



CHRISTIAN COUNSELING

CONFIDENTIAL INTAKE FORM

Please answer the following questions as fully as possible.

Date: _____ Referred by: _____

May I have your permission to thank this person for your referral? Yes No

Full Name: _____ Name you prefer: _____

Address: _____ City: _____ Zip: _____

May I send mail here? Yes No

Mailing Address or Post Office Box: Same as above

Address: _____ City: _____ Zip: _____

May I send mail here? Yes No

Sex: Male Female Birth Date: _____ Age: _____

Ethnicity: White Black Hispanic Asian Other _____

Religious Affiliation _____ Are you a member of a church? Yes No

Where? _____ Are you Active Inactive

Home Phone: _____ Call you here? Yes No Leave message here? Yes No

Cell Phone: _____ Call you here? Yes No Leave message here? Yes No

Work Phone: _____ Call you here? Yes No Leave message here? Yes No

E-mail address: _____ Contact you here? Yes No

Employer: _____ How long have you been here: _____

Occupation: _____ Avg. hours worked per week _____

Annual (pre-tax) Household Income: _____

Highest level of education completed: _____ Are you currently in school? Yes No

If yes, what level? _____ Degree pursuing: _____

In case of emergency, contact:

Name: _____ Relationship: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Primary Care Physician (PCP) _____

Address _____ Phone _____

Relational Information

MARITAL STATUS:

- Single Married How Long? _____
- Previously married — How many times? _____
- Separated — How long? _____
- Widowed — How long? _____

Partner's/Spouse's name: _____ Age _____

Is your partner/spouse supportive of you seeking counseling? Yes No Unsure
 He/ she doesn't know

With whom do you currently live? (*Check all that apply*)

- Alone Spouse Children Parent(s) Sibling(s) Boyfriend Girlfriend
 Roommate Other: _____

List your children (including step, adopted, foster) below:

Name	Sex	Age (or year of death)	Relationship to you	Living with whom?

Have you ever placed a child for adoption? Yes No If Yes, when? _____

Have you ever had a miscarriage or medical abortion? Yes No If Yes, when? _____

List your mother, father, brothers, sisters, step-family relations, or any other family member who had a significant effect (positive or negative) upon your life.

Name	Age or year of death	Relationship to you (e.g., mother, father, sibling, step-relation)	Give 2-3 words to describe this person

FILL IN THE BLANK: God is _____

Counseling History

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the names of the therapists or programs: *(Use the back, if necessary)*

<u>Therapist's name or program</u>	<u>Major issue</u>	<u>Dates</u>

What was helpful about the counseling? _____

What was not helpful about the counseling? _____

Medical History

List any medical conditions, illnesses, treatments, or surgeries: _____

Your height: _____ Your weight: _____ How has your weight changed in the last 2-3 months: little or no change up _____ lbs. down _____ lbs.

List all current medications you are taking, including those you seldom use or take only as needed: *(Use back if necessary)*

Name of medication	Dose	Reason for taking medication

Are you presently experiencing any suicidal thoughts? Yes No

Have you experienced them in the past? Yes No

Have you ever attempted suicide? Yes No

If Yes, when and how: _____

Have any of your friends or family ever committed or attempted suicide? Yes No

If Yes, when and who: _____

Are you presently experiencing any thoughts of harming another person? Yes No

Present Issues

Check any of the following symptoms or problems that you are presently experiencing or have experienced in the past.

Present Past

- Stress
- Anxiety or worry
- Panic
- Depression
- Crying all the time
- Lack of motivation
- Fatigue/Lack of energy
- Poor appetite or overeating
- Trouble sleeping
- Poor concentration
- Feeling worthless or inferior
- Feeling hopeless
- Guilt
- Death of friend or loved one
- Grief
- Chronic pain
- Physical disability
- Terminal illness
- Health concerns
- Loneliness
- Fears
- Shyness
- Low self-esteem
- Don't like myself
- Marital problems
- Other relational problems
- Parenting problems
- Physical abuse
- Emotional abuse
- Verbal abuse

Present Past

- Sexual abuse
- Sexual problems
- Gender identity
- Anger
- Aggressive behavior
- Bad dreams
- Unwanted memories
- Loss of control
- Impulsive behavior
- Controlling
- Controlled by others
- Obsessive thoughts
- Compulsive behaviors
- Seeing things others don't see
- Hearing voices
- Racing thoughts
- Eating problems
- Drug use
- Alcohol use
- Pregnancy
- Abortion
- Legal matters
- Work stress
- Career choices
- Indecisiveness
- Lack of discipline
- Financial problems
- Spiritual apathy
- Other _____

Please use an "X" on the scale below to indicate how distressing your problem(s) are to you.

Minimally
Distressing

Moderately
Distressing

Extremely
Distressing

Please describe why you are coming to counseling (i.e. what are the problem(s) that you want help with)?:

How has this problem affected your life in the following areas?

1. Family: _____

2. Work: _____

3. Social: _____

4. Recreational: _____

5. Health: _____

6. Spirituality: _____

How long have you had this problem? _____

Why have you decided to come for counseling now? _____

What do you hope to gain or change by coming for counseling? _____

TERMS OF SERVICE

I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of intention to cancel, I will be charged the full administrative fee for service.

Signed: _____ Date: _____

Notice of Privacy Practices

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

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of *treatment, payment, and health care operations*.

- *Treatment* means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc.
- *Payment* means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services.
- *Health Care Operations* include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information; to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Your written authorization will be required for any other uses or disclosures. Should you choose to revoke your authorization, you may do so only in writing. We will abide by your written request with the exception of information we released upon obtaining the written authorization and releasing information as required by law.

You may contact our Privacy Officer in writing to invoke your following rights:

- You may request in writing that we restrict using and disclosing your Protected Health Information to family members and relatives, friends, or others you identify. We reserve the right to deny this request.
- You may request an amendment to your Protected Health Information.
- You may request alternative means or locations in which you receive confidential communications.
- You may request an accounting of disclosures of Protected Health Information beyond treatment, payment, and health care operations.

We are required by law to protect the privacy of your Protected Health Information and to abide by the terms of the Notice of Privacy Practices. We will make and post revisions to the Notice of Privacy Practices in accordance with the law. You may obtain a written copy of these changes by written request.

You may file a formal, written complaint with us at the address below or with the Department of Health & Human Services, Office of Civil Rights, if you feel your privacy rights have been violated.

For more information regarding our Privacy Practices, please contact:

- Kalon Christian Counseling
2940 E Park Ave, Suite 1-A
Tallahassee, FL 32301
(850) 778-1460

For more information about HIPAA or to file a complaint, please contact:

- The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877 – 696 – 6775 (Toll free)



Acknowledgement of Receipt of Privacy Practices Notice

I, _____ have received a copy of Kalon Christian Counseling's Notice of Privacy Practices.

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Signature of Client: _____ Date: _____

Signature of Guardian: _____ Date: _____
(If client is a minor)



Informed Consent and Release of Liability

Counseling services offered by Kalon Christian Counseling is for the express purpose of providing emotional, psychological, relational and spiritual support with a distinctively Christian framework to the local church and to the community as a whole. I, Dusty Hart, am a Licensed Mental Health Counselor and practice as such under FL State Law (Chapter 491, Florida Statutes). My training is a combination of Psychology, Theology, and Christian Soul Care. Both my graduate training and counseling approach reflect a unified, biblical perspective on the mental, emotional, spiritual, physical and relational parts of our personhood. Only by personally engaging with the relational and spiritual dynamics that drive your feelings and behavior can you come to know yourself and God in a way that brings deep healing and true freedom, empowering you to love God, yourself and others well. As you participate in this organic, often non-linear, psychospiritual process it is not uncommon that you may initially feel worse rather than better. However, I am convinced that this is the only way that true lasting change and freedom come.

The completion of an **Intake Questionnaire** and an **Informed Consent and Release of Liability** form are required for counseling services to commence. Selected personality and/or vocational assessments may also be administered with your additional consent. While I expect benefits from treatment, I fully understand that such benefits and particular outcomes cannot be guaranteed. I understand that because of the treatment, I may experience emotional strain, feel worse during treatment, and make life changes which could be distressing. I also understand regular attendance will produce the maximum benefits but that I am free to discontinue treatment at any time. If I decide to do so I will notify the provider at least two weeks in advance so that effective discharge planning can be implemented.

1. I _____ understand that Dusty Hart, my counselor, is a Licensed Mental Health Counselor (LMHC) in the State of Florida.
2. I understand that contents of all my therapy sessions are considered confidential. Both verbal information and written information about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:
 - When a client discloses intentions or a plan to harm self or another person, the mental health professional is required to notify legal authorities and those people who may be impacted.
 - If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

- When a mental health professional is made aware of prenatal exposure to controlled substances that are potentially harmful, a report must be made to the appropriate authorities.
 - Insurance companies (when applicable) and other third-party payers are given information that they request regarding services to clients, such as types of service, dates/times of service, diagnosis, treatment plan, progress of therapy, case notes, and summaries.
3. I waive any right I may otherwise have to seek to use my counseling records with Kalon Christian Counseling, except as may otherwise be agreed upon in writing, in any judicial proceeding or to compel the testimony of any Counselor or supervisor associated herewith. If testimony is required, I agree to pay twice the normal hourly rate for any, and all, of these individuals for their testimony, and preparation therefore.

In consideration of the benefits to be derived from counseling, the receipt whereof is hereby acknowledged, I hereby release, remise and forever discharge and covenant not to sue or hold legally liable Kalon Christian Counseling, the Counselors, and supervisors, if applicable, from any and all claims, demands, actions or causes of actions of whatsoever kind and nature related to the counseling process.

I have read and understood the preceding information and agree to the policies of Kalon Christian Counseling as stated herein. I understand that these comments are prerequisite to my receiving and continuing counseling through Kalon Christian Counseling.

Signed: _____ Date: _____

Witness: _____ Date: _____



Statement of Counseling Policies and Procedures

COUNSELING SESSIONS

Counseling sessions are 50 minutes in length for individuals and 80 minutes in length for couples.

FEES

The professional service fee for Individual Sessions range from \$125 to \$150 and for Couples' Sessions range from \$180 to \$225 depending on your therapist.

PAYMENTS

Payment is due upon the completion of each session. You may pay by cash, check or credit card. Checks should be made payable to "Kalon Christian Counseling." Accounts must be kept current in order to continue counseling at Kalon Christian Counseling.

INSURANCE

We counsel on a fee-for-service basis and do not accept or file any insurance on your behalf. However, we can provide you with a medical receipt if you choose to pursue personal reimbursement from your insurance company. To do this, you must call your insurance company directly to see if you have out-of-network mental health coverage.

RESCHEDULING APPOINTMENTS

It is our policy to schedule you for a "standing appointment." Concluding each session we will confirm your next scheduled appointment. Standing appointments will only be rescheduled if an alternative time is available.

CANCELLATIONS/ NO SHOWS

If you must cancel your appointment, please **call at least 24 hours in advance** of your scheduled time. All appointments that are not canceled and/or canceled less than 24 hours before the appointment time (except in case of an emergency out of your control) are subject to a late cancellation charge equal to the session fee.

CONTACT INFORMATION

It is understood that occasionally you may need to consult with your counselor briefly by telephone or email. In most cases your counselor will not be available immediately. However, every effort will be made to return your call or email within 24 hours. For brief consultations there is no charge. However, for all communication lasting longer than ten minutes, there is a \$2.00 per minute fee.

EMERGENCY CONTACT INFORMATION

If you feel that you need immediate help and/or are experiencing a medical emergency contact your family physician or nearest emergency room and ask for the psychologist or psychiatrist on call. If you are experiencing a life-threatening emergency call 911 or go to the nearest hospital emergency room.