** Client Information**

Except in cases of child/elder abuse or immediate danger to yourself/others, all information provided will be kept strictly confidential and released only in accordance with professional ethics and applicable law.

Date Referred by

Name (s) M F Birth Date / /

M F Birth Date / /

Spouse/partner’s name M F Birth Date / /

Relational Status: Married/cohabitating, separated, divorced, widowed, single, engaged

Children’s names/ages

Others living in your home

Address

Street Apt. # City Zip

Home phone Okay to leave message? Yes No

Work phone Okay to leave message? Yes No

Cell phone Email

Occupation Employer

**Current Concerns** Check the areas which apply:

|  |  |  |
| --- | --- | --- |
| * Depression * Anxiety/Stress * Relationships * Eating issues * Life Transitions * Substance abuse * Divorce | * Career * School * Grief * Anger * Abuse * Family * Parenting | * Spiritual issues * Trauma * Finances * Health * Insecurity * Sexuality * Suicidal thoughts |

What are the major concerns for which you’ve seeking counseling?

On a scale of 1 (mild) to 5 (severe), how would you rate your issues? 1 2 3 4 5

How long have these issues been a concern?

What are your goals for counseling?

Describe your personal strengths

Describe your support system (family, friends, church, etc)

Would including spirituality in your counseling be helpful? Yes No

If yes, what is your religious background and/or preference?

Have you received counseling in the past? Yes No

If yes, what were the issues and was it helpful?

**Medical Information**

Physician’s name Phone

Current medical conditions

Hospitalizations/major illnesses in the past 5 years (physical or mental)

List medications and vitamin/herbal remedies taken regularly. Indicate dosage and purpose.

Emergency Contact

Name Relationship Phone

Any additional information that you believe would be helpful:

***Amy Curry LCPC RPT at Meridian Counseling Center***

***Information Disclosure and Consent Form***

\* Amy Curry’s current rate is $125.00 and is not flexible according to insurance laws. Clients are to pay the fee at the beginning of every new session.

\* I understand that Amy Curry does not provide 24-hour crisis counseling. Should I experience an emergency necessitating immediate mental health attention, I will immediately call 9-1-1 or go to an emergency room for assistance.

\* I understand that during the time that we work together, we will meet weekly for approximately 50 minutes. While our sessions may be very intimate psychologically, ours is a professional relationship rather than a social one.

\* I understand that the purpose of counseling is to provide a non-judgmental, safe, and supportive environment for me to explore areas in my life through talk therapy.

\* I also understand our contact will be limited to counseling sessions except, only in case of emergency, you may call Amy Curry 208-949-5886.

\* I understand that, at any time, I may initiate a discussion of possible positive or negative effects of entering into the counseling relationship and that specific results are not guaranteed although benefits are expected from counseling.

\* I understand that counseling can improve as well as upset the equilibrium in any person or family. Counseling is a personal exploration and may lead to changes in your life perspectives and decisions. These changes could be temporarily distressing.

\* I understand that I am in control of the counseling relationship and may choose at any time to end our therapeutic relationship.

\* I understand that our paths may cross in social situations but that our therapeutic relationship comes first, along with protection of my confidentiality, and that Amy Curry does not initiate the greetings.

\* Should I believe that a referral is needed, Amy Curry will provide some alternatives including programs and/or people who may be able to assist me.

\* I understand that all fees for counseling are due at the beginning of each session. If I am late for an appointment, I must still pay for the full session.

\* I understand that if I do not show up for a scheduled appointment, without notifying Amy Curry, I will be charged a $20.00 fee.

\* I understand that the rate for all subsequent therapy services such as: attending parent/teacher conferences, attending ARD meetings, conducting classroom observations, participating in legal depositions, interactions with insurance companies, consultations with attorneys, etc. will be billed at $100.00 per hour.

\* I understand that should I subpoena Amy Curry as a factual case witness or involve her in any court-related processes, Amy Curry charges a retainer fee of $1,000.00, with an additional $120.00 every hour she is involved in legal depositions, case preparation, travel, and witness time. The party issuing the subpoena is responsible for the fee. Even though you are responsible for the testimony fee, it does not mean that Amy Curry’s testimony will be solely in your favor. Amy Curry can only testify to the facts of the case and to her professional opinion

\* I understand that if I do issue Amy Curry a subpoena without her approval (see above) that my subpoena will be directly turned over to her attorney and a bill will be rendered to me for immediate retainer fee payment.

\* I understand that if a check is returned, a processing fee of $25.00 will be assessed to my account. Additionally, I will need to make a cash or money order payment for the returned check and $25.00 processing fee. After a returned check, the office of Amy Curry may require cash payment of future appointments.

\* I understand that if a returned check is not cleared up in 30 days, Amy Curry will file a suit with the Ada County District Attorney’s Office.

\* Documentation is maintained regarding the services I receive. I have the right to access my counseling records. These records are confidential and will not be released to outside parties without my written consent.

\* With my consent, insurance companies or other external agencies may receive information regarding my counseling for reimbursement purposes.

\* Amy Curry is required to adhere to the professional code of ethics adopted by the Idaho Counselor Licensing Board. The Idaho Counselor’s Licensing Board has the general responsibility of regulating the practice of licensed professional counselors. The licensure of any individual under the licensing laws of Idaho does not imply or constitute an endorsement of that counselor, nor guarantee the effectiveness of treatment. I may, at any time throughout my treatment, seek a second opinion.

\* Sexual intimacy between a counselor and client/patient is never appropriate, and should be reported to the Idaho Counselor Licensing Board.

\* You may choose to engage in electronic communications with your counselor. If you and your counselor choose to do so, it is important for you to note that confidentiality through electronic transmissions is difficult to guarantee. However, counselors will follow guidelines as outlined in the ACA Code of Ethics.

\* Initial complaints should be addressed with your counselor. As a client, you have the right to make complaints regarding ethical concerns to the Bureau of Occupational Licenses at 208.334.3233.

**Risks and Benefits of Distance Counseling:**

Some clients receive counseling using electronic delivery, such as Skype, Face Time or telephone.  The benefit of this option is the ability to receive counseling in an area where no provider is available or when travel is prohibitive.  The risks of telecommunication include: the risk of a technological failure, the speed of Wi-Fi or Internet, last-minute changes in personal schedules,

1. Signal failure.  When a connection is lost, I will attempt to re-connect for 10 minutes. I will call your phone and explore alternate forms of communication, or, reschedule to continue.

2. Signal speed.  Communication may be delayed due to the speed of the internet. If responses interrupt the content of messages, we will explore an alternate form of communication.

3. Unexpected schedule changes. If you are unable to keep an appointment, please call and leave a message, and I will return your call as soon as possible.  If you are not available at the time of our session, I will wait for 10 minutes.  Clients are expected to pay a late fee of $20 which will be added to the following session's fee.

**Telehealth procedures:**

Sessions will begin with a verification of identity, which may include your full name, date of birth, or phone number. In some cases a code word will be established to verify the identity of the client and counselor.  No sessions will be recorded without the specific consent of the client. If the session is limited to the telephone where no visual cues are apparent, the counselor will have a greater dependence on the tone of voice and quality of speech. When necessary, the counselor will ask clarifying questions to improve understanding and treatment.

Thank you for your strength in seeking counseling for your specific needs. I hope to be able to assist you in this journey. Please sign this sheet to indicate that you have read the information and understand your rights as a client. Also by signing this you are stating that you were given the opportunity to ask any questions regarding the above presented information and that you have agreed to receive counseling services from me.

Client Name Date

Client Signature Date

Counselor Signature Date

Notice of Privacy Practice, 2013. Your Information. Your Rights. Our Responsibilities.

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.

Your Rights: **You have the right to:** Get a copy of your paper or electronic medical record. Correct your paper or electronic medical record. Request confidential communication. Ask us to limit the information we share. Get a list of those with whom we’ve shared your information. Get a copy of this privacy notice. Choose someone to act for you. File a complaint if you believe your privacy rights have been violated.

# Your Choices: You have some choices in the way that we use and share information as we: Talk with your family about your condition (as needed). Provide disaster relief. Provide mental health care.

# Our Uses and Disclosures: We may use and share your information as we:

|  |
| --- |
| * Treat you * Run our organization * Bill for your services * Help with public health and safety issues * Do research * Comply with the law * Address workers’ compensation, law enforcement, and other government requests * Respond to lawsuits and legal actions |

# Your Rights: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

**Get an electronic or paper copy of your medical record**

* You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

**Ask us to correct your medical record**

* You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say “no” to your request, but we’ll tell you why in writing within 60 days.

**Request confidential communications**

* You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say “yes” to all reasonable requests.

**Ask us to limit what we use or share**

* You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
* If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

**Get a list of those with whom we’ve shared information**

* You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
* We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

* If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
* We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**

* You can complain if you feel we have violated your rights by contacting us using the information on page 1.
* You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [**www.hhs.gov/ocr/privacy/hipaa/complaints/**](http://www.hhs.gov/ocr/privacy/hipaa/complaints/)**.** We will not retaliate against you for filing a complaint.

# Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

* Share information with your family, close friends, or others involved in your care
* Share information in a disaster relief situation

In these cases we never share your information unless you give us written permission:

* Marketing purposes
* Most sharing of psychotherapy notes

# Our Uses and Disclosures: we never market or sell personal information

## How do we typically use or share your health information?

We typically use or share your health information in the following ways.

**Treat you:** We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

**Run our organization:** We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

**Bill for your services:** We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

## **How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

**Help with public health and safety issues:** We can share health information about you for certain situations such as:

* Preventing disease
* Helping with product recalls
* Reporting adverse reactions to medications
* Reporting suspected abuse, neglect, or domestic violence
* Preventing or reducing a serious threat to anyone’s health or safety

**Do research:** We can use or share your information for health research.

**Comply with the law:** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

**Address workers’ compensation, law enforcement, and other government requests:** We can use or share health information about you:

* For workers’ compensation claims
* For law enforcement purposes or with a law enforcement official
* With health oversight agencies for activities authorized by law
* For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions:** We can share health information about you in response to a court or administrative order, or in response to a subpoena.

# Our Responsibilities

* We are required by law to maintain the privacy and security of your protected health information.
* We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
* We must follow the duties and privacy practices described in this notice and give you a copy of it.
* We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

Changes to the Terms of this Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site. **See Attached Informed Consent for further details about confidentiality and client information. Please ask questions if desiring further information.**

Client Signature Date

# Insurance Information Sheet

Client Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M / F

MM DD YY (Circle One)

Client Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Insured: Self  Spouse  Child  Other  Client Status: Part A: Single  Married  Other 

Part B: Employed  Full-Time Student  Part-time Student 

**Is the client’s condition related to**: Employment YES  NO Auto Accident YES  NO

Other Accident YES  NO

Insured’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M / F

Please Print exactly as it appears on your Insurance Card MM DD YY (Circle One)

Insured’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Only list if different from client)  (Only list if different from client)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance: Yes No If yes, list company name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Circle One)

Policy Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Deductible $\_\_\_\_\_\_\_\_Amount met $\_\_\_\_\_ Copay $\_\_\_\_\_\_ # of allowed visits\_\_\_\_\_

I, as a Client or Insured Family Member, give consent and acknowledgement that this and other client information will be released to Insurance Carriers or Medicaid Agencies that provide financial reimbursement for requested services at Meridian Counseling Center:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Family Member Signature Date