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU: (in past *4 months*)

	0 times/wk	1-2 times/wk	3-4 times/wk	5-7 times/wk
Anxiety/Tension/Stress				
Restless				
Easily keyed up				
Irritability				
Muscle tension				
Depressed mood				
Diminished interest/pleasure				
Weight loss/gain				
Increase/decrease in appetite				
Physically slowed down				
Fatigue/loss of energy				
Difficulty Concentrating/Indecisive				
Recurrent thoughts of death/suicide				
Emptiness				
Angry/Mad/Upset				
Not certain on emotional type, just emotional				
I don't think I have emotions				
Angry/Mad/Upset				
Difficulty making or keeping meaningful connections				
Desire for perfection				
Rigidity				
Difficulty being consistent or reliable for others				
Difficulty being consistent or reliable for self (sticking to and maintaining goals and progress)				
Fear of having deep relationships				
Fear of emotions				
Uncontrollable emotions/thoughts				
I try to not have emotions				

CLIENT RESPONSIBILITIES

I understand and agree that my responsibilities as a client include the following:

1. I to agree keep regular appointments, be prepared and actively participate in sessions. I agree to utilize session gains during week. I understand that information about my life is best to be processed during the therapy session and not via email, text message or phone call.
2. I agree to tell Kelcy whenever I feel in crisis, at risk and/or suicidal, to work with them to come up with a crisis plan, and to give my counselor discretion regarding needed disclosures in a crisis situation.
3. I will ask questions right away if I am uncertain about any aspect of my counseling services or policies.
4. When I want to terminate services, I will discuss this with my counselor ahead of time so that the appropriate amount of planning and therapeutic closure may occur. I respect this stage as an important part of the therapeutic process.

CLIENT RIGHTS

I understand and agree that my rights as a client include the following:

1. To be treated with dignity and respect. Refuse treatment.
2. Ask questions and get answers about services. And participate fully in all decisions about treatment or services.
3. Receive treatment in the least restrictive setting - one that provides the most freedom appropriate to my treatment needs.
4. Participate fully in decisions regarding your discharge from a program and receive advance notice regarding the proposed discharge, unless your behavior threatens the well being of another person.
5. Not be subjected to verbal, physical, sexual, emotional or financial abuse; harsh or unfair treatment.
6. Make complaints, have them heard, and not receive any threats or mistreatment as a result.
7. File a grievance if you are not satisfied with the response to a complaint.
8. Not be discriminated against on the basis of race, age, sex, religion, national origin, sexual orientation, disability, or marital status.

_____ _____

Client or Legal Guardian Signature **Date**

Payment & Scheduling

1. I understand and agree to pay $115 per each individual, 1 hour session. If I'm in need of more time, I can request at the rate of $30 per 15 extra minutes.

2. I understand that long phone calls may be charged a fee at my session rate and may or may not be available due schedule availability.

3. I understand that 3 consecutive canceled scheduled sessions may result with a discharge. I respect that this will allow other people who are able to hold appointments, receive help for themselves.

4. I understand that Kelcy reserves my appointment time for me and only me. If I am unable to keep my scheduled appointment, or a **48 hours notice**, I will still be responsible for the full session fee of $100, which insurance will not cover. I understand that if I am late, that the session will still end on time.

5. I understand that any late cancellation fees will need to be payed before scheduling a new appointment.

6. I understand that if I pay with insignificant funds, I may be responsible for a $20 fee.

7. I understand that if myself or my health insurance fails to pay, I may be responsible for for a 20% late fee, after 3 weeks of receiving notice.

8. I understand that Kelcy is not trained or specialized in providing court services. If I ask for Kelcy Eckels to provide court/legal services, I understand that my fee will be $700/hr, including preparation time (not covered by insurance).

_____ _____

Client or Legal Guardian Signature **Date**

Services Consent & Confidentiality Limits

- I hereby voluntarily consent to utilize the counseling and psychotherapy provided by Kelcy Eckels.
- Any requests for additional administrative services like disability certification and special accommodations related to a psychological condition will have to be provided by another psychologist.

- I have read and hereby certify that I understand the following:

I understand that one of my rights involves confidentiality. Within certain limits, information revealed by me will be kept strictly confidential, and will not be revealed to any other person or agency without my written permission.

I understand that there are certain limits to confidentiality, in which it is required by law and/or professional ethics that a clinician, without my permission. These limits to confidentiality are as follows:

A) If I threaten **grave bodily harm or death to a reasonably identified person**, the clinician or psychological associate is required (1) to inform appropriate legal authorities and the intended victims; (2) to arrange for voluntarily hospitalization; or, (3) to take appropriate steps to initiate proceedings for involuntary hospitalization pursuant to law.

B) If I express a **serious intent to grievously harm myself**, it may be necessary for the clinician or psychological associate (1) to reveal information to family members and/or persons authorized to respond to such emergencies, in order to protect me from harm; (2) to arrange for voluntarily hospitalization; or, (3) to take appropriate steps to initiate proceedings for involuntary hospitalization pursuant to law.

C) If a court of law issues a legitimate **subpoena**, the clinician or psychological associate may be required to provide information that is specifically described in the subpoena.

D) If the clinician or psychological associate has good reason to s**uspect that a child, elderly person, or disabled person is a victim of physical abuse, sexual abuse, or neglect**, he/she is required to report the abuse or neglect to the Department of Human Services and/or law enforcement authorities.

If any of these situations were to arise, Kelcy Eckels would make every effort to fully discuss it with me before taking action, and would limit disclosure to what is necessary.

• I understand these limitations to confidentiality as outlined above.
• I have been offered a copy of this Consent Form. (printed from internet)
• I have been offered a copy of my Client Rights and Responsibilities. (printed from internet)
• I have been offered a copy of the HIPPA: Notice of Privacy. (printed from internet)
• I give Kelcy Eckels permission to leave a message at this number/email address:

_____ _____
(your email address) (your phone #)

Client/Legal Guardian Signature: _____ Date: _____

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Insurance Billing

Consent for Release of Information:

- I hereby voluntarily consent for Kelcy Eckels to submit claims to my Health Care Insurance company for billing purposes and coverage.

- I authorize the release of any medical or other information from Kelcy Eckels to process insurance claims to my insurance company, for billing purposes and coverage.

Authorize Payment:

- I also authorize payment of medical benefits to Kelcy Eckels by my Health Care Insurance company, for mental/behavioral health services provided.

Payment Responsibility:

- I understand that I am responsible for keeping my insurance active.
- I also understand that if my insurance does not cover the fee, I am responsible for the full $100 fee.
- I understand that late cancellations/missed appointment fees are not covered by insurance.
- I understand that health insurance companies require a diagnosis in order for them cover service fees.

If you have meet your deductible (according to your insurance company) you will only pay your usual co-pay amount. If you have not reached your deductible (according to your insurance company), you will pay the full session fee at the time of the session, and that amount will be added to help you reach your deductible. At first contact, Kelcy can help you determine what your copay may be, but be aware that insurance companies can not guarantee what they will cover ahead of time.

Primary Health Insurance Company:_____

Birth Date:_____ Identification Number:_____ Group Number:_____

Secondary Health Insurance Company:_____

Birth Date:_____ Identification Number:_____ Group Number:_____

Please understand that if you do have secondary insurance and don't provide the information, the first insurance company can demand a refund of what they have covered, in which you will be responsible for covering that cost. There is no guarantee that the secondary with cover that cost.

Client/Legal Guardian Signature: _____ Date: _____

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HIPPA: NOTICE OF PRIVACY PRACTICES

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, AND SIGN THE ACKNOWLEDGEMENT OF RECEIPT.

Protecting Your Personal and Health Information
Kelcy Eckels is committed to protecting the privacy of patient personal and health information. Applicable Federal and State laws require us to maintain the privacy of our patients' personal and health information. This Notice explains our clinic's privacy practices, our legal duties, and your rights concerning your personal and health information. In this Notice, your personal health information (PHI) is referred to as "health information" and includes information regarding your health care and treatment with identifiable factors, such as your name, age, address, income, or other financial information. We will follow the privacy practices described in this Notice while it is in effect. This Notice takes effect May 1, 2005 and will remain in effect until replaced.

How We Protect Your Health Information
We protect your health information by
•Treating all of your health information that we collect as confidential.
•Stating confidentiality policies and practices.
•Restricting access to your health information only to those Kelcy Eckels Counseling Services staff that need to know your health information in order to provide our services to you.
•Only disclosing your health information that is necessary for an outside service company to perform its function on the clinic's behalf; such companies have, by contract, agreed to protect and maintain the confidentiality of your health information.
•Maintaining physical, electronic, and procedural safeguards to comply with federal and state regulations guarding your health information.

Uses and Disclosures for Treatment, Payment, and Health Care Operations
Kelcy Eckels may use or disclose your Protected Health Information (PHI), for treatment, payment, and health care operations purposes, as long as you consent to receive evaluation or treatment services from the clinic. To help clarify these terms, here are some definitions. "Treatment, Payment, and Health Care Operations"
•*Treatment* occurs when a Psychological Associate provides, coordinates, or manages your health care and other services related to your health care. An example of treatment: a Psychological Associate consults with another health care provider, such as your family physician.
•*Payment* occurs when a Psychological Associate obtains reimbursement for your healthcare. An example of payment activity: Kelcy Eckels discloses some of your PHI to insurance agencies to obtain reimbursement.
•*Health Care Operations* activities relate to the performance and operation of Kelcy Eckels Counseling Services. Examples of health care operations: quality assessment and improvement activities, business-related matters, such as audits and administrative services, case management and care coordination, conducting training and educational programs, or accreditation activities.
•*"Use"* applies only to activities within Kelcy Eckels, Counseling Services such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
•"*Disclosure"* applies to activities outside Kelcy Eckels, such as releasing, transferring, or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization
Kelcy Eckels may use or disclose PHI for purposes outside treatment, payment, or healthcare 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 Kelcy Eckels is asked for information for purposes outside treatment, payment or healthcare operations, she will obtain an authorization from you before releasing this information.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization (1) to the extent that Kelcy Eckels has 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.

Uses and Disclosures with Neither Consent nor Authorization
Kelcy Eckels may use or disclose PHI without your consent or authorization in the following circumstances.
•**Abuse** – If we have reason to believe that a minor child, elderly person or disabled person may have been abused, abandoned, or neglected, Kelcy Eckels must report this concern or observations related to these conditions or circumstances to the appropriate authorities.
•**Serious Threat to Health or Safety** – If you communicate to Kelcy Eckels personnel an explicit threat of imminent serious physical harm or death to identifiable victim(s), and we believe you may act on the threat, we have a legal duty to take the appropriate measures to prevent harm to that person(s), including disclosing information to the police and warning the victim. If we have reason to believe that you present a serious risk of physical harm or death to yourself, we may need to disclose information in order to protect you. In both cases, we will only disclose what we feel is the minimum amount of information necessary.

Patient's Rights and Clinician's Duties

Patient's Rights
•*Rights to Request Restrictions* – You have the right to request additional restrictions on certain uses and disclosures of PHI. Kelcy Eckels may not be able to accept your request, but if we do, we will uphold the restriction unless it is an emergency.
•*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 being seen at Kelcy Eckels Counseling Services. On your request, Kelcy Eckels will send your bills to another address.
•*Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of your clinic health records. A reasonable fee may be charged for copying or, if necessary, redacting the record(s). Access to your records may be limited or denied under certain circumstances, but in most cases, you have a right to request a review of that decision. On your request, we will discuss with you the details of the request and denial process.
•*Right to Amend* - You have the right to request, in writing, an amendment of your health information as long as PHI records are maintained. The request must identify which information is incorrect and include an explanation of why you think it should be amended. If the request is denied, a written explanation stating why will be provided to you. You may also make a statement disagreeing with the denial, which will be added to the information of the original request. If your original request is approved, we will make a reasonable effort to include the amended information in future disclosures.

Amending a record does not mean that any portion of your health information will be deleted. •Right to an Accounting –You generally have the right to receive an accounting of disclosures of PHI. If your health information is disclosed for any reason other than treatment, payment, or operation, you have the right to an accounting for each disclosure of the previous six (6) years. The accounting will include the date, name of person or entity, description of the information disclosed, the reason for disclosure, and other applicable information. If more than one (1) accounting is requested in a twelve (12) month period, a reasonable fee may be charged.
•*Electronic vs. Paper Copy* – If you received this notice electronically (e.g., accessing a website), you have the right to obtain a paper copy of the notice from Kelcy Eckels upon request.

Therapist's Duties
Kelcy Eckels, and all associated persons, are required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices. Kelcy Eckels reserves the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, Kelcy Eckels is required to abide by the terms currently in effect.

Changes to this Notice
Kelcy Eckels reserves the right to change our privacy practices and terms of this Notice at any time, as permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make such changes, we will update this Notice and post the changes in the waiting room or lobby of the facility. You may request a copy of the Notice at any time.

Questions and Complaints
For questions regarding this Notice or our privacy practices, please contact the Kelcy Eckels. If you are concerned that your privacy rights may have been violated, you may contact Kelcy Eckels to make a complaint. You may also make a written complaint to the U.S. Department of Health and Human Services. If you choose to make a complaint with us or the U.S. Department of Health and Human Services, we will not retaliate in any way.

Department of Health and Human Services
Office for Civil Rights 1301 Young Street - Suite 1169 Dallas, TX 75202 (214) 767-4056; (214) 767-8940 (TDD) (214) 767-0432 FAX Toll free: 1-800-368-1019 http://www.hhs.gov/ocr/hipaa/

LOCATION: Practicing within the Grove Counseling & Psychotherapy group.

You may type: Kelcy Eckels Counseling & Psychotherapy into Google-maps.

5225 N. Shartel Ave. Okc, Ok 73118 Ste. 201

North of 50th & Shartel, across the street to the West from Post Office, 2nd Floor. Additional parking in small lot to the North of the building.

Have a seat in the Grove waiting room and I'll meet you there at your appointment time. I'll be available by phone a few minutes prior for directional support.