CLIENT INTAKE PACKET

PATIENT INFORMATION

Last Name: _____ First Name: _____

Date of Birth (DOB): _____ Okay to leave voicemail/text? _____
Yes/No

Address (physical): _____

Address (mailing): _____

City: _____ State: _____ Zip Code: _____

Primary Phone Number: _____ Alternate #: _____

Employer:_____

If student, school name: _____ Grade: _____ iep? Yes/No

Sex: ___Male ___Female ___Transgender ___Intersex

Marital Status: ___Single ___Married ___Separate ___Divorced ___Widowed

Race/Ethnic: ___African-American ___Asian ___Hispanic ___Caucasian

INSURANCE INFORMATION **Please bring your card (or copy front/back) to the 1st session*

Insured (Name on Card) _____ Insured ID# _____

Insured Company Name: _____ Group #_____

Address: _____ Effective Date: _____

The client (or Client's Guardian, if a minor) is ultimately responsible for payment for treatment and care. I will bill your insurance for you if I participate in your provider network. However, the client is required to provide the most correct and updated information regarding insurance. Clients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by your insurance plan. By signing below, you authorize assignment of financial benefits directly to Lori Carroll, EdS, MFT understanding you are ultimately responsible for payment.

Client Name: _____ Date: _____

AUTHORIZATION OF DISCLOSURE IN CASE OF EMERGENCY

In case of emergency I, _____, hereby authorize Lori Carroll, Ed.S., MFT to notify the following persons. I also authorize her to contact the following persons in the event that she cannot reach me through the contact information provided by me:

_____	_____
Name	Name
_____	_____
Relationship	Relationship
_____	_____
Physical Address	Physical Address
_____	_____
City/State/Zip Code	City/State/Zip Code
_____	_____
Telephone	Telephone

Okay to leave a voicemail or text: _____Yes _____No

This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon. If not previously revoked, this consent will terminate upon the termination of treatment.

_____	_____
Client/Guardian Signature	Date

Client/Guardian Initials: _____

I agree that the signature I have entered above will be the electronic representation of my signature and initials for all purposes when I use them on documents, including legally binding contracts – just the same as pen-and-paper signature.

HIPPA INFORMATION AND CONSENT FORM

The Health Insurance Portability hand Accountability Act (HIPPA) provides safeguards to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2003. HIPPA provides rules and restrictions on who may see or be notified of your Protected Health Information (PHI.) These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protection to you, the client. I balance these needs with my goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. (www.hhs.gov.)

The following policies have been adopted:

1) Client information will be kept confidential, except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This includes the sharing of information with other health care providers, health insurance payers, as is necessary and appropriate for your care. Client records may be stored in files. The normal course of providing care means that such records may be left, at least temporarily, outside the file. You agree to the normal procedures utilized with this office for the handling of charts, patient records, PHI, and other documents of information.

2) It is the policy of this office to remind clients of their appointments. I may do this by telephone, text, U.S. mail, or by any means convenient to the practice or requested by you.

3) You understand and agree to a review of documents, which may include PHI, by insurance payers the normal performance of their duties.

4) You agree to bring any concerns or complaints regarding privacy to my attention.

5) Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.

6) I agree to provide clients with access to their records in accordance with state and federal laws.

7) I may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the client.

8) You have the right to request restrictions in the uses of your PHI and to request a change in certain policies within this office concerning your PHI. However, I am not obligated to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPPA information and consent section and any subsequent changes in practice or office policy. I understand that this consent shall remain in force from his date forward.

_____	_____	_____
Client/Legal Guardian Printed Name	Client/Legal Guardian Signature	Date

_____	_____
Lori Carroll, Ed.S., MFT	Date

LIMITS of CONFIDENTIALITY

Confidentiality means that I will, within the law, not share or release your personal or private information without your consent.

Federal and Nevada State laws require therapists to report certain information as detailed below. It is the professional and legal duty of therapists to give information about you to the appropriate authorities or agencies with or without your consent for the following reasons:

1) To stop a serious threat to your health and safety
2) To stop a serious threat to the health and safety of another
3) To report child abuse or neglect or elder abuse or neglect
4) In response to written Order of the Court or where otherwise required by law
5) To the extent necessary for emergeny medical care to be rendered

When I do give information, I give only the key and necessary information to meet my duty. If possible, I will try to let you know ahead of time. By signing this form, you are saying you understand the limits of your right to confidentiality or protection of your private or personal information.

Client/Guardian Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

CANCELLATION POLICY

It is my goal to provide personalized caring services to assist you in meeting your mental health goals. Therapy is a commitment of both time and effort. After your assessment, I will typically hold a weekly time slot on my schedule, reserved just for you. To make the most of your therapy, it is to your benefit for you to commit to attending all scheduled sessions. I understand that occasional emergencies arise beyond your control, at which time it is important for you to contact me to reschedule or cancel your appointment. ***I require a minimum of 24-hour notice but prefer as much notice as possible.***

Charge for missed appointments without 24-hr notice: $50.per occurrence

Missed appointments not only impede your progress, but they prevent another client in need from receiving services. In addition, they deprive me of the opportunity for compensation. Please note that Insurance companies only pay for sessions that are attended by the client and therapist.

Thus, it is my policy that ***after 2 missed appointments without 24-hour notice, I may remove you from my regular schedule and place you on a waiting list for the availability of an on-call appointment.***

If you have any questions or concerns regarding this policy, please feel free to discuss it with me.

I have read and understand the above:

Client/Guardian Signature: _____ Date:_____