ADULT INTAKE FORM

Please provide the following information and answer the questions. Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Name:_____

Age:_____ Birthdate (DOB):___/___/_____ Gender:☐Male ☐Female /☐Trans

Address:_____ Race☐W☐B/☐H/☐A/☐Biracial

City: _____ State: ____ Zip: _____

Mobile phone #:_____ May I leave a voicemail or text☐Yes ☐No

Email: _____ May I email you?☐Yes ☐No

(Email/Text communication is necessary for appointment scheduling or credit receipt purposes; it is not considered confidential).

Preferred pronouns: ☐he/him/his ☐she/her/hers ☐they/them/theirs ☐other:specify:_____

Emergency contact:

Name: _____ Phone #:_____ Relationship:_____

Referred by:

Name: _____ Phone #: _____ Relationship:_____

May I contact the referral person to thank them/acknowledge about this referral?☐Yes ☐No Please initial: _____

What is the <u>main reason</u> you are seeking counseling for yourself? (Include how long had symptoms or problems):

_____

_____

_____

Please list *significant life events or stressors in the past 12 months* that may be contributing to difficulties (e.g., illness, deaths, operations, accidents, separations, divorce of parents, parent changes job, changed schools, family moved, family financial problems, remarriage, sexual trauma, other losses, exposure to repeated traumatic events)?

_____

_____

_____

_____

Veteran Status (check all that apply) Years served: _____

☐Active ☐Inactive ☐Drafted ☐Retired ☐Deployed (# ____)

First Responder Status (check all that apply) Years served: _____

☐Active ☐Inactive ☐Retired ☐Police ☐Fire ☐EMS ☐Dispatch

Relationship Status: (check all that apply):

☐Single ☐Dating ☐Cohabitating ☐Partnered ☐Engaged

☐Married ☐Divorced ☐Separated ☐Widowed ☐Other:_____

How would you rate your current relationship, on a scale of 1-10? (1=very low quality and 10=very high quality) _____

Do you feel safe in this relationship? ☐ Yes / ☐ No Concerns: _____

Name and ages of children (if any): _____

_____

_____

Have you received counseling services in the past and was it helpful? ☐ Yes ☐ No _____

HEALTH INFORMATION:

Please list <u>current</u> medical/health problems (e.g. headaches, chronic pain, hypertension, diabetes):

_____

_____

Please list all hospitalizations (e.g. medical, psychiatric, substance): _____

_____

Please list <u>current</u> medication(s) (including medical, antidepressant, antianxiety, or psychotropic medications):

_____

_____

Please list any <u>previous</u> <u>psychiatric</u> medications: _____

_____

How would you describe your present health? (mark one)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Very good ☐ Excellent

Please describe any alcohol usage/frequency/amount: _____

_____

Please describe any recreational drug usage (include marijuana, cocaine, LSD, pills): _____

_____

Do you or anyone close to you consider your drinking/drug use to be a problem? ☐ Yes ☐ No

Explain: _____

_____

FAMILY MENTAL HEALTH HISTORY

In the section below identify if any members of your family and extended family has a history of any of the following (parents, siblings, Aunts/Uncles, step-family). If yes, please indicate the family member's relationship to you in the space provided.

Please list Family Member(s)/Relationships (eg. Parent, Aunt/Uncle, sibling)

Anxiety (general) _____
Obsessive Compulsive _____
Depression _____
Suicide Attempts _____
Bipolar _____
Alcoholism _____
Substance Abuse _____
Domestic Violence _____
Eating Disorders _____
Obesity _____
Schizophrenia _____
Counseling _____
Psychiatric Hospitalizations _____

Symptoms or Problems:

How much are *each* of the following areas *currently* a problem for *you*?

	Not at all	A little	Somewhat	Frequently	Constantly
Anxiety	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Physical health concerns	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Problems with sleep	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Depression/Down	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Alcohol or Substance Use	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Family Conflicts	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Repeated/intrusive/unwanted reminders	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Nightmares	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Irritability/Angry outbursts	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Loss of interest/less enjoyment	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Withdrawn/distant from others	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Disconnected	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Abuse (physical, emotional, sexual)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Therapy Agreement and Informed Consent

Please initial where indicated.

I have read and have had explained to me the following materials pertaining to therapy. My therapist has offered me the following or I viewed it online:

_____ Privacy Notice (HIPAA)

I believe I understand the basic goals, ideas, and methods of this therapy. I have no important questions or concerns that the therapist has not discussed with me. I understand that reaching the agreed upon therapy goal is not guaranteed. I further understand that the initial symptoms or problems that were presented to the therapist may initially become more intense.

With enough knowledge, and without being forced, I enter into therapy with this therapist. I will keep my therapist fully informed about any changes in my feelings, thoughts, and behaviors. I expect us to work together on any difficulties that occur and to work through them in my long-term interest. Our goals may have changed in nature, order of importance, or definition.

Cancellation Policy

I understand I am welcome to come to any part of my scheduled session, even if I have to be late. If I am running late, I will call my therapist to let them know. If I need to cancel or reschedule an appointment, I will give my therapist at least 24 hour's notice. Sessions may be switched to Telehealth for purposes of exposure/illness/travel.

_____ **I understand failure to attend a session without giving notice or with less than a 24-hour notice will result in a fee equal to the full amount for the session.** I understand that exceptions for unforeseen or unavoidable situations are at the discretion of the therapist. ***I understand that if services are not covered by my policy, such as telehealth, I am responsible for those session fees.***

Payment Policy

KM Counseling will bill your insurance but can also be a self-pay counseling center, which allows clients to be seen without the involvement of an insurance company. By paying without insurance, you protect your privacy, avoid being given an insurance-mandated diagnosis in order to receive counseling services, and are more in control of the services you receive.

_____ I understand I may be able to receive reimbursement through my insurance provider's out-of-network benefits, flexible spending account (FSA), or health savings account (HSA). If I choose to do so, KM Counseling can provide me with an itemized receipt of services. I understand that if I wish to use any of these health benefits, it is my responsibility to verify coverage and submit any invoices for reimbursement. **I understand that, even if I use out-of-network, FSA, or HSA benefits, I am responsible to pay for my session in full at the time of service, or I may prepay for sessions.**

Fees

- $200 per intake
- $150 per 60-minute individual, couples, or family session
- $175 per crisis session

_____ I understand that KM Counseling may increase the cost per session, but that I will be notified at least 30 days in advance of any rate increase.

Cell phone/Email/Fax Communication

If I choose to use email or a cell phone for communication, I understand it may compromise the confidentiality of my information in ways my therapist cannot control. I also understand my therapist may share a printer with other therapists and that those therapists will work together to ensure my privacy to the best of their ability.

_____ I understand the security of client information is not guaranteed when information is left on a voicemail, texted or emailed.

Emergency Procedure

In the event of a life-threatening emergency, I should call 911. If I have another crisis that cannot wait I am aware I can call the National Suicide Hotline at 800-273-8255. If I have a crisis plan with my therapist, I will follow that first.

Inactive Records

Your complete record will be retained for seven years after you have completed treatment. At the end of seven years, the record will be entirely destroyed, leaving only the name of the client and date of record destruction. The time period begins from the date of the last visit (or for minors from the date they reach 18). Should there be any further direct client contacts the counting period will begin again at the date of new service.

Confidentiality Statement

Under the rules governing Licensed Counselors in the state of Illinois, a therapist, and employees and professional associates of the therapist, must not disclose any private information that the therapist, employee, or associate may have acquired in rendering services *except* as follows.

- When disclosure is required by state law like reports of child abuse and neglect and vulnerable adults abuse and neglect.
- When failure to disclose the information presents a clear and present danger to the health or safety of an individual.
- When a patient agrees to a waiver of the privilege accorded by this section, and in circumstances where more than one person in a family is receiving therapy, each such family member agrees to the waiver. Absent a waiver from each family member, a marital and family therapist cannot disclose information received by a family member.

All other private information must be disclosed only with the informed consent of the client.

Illinois Mental Health Bill of Rights

- Expect that a therapist has met the minimal qualifications of training and experience required by state law.
- Examine public records maintained by the Illinois Financial & Professional Regulation Board, which contain the credentials of the therapist.

- You, the client, are billed directly for services, or your insurance coverage may be billed with your permission.
- You have a right to reasonable notice of changes in services or charges.
- You have the right to receive a summary, in plain language, of the theoretical approach used by us in working with clients.
- You have the right to complete and current information concerning our assessment and recommended course of treatment, including the expected duration of treatment.
- You have the right to expect courteous treatment and to be free from verbal, physical, or sexual abuse by the practitioner working with you;
- Your records and transactions with us are confidential, unless release of these records is authorized in writing by the client, or otherwise provided by law.
- You have the right to be allowed access to records and written information from records in accordance with Illinois statutes.
- You have the right to choose freely among available practitioners, and to change practitioners after services have begun, within the limits of health insurance, medical assistance, or other health programs.
- You have a right to coordinated transfer when there is a change in the provider of services.
- You may refuse services or treatment, unless otherwise provided by law.
- You may assert these and other rights without retaliation.

My signature on this Therapy Agreement and Informed Consent indicates that I:

- **Have reviewed, understand, and consent to the policies and information above, and**
- **Consent to participate in therapy at KM Counseling**

Client Signature: _____ Date: _____

*Typed Name:*_____

CLIENT FINANCIAL AGREEMENT

Payment of session fees, insurance co-payment, coinsurance and deductible, or other charges are due at the time of service unless prior arrangements have been made with Katharine Martin/KM COUNSELING. Verification of insurance coverage and referrals is the responsibility of the client.

There will be a $ 35.00 charge for all checks returned for any reason.

There may be a charge for telephone consultations over 10 minutes. Insurance plans will not cover these charges.

A statement will be sent on a monthly basis. You are financially responsible for all charges. This may include a balance remaining after payment of insurance benefits, charges for non-covered services or missed appointments, and any billing charges, collection agency fees of up to 60% of the delinquent balance, and legal fees related to payment of your account in full. All delinquent accounts will accrue added billing charge of 1.5% on a monthly basis. If payments are not made as agreed, your account may be turned over to a collection agency after 90 days delinquency.

Mental Health Evaluation/Assessments/Consultations: Reports for probation, court, disability, FMLA, and letters to physicians, teachers, schools and completion of paperwork are pro-rated for the amount of time taken to prepare the report. All reports and court testimony must be paid in advance of receipt of report or court testimony.

____ (*initial*) **If you need to reschedule or cancel an appointment, I require a 24-hour notice.** If I have notice, I can offer the time to another client. Failure to provide notice will result in a full charge for the missed appointment. This charge may be waived in the case of illness, unforeseen sudden circumstance, or emergency.

INSURANCE INFORMATION

Insured Name and Address of primary person:

_____

_____

Employer:

_____

Insurance company:

_____

Please provide a copy of your insurance card and photo ID.

If different than client, Insured Relationship to Client:

_____

Insured DOB:_____

Insured phone#:(____)_____

Insurance Policy number:_____

Insurance Group number: _____

By signing here I agree to the policies set forth in the Financial Agreement, **and** I authorize KM COUNSELING/KATHARINE MARTIN to use or disclose my personal health information to my health insurance carrier or other covered entity for the purpose of continued care and payment. I understand I am financially responsible for charges not covered by this authorization.

_____ _____ _____

Print Client Name Client/Guarantor Signature

_____ _____ _____

Print Parent/Guarantor Name (if child or other) Guarantor Relationship to Client Date

Edited 01/2022

KM COUNSELING
1224 Centre West Drive
Suite 200-E
Springfield, IL 62704
Phone: 217.717.4399

CLIENT DIRECTIVES FOR CONFIDENTIALITY

KM COUNSELING/KATHARINE MARTIN may contact you with an appointment reminder the day prior to your appointment. Also, billing statements are sent out monthly, unless the account has a zero balance. Because of the sometimes delicate nature of our practice, please indicate your preferences below to protect your confidentiality.

Please read the following three sections carefully and indicate your preferences for each directive:

1.Telephone / Text / Email reminder calls:

☐ It is OK to text appointment reminders (list mobile number): (_____)_____--_____

☐ Check if you have special instructions (indicate the numbers to contact you and any special instructions to use when calling): _____

2.Billing statements (for statements other than those with a zero balance):

☐ It is OK to mail billing statements to your residence.

☐ Check if you do not wish to have the billing statement mailed to your home (indicate the special arrangements you prefer): _____

3. Other mailings from the office

☐ It is OK to mail information to your residence.

☐ Check if there are special instructions (indicate your preferences): _____

4.Consent to Authorize Release of Information

☐ I am willing to sign a release for KM Counseling / Katharine Martin, Provider to communicate with your Primary Care Physician, *if needed*. (Signed Authorization to Release Information required).

☐ Check if you decline to give consent to Authorize Release of Information at this time.

I have read and checked my preferences regarding the four items detailed above.

_____ _____

Printed name Date

_____

Signature of Patient (or legal Representative - state relationship)

For Office Use Only

Accept☐ Refuse☐ Reason:

Privacy Officer: Signature_____ Date_____

KM COUNSELING
1224 Centre West Drive
Suite 200-E
Springfield, IL 62704
Phone: 217.717.4399

AUTHORIZATION FOR THE RELEASE/EXCHANGE OF INFORMATION

I understand that my records are protected under HIPAA and the Illinois Department of Mental Health & Developmental Disabilities Confidentiality Act and that they cannot be disclosed without my written consent, unless otherwise provided for in the regulations and/or under state specific provisions. I understand that my records may contain information regarding my mental health, substance use or dependence, sexuality, suicidality, and may contain confidential HIV (AIDS) infectious diseases related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below.

I authorize **KM COUNSELING / KATHARINE MARTIN** to release / exchange information with:

TO/FROM: _____(_____)_____
PROVIDER NAME PHONE#

_____,_____
STREET ADDRESS CITY, STATE, ZIP CODE

RE: _____ _____ /_____/_____
CLIENT NAME DATE OF BIRTH

The following types of information:

☐ Complete record ☐ Treatment Summary ☐ Initial Evaluation ☐ Oral Communication only
☐ Other: _____

This information will be used for the purpose of evaluation, treatment and continuity of care (or):_____
_____

Further, I understand that refusal to consent to release of information will result in records not being released. If you consent to release your records, but do not wish certain information to be released, state type of information to be *excluded*:_____

I understand that the information or records above will not be used for any purpose other than the intended use. The re-release of this information to parties other than those named above is prohibited. I understand that this consent is revocable at any time PRIOR to the release of information. This authorization will expire ONE YEAR from the date below. I hereby release you and your personnel from all legal responsibility or liability that may arise from the act I have authorized above.

_____ _____ _____
Signature of Client (age 12yrs & older) Date TYPED NAME

_____ _____ _____ _____
Parent/Guardian/Legal Representative Date Witness Date