Life Practice Counseling Group

a non-profit agency Sliding-Fee

"*Life* is comprised of continuous opportunities to *practice*."

Main Line: (916) 300-6576 3650 Auburn Blvd. #C-208, Sacramento, CA 95821
3336 Bradshaw #215, Sacramento, CA 95827 / 5651 N. Pershing Ave. #C-6, Stockton, CA 95207

CLIENT INTAKE FORM

Confidentiality: What is revealed in this setting is protected by professional and ethical standards. All material is confidential and not released without your written consent except information related to child abuse, elder abuse, threatened homicide or suicide, threatened or real fatal harm to self or harm to others, or to consult with health care professionals you are seeing in regards to your health.

_____ Initials For couples/family therapy your counselor may utilize a "No Secrets" Policy. This means that if you participate in family/marital/couples therapy, your counselor is permitted to use information obtained in an individual session with other members of the family unless you specifically tell your counselor not to disclose certain information.

_____ I AGREE or _____ I DO NOT AGREE to a "No Secrets" Policy.

Email/Text Disclosure: If you choose to correspond with us using email or text, please be advised that although we take responsible precautions to ensure confidentiality through email or text, we cannot guarantee secure electronic transmissions arising from the use of email or text or any attachments.

Counselors: Counseling is provided by counselors who are in training to become Licensed Marriage & Family Therapists (MFT), Licensed Professional Clinical Counselors (LPCC), or Licensed Clinical Social Workers (LCSW) and are in a weekly group supervision to discuss cases with a qualified licensed therapist.

Fees and Payments: Your fee is based on a sliding fee scale according to your household income. We request you pay your fee at the time of each session. You are responsible for any bank fees incurred due to returned or re-deposited checks. If you prepay, credits will be applied or we can offer a tax-deductible receipt for overpayments as a donation, there are no refunds given. _____ Initials

Cancellations: Cancellations need to be made at least 24-hours in advance. If an appointment is canceled or missed without at least a 24-hour notice, you may be charged for the fee. _____ Initials

Your Session: The therapy session is 50 minutes in duration.

Counseling Process: Counseling is a partnership between you and your counselor and progress depends on many factors that include motivation, effort, and a willingness to participate and cooperate. You have a right to agree or disagree with your counselor and ask questions about the process. During counseling there may be times that you remember unpleasant or disturbing events from your past and it can bring about some intense emotions. The benefits of counseling can include the ability to better cope with your relationships, increase in your self-awareness, personal growth, and you may achieve your personal goals. Counseling can bring resolution of the presenting problem or can bring unwanted and unexpected changes. Our counselors bring expertise and knowledge to help you make healthy and appropriate decisions and choices for yourself.

We hope your experience at Life Practice Counseling Group is a positive one and assists you in the development of your life. Signing says you agree to and fully understand the contents of this intake.

Client's Signature_____ Date _____

Counselor's Signature & Printed Name _____ Date _____ 11/9/13

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NEW CLIENT INFORMATION

Welcome. So that we may assist you, please complete the following:

Date: _____ Marital Status: _____ Occupation: _____

Name:_____ Date of Birth: _____ Age:_____

Name of Significant Other:_____ Date of Birth: _____ Age: _____

Home Address: _____City: _____

Home phone: ( ) _____ Cell phone: ( ) _____

Work phone: ( ) _____ Fax: ( ) _____

If we call, can we identify ourselves as counselors from Life Practice Counseling? Yes___ No ___

Can we contact you by email? Yes__ No__ Email Address: _____

Emergency contact: _____Phone: _____

Emergency contact: _____Phone: _____

Highest Grade Completed in School: _____ Monthly Income: _____ (Couples combine)

Physician: _____ Phone: _____ Last Checkup Date: _____

Medications currently taking: _____

Reason for Counseling:_____

Previous psychotherapy? Yes ___No ___Year and reason: _____

On average how many days/week do you drink alcohol? _____ **How many drinks/day?** _____

Have you ever tried drugs? ___ **What types?** _____ **Currently using?** ___ **How often?** _____

How did you find us? Yahoo Google Yellowpages.com Craigslist Facebook Other:_____

May we know who referred you? _____

Termination of Therapy: You have the right to terminate therapy at any time and as you reach the end of your goals, you and your counselor will discuss termination. Therapy can be terminated if either of you feel you are not benefiting from therapy, if the counselor can no longer be objective, if you have not paid for the last two sessions, or failed to provide a 24-hr notice of cancellation two or more times. Treatment alternatives will be provided.

Your signature: _____ Date:_____

7/12/10

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HIPAA Notice of Privacy Practices

1. This notice describes how medical information about you may be used and disclosed electronically and how you can get access to this information. Please review it carefully.

2. I have a legal duty to safeguard your protected health information (PHI) when I transmit information electronically. I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care.

I must provide you with this Notice about my privacy practices, and such Notice must explain how, when and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made.

By signing this notice you acknowledge we may use your PHI, but may not disclose your PHI without further written authorization by you. We do not keep separate treatment notes and psychotherapy notes, all of our notes are treatment notes and can be found in the client file. Your PHI will not be disclosed for marketing purposes. Your PHI will not be sold without your authorization. You will not be contacted for fundraising purposes. If you pay for any service out-of-pocket, then you have the right to restrict disclosures of PHI to health plans from that service. If there is a breach of your unsecured PHI, you will receive notification.

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website. You can also request a copy of this Notice from me, or you can view a copy of it in my office or at my website.

Please sign this Notice, stating that you acknowledge receipt of this Notice of Privacy Practices of Life Practice Counseling Group.

I _____ was or _____ was not offered a copy of this notice.

Signature: _____ Date: _____

_____ Initial here if you decline to receive a copy of this notice.

1/16/14

Please check the feelings that apply to you today:

AI

_____ 1. I feel tense most of the time.

_____ 2. I have a lot of physical problems that can't be explained.

_____ 3. I worry most of the time.

_____ 4. I have compulsions such as constant hand washing, checking the door locks repeatedly, or other rituals that interfere with my daily activities.

_____ 5. I have nightmares and/or "flashbacks" that I can't get out of my head.

_____ 6. I have experienced sensations of shortness of breath, heart palpitations or shakiness while resting.

_____ 7. I avoid social situations because I am fearful.

_____ 8. There are some things I am really afraid of.

_____ 9. I am afraid to leave my house.

_____ 10. I think about dying or killing myself.

_____ 11. I have thoughts constantly in my mind, which interfere with my ability to concentrate and function effectively.

DI

____ 1. I no longer have any interest in the things that used to interest me.

____ 2. I feel hopeless about the future.

____ 3. I can't make decisions because I have a difficult time concentrating.

____ 4. I feel sluggish or restless.

____ 5. I am gaining or losing weight without trying to.

____ 6. I get tired for no reason.

____ 7. I am sleeping too much, or too little.

____ 8. I feel unhappy.

____ 9. I become irritable or anxious easily.

____ 10. I think about dying or killing myself.

____ 11. I have spontaneous urges to cry.

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HIPAA Notice of Privacy Practices (Your Copy)

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2. I have a legal duty to safeguard your protected health information (PHI) when I transmit information electronically. I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care.

I must provide you with this Notice about my privacy practices, and such Notice must explain how, when and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made.

By signing this notice you acknowledge we may use your PHI, but may not disclose your PHI without further written authorization by you. We do not keep separate treatment notes and psychotherapy notes, all of our notes are treatment notes and can be found in the client file. Your PHI will not be disclosed for marketing purposes. Your PHI will not be sold without your authorization. You will not be contacted for fundraising purposes. If you pay for any service out-of-pocket, then you have the right to restrict disclosures of PHI to health plans from that service. If there is a breach of your unsecured PHI, you will receive notification.

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website. You can also request a copy of this Notice from me, or you can view a copy of it in my office or at my website.

Please sign this Notice, stating that you acknowledge receipt of this Notice of Privacy Practices of Life Practice Counseling Group.

Signature: _____ Date: _____

10/24/13

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Credit Card Agreement

Please Note: New clients are required to keep a valid credit card number on file. Please complete the following information and provide your credit card to your therapist at your initial session. This is set up for your convenience.

Credit Card Type: MasterCard Visa American Express Discover Other:_____

Name as shown on card:_____

Credit Card Number:_____exp: _____/_____

3 digit security code on back of the card:_____

If American Express, code on front of the card:_____

Billing Address associated with the card:_____

City, state, zip: _____

Email Address: _____

This card may be charged for (Please initial each one):

_____ Regular session fees (at your request, as a convenience to you)
Initials

_____ Fees for same-day cancellation
Initials

_____ Fees for cancellation without _____ hours notice (according to your counselor's policy)
Initials

_____ Delinquent session fees (fees more than 30 days overdue)
Initials

_____I understand there are no refunds given
Initials

"I _____ (print name) have read and understand the terms of providing my credit card to Life Practice Counseling Group. I understand that my credit card may be charged for the reasons indicated above. I also understand there are No refunds given. Any questions I have about this practice have been answered and I give my full consent to charge my credit card under the circumstances checked above."

_____	_____	_____
Your Signature Consenting to Charges	Today's Date	Valid Until

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Health Insurance Agreement/Patient Responsibility

Life Practice currently accept only Healthnet Medi-Cal, Anthem Medi-Cal, Molina, or MHN EAP insurance.

I _____(print your name) am using _____ Insurance to cover the cost of my services. My subscriber ID is _____ and my date of birth is _____. With my insurance there is no co-pay I have to pay at the time of my service. I understand that my insurance only covers the cost of the services provided if I attend my counseling appointment.

I understand that if I do not show up for my appointment or do not provide the 24-hour notice of cancellation, that I will be charged for my missed appointment at the rate of _____ per session missed. And that I will need to pay _____ for each session missed, out of pocket with cash, check, or credit card before or at the start of my next session. _____
Initials

If I cancel my insurance or for some reason I am no longer covered, I understand it is my responsibility to let my counselor know. _____
Initials

I also understand that I am responsible for any fees that are not covered by my insurance. _____ I understand that Life Practice will bill my insurance and will make every effort to insure the insurance company reimburses for the services, but I fully understand that if the insurance does not pay for the service, that I am responsible for the fees incurred and will pay for the unpaid balance out of pocket with either cash, check, or credit card. _____
Initials
Initials

"I _____ (print name) have read and understand the terms of using my health insurance. I understand that I am responsible for any missed appointments or any unpaid balances. Any questions I have about this practice have been answered and I give my full consent and agree to pay out of pocket if I miss a session, do not provide the 24-hour notice of cancellation, or if my insurance does not cover the services provided."

Print your name: _____

_____ _____
Your Signature Agreeing to the Patient Responsibility Today's Date