Christian Family Services, Inc.

Counseling Intake Form

Please complete the information requested based on the person who will be receiving counseling:

The client is a(n): ☐ Adult ☐ Child ☐ Couple ☐ Family

Intake Date: _____ Have you been treated here before? ☐ **Yes** ☐ **No**

Name_____
First Middle Last Maiden

Address: _____
Street Apt. #

_____
City State Zip Code

Home Telephone #: ( ) _____ Daytime #: ( ) _____

Cell Phone #: (_____) _____

Can we leave a message/text regarding your appointment: ☐ **Yes** ☐ **No** Phone number: _____

Can we send you an e-mail regarding your appointment: ☐ **Yes** ☐ **No** E-mail address: _____

Date of Birth: _____ Age: _____ Sex: M F Custom: _____

Social Security #: _____

Place of employment: _____ Occupation / Job Title: _____

If Sliding Scale: Annual Household Income: $_____

If filing on insurance:
*We are requesting this information for the purposes of insurance reimbursement.

For Office Use:

☐$40 ☐$60 ☐ $90 ☐$120

Primary Insurance:

Name of insured _____SSN _____ Birth date_____

Type of Insurance: _____

Subscriber ID: #_____ Group Number: #_____

If Tricare: Name of Primary Care Physician_____

Provider Phone Number: _____ Provider Website: _____

Secondary Insurance: ☐Yes ☐No

Name of insured _____SSN _____ Birth date_____

Type of Insurance: _____

Subscriber ID: #_____ Group Number: #_____

For Office Use:

Counselor: _____

REFERRAL REASON

☐ Anger
☐ Anxiety
☐ Depression
☐ Drug/Alcohol
☐ Employment Problems
☐ Home/Family Problems
☐ Law Violation
☐ Marital Problems
☐ Neglect
☐ Parenting Skills
☐ Pressure/Stress
☐ School Problem
☐ Self Esteem Problems
☐ Sexual Abuse
☐ Self
☐ Sexual Dysfunction
☐ Suicide Issue

Church Affiliation?

_____

How did you find out about CFS?

_____

_____

Person to contact in case of emergency: _____

Relationship: _____ Phone Number: _____

Briefly describe the circumstances that have brought you to counseling:

_____

_____

What do you hope to gain from counseling services? _____

_____

_____

MARITAL HISTORY

Total number of marriages: _____ Current Marital Status: _____

Most recent marriage: Date married: _____ thru _____
If terminated, circumstances why:

_____

Other marriages: _____

PERSONAL HISTORY

Have you ever experienced physical abuse: ☐ Yes ☐ No If yes, please give age(s) and circumstances: _____

Have you ever experienced sexual abuse: ☐ Yes ☐ No If yes, please give age(s) and circumstances:_____

Have you ever had self-harm thoughts or behaviors: ☐ Yes ☐ No If yes, please give age(s) and circumstances:_____

Have you ever had suicidal thoughts: ☐ Yes ☐ No If yes, please give age(s) and circumstances:_____

Have you ever had suicidal attempts: ☐ Yes ☐ No If yes, please give age(s) and circumstances:_____

HEALTH HISTORY

Are you currently taking prescribed **or** over the counter medications? ☐ Yes ☐ No
If yes, please explain why and list medications below (list dosage):

_____

_____

List any physical limitations or handicaps: _____

_____

Do you have any sleeping difficulties? If so, please explain: _____

_____

Do you have any problems related to eating? If so, please explain: _____

_____

How many pregnancies have you had? _____ How many miscarriages?_____

Do you have any other physical conditions or complaints not mentioned above? ☐ Yes ☐ No
If yes, please briefly discuss them:

_____

_____

CURRENT FAMILY
List all persons living in current household:

Name	Age	Relationship

_____

_____

_____

_____

_____

_____

FAMILY OF ORIGIN

Mother: _____ Age: _____ Occupation: _____

If mother is deceased, when? _____ How? _____

Father:_____ Age: _____ Occupation: _____

If father is deceased, when? _____ How? _____

SUBSTANCE USE

Please list all illegal drugs (including alcohol) that you have used in the last year:

Substance	Frequency	Last Used

VALUES

How has your faith, religion, belief system, et cetera influenced your current situation?

_____

_____

_____

_____

Counseling & Therapy Services at Christian Family Services, Inc.
Outpatient Services Contract- Statement of Professional Disclosure

Welcome to Christian Family Services, Inc. (CFS) Counseling Center. This document contains important information about our professional services and business policies. Please read it carefully and write down any questions you might have so that we can discuss them promptly. When you sign this document, it will represent an agreement between us.

GENERAL INFORMATION

At CFS, we have a variety of mental health professionals to serve you. Among them are: Licensed Professional Counselors (LPC's and Interns), Marriage and Family Therapists (LMFT's and Interns), Provisional Licensed Professional Counselors (PLPC) and Social Workers (LCSW's and Interns). Each licensed clinician holds a Master's degree or PhD and has gone through years of education, training and supervision to become licensed by the state. "Interns" are unlicensed individuals who are under the direct supervision of a licensed supervisor. Our interns have Master's degrees and are practicing under supervision for licensure or are graduate students who have completed the bulk of their education and are gaining the necessary clinical experience to graduate. Your therapist will inform you of their level of training and answer any questions you may have about their qualifications.

COUNSELING SERVICES

Psychotherapy varies depending on the personalities of the therapist and patient, and the particular problems you bring. There are different methods we may use to deal with your concerns. In order for the therapy to be most successful, you will work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since 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. But there are no guarantees of what you will experience.

CONFIDENTIALITY

The laws and standards of the mental health profession require that clinicians keep treatment records. In general, the law protects the privacy of all communications between a patient and a therapist, and your information can only be released with your written permission. But there are a few exceptions:

In most legal proceedings, you have the right to prevent disclosure of any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order a therapist's records or testimony if he/she determines that the issues demand it.

There are some situations in which mental health professionals are legally obligated to take action to protect others from harm, even if they have to reveal some information about a patient's treatment. For example, if the clinician believes that a child, elderly person, or disabled person is being abused, they may be required to file a report with the appropriate state agency.

If a therapist believes that a client constitutes a danger to him/herself or to others, they are required to take protective actions. These actions may include helping the client make a safety plan, notifying any potential victims, contacting the police, or seeking hospitalization for the patient.

These situations rarely occur in our practice. If such a situation does arise, we will make every effort to fully discuss it with you before taking any action.
We may also release information to your insurance company, including diagnosis, for the purpose of reimbursement.

MINORS: If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records.

As a training facility, we routinely consult with our interns and other licensed professionals about cases. During consultation, we make every effort to maintain the confidentiality of the patient. The consultants, interns, and supervisors are also legally bound to keep the information confidential. The process of training and supervision is fundamental to the work we do at CFS, so we will routinely use live observation, "co-therapy" with a senior therapist, video and audio-recording during therapy sessions. All the rules concerning confidentiality apply to live and taped observation, and any recordings made will be treated in the same manner as your written records. You may choose to "opt-out" of the observation/recording process. However, this may preclude you from participating in our reduced-fee services, which are offered by our supervised interns.

It is important that you discuss any questions or concerns that you may have regarding confidentiality with your therapist. We will be happy to discuss these issues with you if you have specific questions. While we can provide you with the general legal and ethical guidelines which govern our practice, we cannot provide formal legal advice.

FEES

The fee schedules have been posted in the waiting area. All clients have the option of being billed according to the sliding scale fee schedule which takes into account the family income and the number of members in the family.

Some of our therapists accept heath insurance reimbursement. However, it is the client's responsibility to ensure that your therapist is covered by your insurance. We will attempt to

provide you with the most accurate data on what insurances are accepted and by whom. If you would like us to file insurance claims on your behalf, you will be billed according to the schedule of reasonable and customary fees. If there is a deductible that must be met, you will be responsible for paying the full amount of the reasonable and customary fee until the deductible is met. After meeting the deductible, you will be responsible for meeting the co-pay. Submitting for insurance reimbursement requires your authorization to release the protected health information necessary to process the claim, including a mental health diagnosis. Your authorization is also necessary so that we may receive payment directly from the insurance company. If we are assisting you with filing for insurance, please initial the following statements:

_____ I authorize the release of any medical or other protected health information necessary to process the claim (Form HCFA 1500). I also request payment of government benefits either to myself or to the party who accepts assignment as indicated on the claim.
_____ I authorize payment of medical benefits to the physician or supplier for services described on the claim. You will inform CFS of any other special arrangements that have been made to cover the cost of counseling (e.g., assistance provided by your church or another source).

PROFESSIONAL AND OTHER FEES

Your hourly fee is $_____. In addition to appointments, we charge this amount for other professional services you may need. "Other services" include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or 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 our professional time even if we are called to testify by another party. Because of the difficulty of legal involvement, we charge a flat fee of $500, plus $90 per hour for preparation and attendance at any legal proceeding.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, your therapist may be willing to negotiate a fee adjustment or payment installment plan.

APPOINTMENT REMINDER

CFS will text or e-mail the client the day before the scheduled appointment as a reminder. CFS will contact the client at the phone number or e-mail provided on the first page of the intake form specified by the client. If the client does not wish to be reminded of the appointment, please make your therapist aware of this information.

PHONE CALLS

Telephone appointments may be set at the discretion of the counselors and will be billed in the same manner as in-person appointments with the exception that insurance cannot be billed.

In general, the therapists have very limited availability outside of scheduled appointments and there is no after-hours answering service. Therefore, clients are encouraged to contact a crisis line (e.g., **"Life Crisis" at (314) 647-4357** in Missouri or **"Call for Help" at (618) 397-0963** in Illinois) or emergency services (e.g., **9-1-1**, or going to the emergency room) if a need arises. If the counselor is available, the client will be billed for any phone call lasting longer than 10 minutes. The phone calls will be billed in the same manner as in-person appointments with the exception that insurance cannot be billed.

NON-DISCRIMINATION POLICY STATEMENT

It is the policy of Christian Family Services, Inc. to provide services to all persons without regard to race, color, national origin, religion, sex, age or disability. No person shall be excluded from participation in, or be denied the benefits of any service, or be subject to discrimination because of race, color, national origin, religion, sex, age or disability.

COMPLAINT PROCEDURE

Any grievances must be made in writing to the agency's Executive Director. If they are unable to respond satisfactorily to your concern they will be able to refer you to the appropriate channel to follow. For example, if you believe you have been subject to discrimination, the following steps can be followed:

If you believe you have been denied a benefit of service because of your race, color, national origin, religion, sex, age, or disability, you may file a Complaint of Discrimination with the Executive Director, in writing.
The complaint should include your name, address, telephone number and a brief description of what occurred which led you to believe you were discriminated against. In this way the appropriate person may respond to your complaint.

You may also file a Complaint of Discrimination by contacting either of the external agencies listed below.
You will not be intimidated, harassed, threatened or suffer any penalty because you file a complaint. Any penalty or reprisal against you or any other involved person(s) is prohibited by law.

Department of Social Services
Office for Civil Rights
PO Box 1527
Jefferson City, MO 65102
(573) 751-9092
(800) 776-8014 or (800) 877-6916 (TDD)

Department of Health and Human Services
Office for Civil Rights
601 East 12th Street
Kansas City, MO 64106
(816) 426-7277

CONSENT

I voluntarily consent to receive therapy through Christian Family Services, Inc. (CFS).

I understand that I have the right to end therapy at any time without any moral, legal, or financial obligations other than those already accrued. Furthermore, if I decide not to receive therapeutic assistance from CFS, referrals to other qualified professionals can be provided.

If I have any questions or concerns now or in the future about the limitations of confidentiality, qualifications of my therapist, the potential risks of therapy, or anything else related to therapy, I understand that I should consult my therapist.

By signing this form, you are granting consent to Christian Family Services, Inc. to use and disclose your protected health information, such as your name, address, phone number, for the purposes of treatment, payment and agency operations. CFS' Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. You have the right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or agency operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

I certify that this form has been fully explained to me, that I have read it or had it read to me, and that I understand its contents.

_____ _____

Client Signature Date

_____ _____

Client Signature Date

_____ _____

Therapist Signature Date

BILLING TO CREDIT CARD

Christian Family Services is requesting to keep a credit card number on file for each client.

- Credit card information will not be kept electronically. All information will be kept in a locked and secure file in the office.
- Our office staff will call to obtain credit card information.
- You may still choose to pay for your balances using another form of payment.
- Unless prior arrangements are made with your counselor or with the business office, any unpaid balances for counseling sessions will be treated as follows:
    - A follow-up bill will be mailed after 30 days of the original billing date.
    - After 60 days from the original billing date, any unpaid balances will be automatically charged to the client's credit card on file.

CANCELLATIONS AND NO-SHOWS

The therapists' counseling schedules are very busy, and appointments are reserved for you. If you must cancel an appointment, you must call the office to cancel one day before the scheduled appointment to avoid a missed appointment fee. In order to remain as accessible to people as possible, the following guidelines have been established:

- In the event of a no-show (or missed) appointment or same-day cancellation, the client's credit card will be automatically billed $30. (No portion of the fee will be billed to your insurance or any other third-party reimbursement).
- Same-day cancellation and no-show fees must be paid before the next scheduled appointment.

By signing I agree to the Cancellation and No-Show policy and the Billing to Credit Card policy.

_____ _____

Client Signature Date

Electronic Communication and Consent for Use

The use of emailing, texting, and other forms of communication via technology all have inherent risks. Although it is unlikely, there is a possibility that information you include via text or email can be intercepted and read by other parties. It is advised that you do not include personal identifying information such as your birth date or personal medical information in any messages you send.

Email/texting communication with Christian Family Services, Inc. will be used for the purpose of scheduling and administrative matters only. You should also know that any electronic communication Christian Family Services, Inc. receives from you and any responses that might be sent to you may become a part of your records.

Email/texting communication is NOT to be used to provide/receive treatment services or take the place of a therapy session and should NOT be used to communicate: suicidal or homicidal thoughts or plans, urgent or emergency issues, serious or severe side effects or concerns, or rapidly worsening symptoms. In a life-threatening emergency clients should: call 911 or proceed to the nearest hospital emergency room. Christian Family Services, Inc. does not provide crisis intervention, and email/cell phone texting is not a reliable way of obtaining urgent help from the therapist in an emergency.

I have thoroughly considered all of the above information. By signing this form, I consent to the use of email/cell phone texting as needed for scheduling and administrative purposes only. If more urgent help is needed, I will utilize the crisis services listed above.

Client Signature _____Date_____

Cell phone number to text _____

Please fill out the following information regarding the credit card
that we will be keeping on file. Thank you!

NAME ON CARD: _____

___ AMERICAN EXPRESS ___ MASTER CARD ___ VISA ___ DISCOVER

CARD #: _____

EXPIRES: _____ MONTH _____ YEAR V CODE _____

BILLING ZIP CODE: _____

SIGNATURE: _____