Serenity Family Therapy

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INTAKE INFORMATION

*Please list all persons currently living in the home (Place a star by those to be included in counseling):

Patient Name	**Age**	**Birthday**	**Social Security Number**	
***Name(s)**				**Relationship**

Relationship Status: □ married □ single □ living together □ divorced □ widowed

How long: _____

Address: _____
Street City State Zip

Please place check mark by the phone number where you prefer to be reached and/or receive messages:

		Okay to leave confidential message?
□ Home Phone	_____	□ yes □ no
□ Cell Phone	_____	□ yes □ no
□ Other Phone	_____	□ yes □ no

Emergency Contact: Please list the name and phone number of someone I can contact in case of an emergency. Please note that this will compromise your confidentiality and will only be used in one of the instances listed on the consent form, e.g., threat of harm to self or other(s).

Name **Phone number** **Relationship**

How did you learn of our services? _____

Please briefly describe why you are seeking our services:

What are your goals for counseling?

MEDICAL HISTORY

Are you currently being treated by a physician for any medical conditions? □ No □ Yes If yes, please describe: _____

Current Medications/Doses: _____

Have you ever seen a Psychiatrist or any other mental health provider? □ No □ Yes If yes, when? _____

Focus of treatment: _____

Helpful? □ No □ Yes

ALCOHOL / SUBSTANCE ABUSE SURVEY

How often do you have a drink containing alcohol? ☐ Never ☐ 1/month ☐ 2-4/month ☐ 2-4/week ☐ more than 4/week

How many drinks containing alcohol do you consume on a day you are drinking? ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7 or more

Do you use marijuana or other "street drugs?" □ No □ Yes

If yes, what type/quantity/frequency of use: _____

If you prefer not to answer in writing and choose to discuss this privately with the therapist, check here ☐

RISK ASSESSMENT

Is there any family history of mental illness or substance abuse? □ No □ Yes

If so, please list relationship & diagnosis: _____

Please list family, friends, support groups and community groups which are helpful to you: _____

List any personal history of emotional, physical, and/or sexual abuse: _____

Has a family member or close friend ever committed suicide? □ No □ Yes, relationship: _____

Have you been having any thoughts of harming yourself or others? □ No □ Yes If so, ☐ Self ☐ Other(s)

Are there any guns or weapons in your house (specify whose & what type)? _____

Have you ever been involved in any significant legal actions, currently or in the past (e.g., lawsuit, probation, parole)? □ No □ Yes

If so, please state who and under what circumstances: _____

Do arguments with your significant other/spouse ever get physical? □ No □ Yes

If so, please describe: _____

INFORMED CONSENT

YOUR RIGHTS AS A CLIENT

1. You have the right to ask questions about any procedures used during therapy. If you wish, your therapist will explain her approach and methods with you.

2. You have the right to decide not to receive therapeutic assistance from your therapist. If you wish, she will provide you with the names of other qualified professionals whose service you may prefer.

3. You have the right to end therapy at any time without any moral, legal, or financial obligations other than those already accrued.

CONFIDENTIALITY

1. One of your most important rights involves confidentiality. Within certain limits, information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency without your written permission. At times therapy may involve the participation of more than one family member and/or significant persons.

2. There are certain situations in which your therapist is required by law to reveal information obtained during therapy to other persons or agencies without your permission. Also, your therapist is not required to inform you of her action in this regard. These situations are as follows:

   A. If you threaten bodily harm or death to another person, your therapist is required by law to inform the intended victim and the appropriate law enforcement agencies.

   B. If you threaten bodily harm or death to yourself, your therapist will inform the appropriate law enforcement agencies and others (such as spouse, friend, or an inpatient psychiatric institution who could aid in prohibiting you from carrying out your threats).

   C. If, during the course of our work together, your therapist suspects that a child, elderly, or disabled person is being or has been abused, she will inform the appropriate agencies/authorities.

   D. If a court of law issues a legitimate subpoena, your therapist is required to provide the information in the subpoena.

   E. If you are in therapy by order of a court of law, the results of the treatment ordered must be revealed in court.

LIMITATIONS OF THERAPY

1. Your therapist cannot prescribe medication or give recommendations about physical problems. She may require you to consult with a physician before proceeding with therapy.

2. Your therapist cannot guarantee that each patient's goals in therapy will be completely met. Seeking to resolve issues between family members and/or other persons can lead to discomfort, as well as relationship(s) changes that may not be originally intended.

3. I understand that I must be committed to attend sessions on a consistent basis in order to receive the greatest benefit from therapy.

4. If my therapist believes that I can receive more effective treatment elsewhere, I will be given referrals.

5. I understand that I may not attend a session if I am under the influence of alcohol or drugs, or if I am in possession of a dangerous weapon.

FEES FOR THERAPY SERVICES

My therapist has discussed the fee for therapy with me. My therapy fee is $_____per 50 minute hour. My therapist will not file insurance but will give me all necessary information to file my own insurance under my out of network benefits. I understand that payment is due at the end of each session unless we have discussed another arrangement.

I have read, understood, and agreed to the contents and terms of this document. My signature below indicates my desire and consent to receive mental health services from Serenity Family Therapy.

Client(s): _____ Date: _____

_____ Date: _____

_____ Date: _____

Therapist: _____ 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 IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act 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. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- 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 be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of October 1, 2007 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and make the new notice provisions effective for all protected health information that we maintain. You may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.	For more information about HIPAA or to file a complaint: The U.S. Department of Health & Human Services Office of Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201 Toll Free: (877) 696-6775

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Client(s): _____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

Therapist: _____ Date: _____