Alabama Center for Counseling

Alabama Center for Counseling, LLC
Intake Form

212 Bob Wallace Ave, SW
Huntsville, AL 35801
Phone: 256-808-2522
Fax: 256-808-2523

Patient Information

First appointment:_____

Name (*legal*) _____ Date of Birth: _____

Preferred Name _____ Gender ☐ Male ☐ Female
(if different from above) *(as listed with insurance)*

Address _____
(complete mailing address)

Primary language used to communicate ☐ English ☐ Other _____

Primary care doctor_____ PCP Phone Number _____

Primary concern that prompted this evaluation/treatment _____

_____

Referral source *(recommended by)*_____

Education
☐ Full-time student
☐ Part-time student
Highest level of education achieved:
_____

Employment
☐ Full-time at_____
☐ Part-time at _____
☐ Currently unemployed

Marital Status
☐ Single/never married
☐ Married
☐ Separated/Divorced
☐ Widowed

Contact Means

Okay to leave text and voice messages about:

Home _____	Appointments? ☐ Yes ☐ No	Clinical information? ☐ Yes ☐ No
Cell _____	Appointments? ☐ Yes ☐ No	Clinical information? ☐ Yes ☐ No
Work _____	Appointments? ☐ Yes ☐ No	Clinical information? ☐ Yes ☐ No
Email _____	Appointments? ☐ Yes ☐ No	Clinical information? ☐ Yes ☐ No

Circle which number you would like to have automated reminder call/ texts sent to or none if you do not want this service.

Patient Portal grants you free online access to schedule or change your future appointments at our office.

Would you like an email invitation to our Patient Portal (from TherapyNotes)? ☐ Yes ☐ No

Preferred email _____

Insurance Information

Insurance Company _____Policy Number_____Group_____

Full Name of Insured_____Insured's Social Security Number _____

Insured person's date of birth _____ Employer *(if insured through an employer)* _____

Emergency Contact

Name_____Relation to client _____

Home phone_____Cell phone_____ Work phone_____

Current medications *(please list names of medications and dosages)*

____

Relevant treatment history *(include dates of psychiatric/psychological treatment, psychiatric hospitalizations, etc.)*

Relevant medical history *(include chronic/ major illnesses, medical hospitalizations, surgeries, head injuries, etc.)*

People living in the household *(not including client)*

Name	Age	Relationship to client
		☐ Mother ☐ Father ☐ Step-parent ☐ Sibling ☐ Spouse ☐ Child ☐ Other: ________
		☐ Mother ☐ Father ☐ Step-parent ☐ Sibling ☐ Spouse ☐ Child ☐ Other: ________
		☐ Mother ☐ Father ☐ Step-parent ☐ Sibling ☐ Spouse ☐ Child ☐ Other: ________
		☐ Mother ☐ Father ☐ Step-parent ☐ Sibling ☐ Spouse ☐ Child ☐ Other: ________
		☐ Mother ☐ Father ☐ Step-parent ☐ Sibling ☐ Spouse ☐ Child ☐ Other: ________
		☐ Mother ☐ Father ☐ Step-parent ☐ Sibling ☐ Spouse ☐ Child ☐ Other: ________

If more space is needed, please list additional household members on a separate sheet of paper and attach.

For child/adolescent clients:

Does the client live with both parents? ☐ Yes ☐ No If no, what is the custody arrangement? ____________________

Please list the address of any parent/guardian who does not live at the same address as the client:

Name________________________________ Phone________________________

Address ____

Symptom Checklist

Name:_____ Date:_____

Please CHECK as many of the following items which apply to you. Do you have trouble with:

SLEEP PROBLEMS:
□ Difficulty Falling Asleep
□ Early morning waking
□ Waking during the night
□ Feel tired when waking
□ Increase in dreams
□ Unpleasant dreams
□ Excessive sleep

CHANGES IN:
□ Weight_____lbs lost/gained
□ Health
□ Sexual interest
□ Sexual performance
□ Appetite
□ Energy level

FEELINGS OF:
□ Anxiety
□ Tiredness
□ Boredom
□ Lack of interest
□ Sadness
□ Depression
□ Despair
□ Worthlessness
□ Helplessness
□ Emptiness
□ Rage
□ Tension
□ Loneliness
□ Guilt
□ Hopelessness

THOUGHTS OF:
□ Harming yourself
□ Harming others

DO YOU HAVE ALLERGIES?
□ No
□ Yes _____

RECENT HISTORY OF:
□ Nausea/vomiting
□ Diarrhea
□ Fever/chills
□ Sweating
□ Chest pain
□ Dizziness
□ Headaches
□ Trembling
□ Lower back pain
□ Dry mouth
□ Shortness of breath
□ Palpitations
□ Rapid breathing
□ Head injury
□ Loss of consciousness
□ Loss of memory
□ Confusion
□ Seizure
□ Bleeding
□ Swollen Joints
□ Numbness, tingling
□ Paralysis
□ Flashbacks
□ Blackouts

DIFFICULTY WITH:
□ Short attention span
□ Carelessness or sloppy work
□ Listening when spoken to
□ Following through on instructions
□ Organizing tasks or activities
□ Avoiding homework or paperwork
□ Losing things at home or school
□ Forgetfulness in daily activities
□ Fidgeting or squirming in seat
□ Sitting still
□ Restlessness or hyperactivity
□ Playing quietly
□ Talking excessively
□ Speaking out of turn
□ Waiting for others
□ Interrupting or intruding on others

CONFLICT WITH:
□ Spouse
□ Family member
□ Other loved one

PROBLEMS WITH:
□ Arguing a lot
□ Lying
□ Stealing
□ Losing Temper
□ Avoiding people
□ Spending/finances
□ Sexual behavior
□ Gambling
□ Eating
□ Fighting
□ Increased drinking
□ Substance abuse
□ Destroying things

FEAR OF:
□ Loss of control
□ Death
□ Being alone
□ Places/situations
□ Objects or animals
□ Cancer
□ AIDS
□ Being possessed
□ Being insane

EXPERIENCE OF:
□ Vivid dreams
□ Nightmares
□ Hearing voices
□ Seeing visions
□ Being out of body

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Outpatient Services Contract

Welcome to Alabama Center for Counseling, LLC. This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them. When you sign this document, it will represent an agreement between us.

Please initial each section to indicate that you have read and agree with each part.

_____ *initials* **MENTAL HEALTH SERVICES – Mental Health Services provided include diagnostic interviews and psychotherapy.**

Diagnostic Interview: A diagnostic interview will be completed during your first visit. It is an assessment to determine diagnosis and client-therapist fit. This session will last up to one hour and include recommendations for treatment.

Psychotherapy: Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the particular problems you hope to address. There are many different methods we may use to deal with those problems. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about during our sessions on your own outside our sessions.

Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees as to what you will experience.

Therapy can involve a large commitment of time, money, and energy, so you should be very careful about the therapist you select. We will usually schedule one 53-min session (one appointment hour of approximately 53 minutes duration) every one or two weeks, at a time we agree on. If you have questions about our procedures or you feel like we are not the right therapy group for you, we should discuss these concerns whenever they arise. If your doubts persist, we will be happy to try to help you set up a meeting with another mental health professional for a second opinion or as a referral.

_____ *initials* **PROFESSIONAL FEES**

Our hourly fee is $140 for the diagnostic interview and $150 for psychotherapy. In addition to scheduled appointments, we charge $150 an hour for other professional services you may need, though we will prorate the hourly cost if we work for periods of less than one hour. Other professional services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request.

If you become involved in legal proceedings that require our participation, you will be expected to pay for any professional time we spend on your legal matter, even if the request comes from another party.

_____ LATE CANCELLATION/NO SHOW CHARGES

initials

Once an appointment is scheduled, you will be expected to attend unless you provide at least 24 hours advance notice of cancellation. While a complimentary automated text reminder is offered, you maintain responsibility of tracking your scheduled appointments regardless of receipt of or lack of receipt of these reminders. **Note that insurance will not pay for late cancellation/no show charges. Late cancellations (less than 24-hour notice) will be charged $40. No shows will be charged $75.** Services may be terminated due to excessive late cancellations and/or no shows. Typically, three or more late cancellations/no shows in the matter of 6 months is considered excessive.

_____ BILLING AND PAYMENTS

initials

Full payment is due at the time services are rendered. Additionally, no-show and late cancellation fees must be paid prior to your next appointment. We accept the following forms of payment: Cash, Check, or Credit Card. **If you would like us to keep your credit card on file and have it charged automatically at each visit, please fill out the credit card authorization form included in this packet. Otherwise, payment will be collected by our receptionist prior to the start of session.** Non-sufficient funds transactions and returned checks will incur a $30 service charge.

If your account has not been paid for more than 90 days, services may be suspended and we have the option of using other legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information we will release regarding a patient's treatment is his/her name, the dates, times, and nature of services provided, and the amount due.

_____ *initials* INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. It is very important that you find out exactly what mental health services your insurance policy covers and ensure that coverage is in effect at the time of service.

We will be pleased to file your primary insurance for your convenience and provide you with a complete itemized statement in order for you to file your secondary insurance. If you would like us to file your primary insurance, all deductibles and copayments will be required at time of visit. By initialing this section, you are acknowledging that you (not your insurance company) are responsible for full payment for services. Should your account be turned over to an attorney/collection agency for nonpayment, you will be responsible for additional attorney/collection fees as well. In addition, you are authorizing Alabama Center for Counseling to file insurance on your behalf and to provide your insurance company any necessary information. You are also authorizing payment to be made directly to Alabama Center for Counseling.

_____

initials

TREATMENT TERMINATION

Throughout treatment, we will periodically evaluate progress towards our treatment goals. If it is mutually agreed that we have made satisfactory progress on those goals, then discussion of treatment termination will occur. This discussion will include plans for relapse prevention strategies, as well as possibly "booster" treatment sessions periodically, as appropriate.

Treatment may also be terminated if an appointment is cancelled or missed and the office is not contacted within 30 days of the cancelled/missed appointment for reschedule. At that time, it will be assumed that you are no longer seeking services and your therapy will be discontinued. If 30 days have past, inactive clients are welcome to check therapist's availability, but are not guaranteed services after that time.

CONTACTING US

initials

Our therapist are often not immediately available by telephone. Though we are usually in the office between 9:00 am and 4:00 pm, Monday through Thursday and between 9:00 am and 3:00 pm on Fridays, our therapist's will not answer the phone when they are with a patient. When therapists are unavailable, our telephone is answered by our receptionist who will gladly take a message and provide it to your therapist. Additionally, you may also contact your therapist via their individual email. We will make every effort to return your call or email within 24 hours (with the exception of some Fridays, weekends, and holidays). If you are difficult to reach, please inform us of some times when you will be available. If it is urgent, please make that clear in the message and we will return the call as soon as possible. If it is an emergency, please contact emergency services at 911 or go to the closest emergency room. If any therapist will be unavailable for an extended time, our outgoing voicemail message will provide you with instructions for contacting a covering provider, if necessary.

ELECTRONIC COMMUNICATION

initials

We use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with our office should be limited to things like setting and changing appointments, billing matters, and other related issues. We recommend that you do not email us about clinical matters because email is not a secure way to contact us If you need to discuss a clinical matter with us, please feel free to call the office so we can discuss it on the phone or wait so we can discuss it during our next session. The telephone or face-to-face context simply is much more secure as a mode of communication. If you choose to email regarding clinical information, understand that confidentiality cannot be ensured. Additionally, any phone consultations taking longer than 15 minutes will be billed as an out-of-pocket fee.

We **do not** contact any of my clients through social media. In addition, if we discover that our therapist have accidentally established an online relationship with you,we will discontinue that relationship as these types of casual social contacts can potentially compromise the professional relationship.

Alabama Center for Counseling, LLC has a website, Instagram, and Facebook page that you are free to access. They are used for professional reasons to provide information to others about the practice. You are welcome to access and review the information and, if you have questions about it, we can discuss them during your therapy sessions. Our practice uses a web-based practice management program called TherapyNotes for tasks such as scheduling, record keeping, and billing. TherapyNotes maintains HIPAA business associate agreements with its providers and is therefore held to the same standards regarding confidentiality of health information as we are. TherapyNotes has a patient portal that can be used, if you choose, to contact the office regarding scheduling.

_____ **CONFIDENTIALITY**

initials

In general, the privacy of all communications between a patient and a therapist is protected by law, and we can only release information about our work to others with your written permission, but there are some exceptions.

In many legal proceedings, you have the right to prevent us from providing any information about your treatment. In some legal proceedings, a judge may order my testimony if he/she determines that the issues demand it, and we must comply with that court order.

There are some situations in which we am legally obligated to take action to protect others from harm, even if we have to reveal some information about a patient's treatment. For example, if we believe that a child is being or has been abused, we must make a report to the appropriate agency and can break confidentiality to do so.

If we believe that a patient is threatening serious bodily harm to another, we may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient presents a serious risk of harm to him-/herself, we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

We may occasionally find it helpful to consult other professionals about a case. During a consultation, we make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. we will not tell you about these consultations unless we believe that it is important to our work.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that we discuss any questions or concerns that you may have at our next session. We will be happy to discuss these issues with you and provide clarification when possible. However, if you need specific clarification that we am unable to provide, formal legal advice may be needed, as the laws governing confidentiality are quite complex and we am not an attorneys.

Treatment of minors: The limits of confidentiality described above apply to the treatment of minors as well. With minors, specific information regarding treatment may also be kept confidential from parents/guardians. However, if there is information disclosed that indicates that a minor is engaging in behavior that we believe, in our professional judgment, puts him/her or others at risk for serious harm, this will be disclosed to the parent/ guardian.

_____ **HIPAA**

initials

Please acknowledge that you were offered a copy of HIPAA Notice of Privacy Practice document for review (this is available on Alabama Center for Counseling website at all times).

Your signature below indicates that you have read the information in this document and agree to abide by its terms.

If you do not initial a component of this agreement or choose not to sign below, please understand that this voids the agreement and services will not be rendered.

SIGNATURE_____ DATE _____

Relationship to client_____*(if other than client, e.g., parent, legal guardian)*

Alabama Center for Counseling, LLC

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Authorization to Release Health Information

I hereby authorize the use and disclosure of any protected health information as set forth below.

I understand that I may revoke this authorization at any time by notifying my provider in writing. In the event of any revocation of this authorization, the revocation will not affect any action taken by the provider in reliance on this authorization.

I understand that the provision of treatment or health care may not be conditioned on my providing this authorization.

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the federal privacy regulations.

By signing below, I authorize Alabama Center for Counseling, LLC (and/or administrative staff, if applicable) to exchange (receive and release) confidential information about my health treatment/services (including mental health services) with the persons/agencies listed below:

Insurance company (required if using insurance to pay for services) _____

Primary care provider _____

Specialty provider (e.g., psychiatrist, counselor, etc.) _____

Specialty provider (e.g., psychiatrist, counselor, etc.) _____

School / School District _____

Other _____

Other _____

Disclosure will be made for the purpose of coordination of care and/or access to insurance benefits.
This authorization will be valid for one (1) year from the date of signature, unless otherwise specified as expressed by the patient, parent, or guardian in writing, prior to that date.

Client's Name *(printed)* _____ Date of Birth _____

Signature _____ Today's Date _____

Relationship to client _____ *(if other than client, e.g., parent, legal guardian)*

Witness _____ Date _____

Automatic Payment Processing

For your convenience, we will use this authorization to charge your credit card for charges incurred as a result of services rendered at Alabama Center for Counseling. Your information will be kept in a secure location to ensure its safety and protection. Circumstances when your card would be charged include but are not limited to: missed or canceled sessions without 24-hour notice, unpaid co-payments, deductible and co-insurance, any non-covered services, and denial of services. Please note there will be an additional $30 charge for a non-sufficient funds transaction.

Credit Card Authorization

By signing below, I authorize Alabama Center for Counseling, LLC to keep my credit card information on file and to charge my credit card for services rendered at Alabama Center for Counseling, LLC for which I am responsible without my physical presence at the time of charge. I allow Alabama Center for Counseling, LLC to charge my credit card for fees not covered by my insurance company to include co-pays, court fees, or other services not covered by my insurance policy. If I wish to pay for services in another manner, I understand that it is my responsibility to notify Alabama Center for Counseling, LLC and make arrangements to pay for services rendered.

If the credit card that I give today changes, expires, or is denied for any reason, then I agree to immediately give Alabama Center for Counseling LLC a new, valid credit card, which I will allow them to key-in over the phone. Even though Alabama Center for Counseling, LLC is not swiping this card in person, I agree that the new card will still be subject to the financial policy listed here and may be used with the same authorization as the original card that I presented in person.

I agree to not dispute charges for services I have received or for fees associated with non-compliance of the cancellation/no show policy. I further authorize Alabama Center for Counseling, LLC to disclose information about my attendance/cancellations to my credit card issuer if I dispute the charge.

I authorize Alabama Center for Counseling, LLC to continue to charge my credit card for fees associated with services rendered from the first day of services until the close of my case/child's case.

Patient Name: _____

Responsible Party: _____

Name exactly as it appears on card: _____

_____

Card Holder's Signature Date