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NEW CLIENT INFORMATION PACKET

This information is used by your therapist for administrative purposes, and to become familiar with your presenting concerns, history, and possible areas of mental health and wellness to be worked on in your counseling services. Please answer as thoroughly as you can. Thank you for giving us the opportunity to serve you.

Date _____

Client Information

First Name _____Middle Initial _____Last Name _____

Nickname _____ Gender: □ Male □ Female

Date of Birth _____/____/_____ Social Security Number_____

(required by most insurance companies)
Marital Status: □ Married □ Single □ Separated □ Divorced □ Other (explain)_____

Employment: □ Employed □ Full-time Student □ Part-time Student □ Unemployed/Other

□ **HIPAA Agreement was provided (sign here):** _____

Telephone: ☐ Mobile ( ) _____ □ No messages □ Voice Messages □Text Messages

☐ Home ( ) _____ □ No messages □ Voice Messages

☐ Work ( ) _____ □ No messages □ Voice Messages □Text Messages

Preferred Phone:_____

Health Insurance Company Name: _____Group #_____

Health insurance ID#_____

Personal Email Address:_____

Home Address _____
Street City State Zip

Employer _____

Employer Address_____
Street City State Zip Phone

Occupation/Title/Position:_____

Background Information

Spouse &/or Parents Name (circle which applies)_____ _____
Date of Birth _____/_____/_____

Home Address _____ Phone: Mobile ( ) _____

Please list additional family members living with you:

	Name	Relationship	Date of Birth	Employer/School
1.				
2.				
3.				
4.				

Who may we contact in the event of an emergency?
Name:_____ Phone number:_____
Relationship?_____

Please describe briefly the concern or situation, which led you to seek services at this time:

_____

_____

_____

How long has this been a concern?_____

Have you experienced this type of concern before? □ YES □ NO If so, when?_____

Have you had any significant events, either positive or negative, occur recently or in a notable amount of time, such as job/school changes, death(s), changes in finances, living situation, illness, infertility, etc?

_____

_____

Physician _____
Name Address Phone #

Do you regularly have physical wellness check-ups? □ YES □ NO

If you have noticed any recent changes in the following areas, please circle those changes:

A) vision, hearing, coordination, balance, strength, speech, memory, or thinking
B) energy, sleeping, eating, elimination, menstrual cycle, or sexual activity

Are you currently seeing a counselor, therapist, psychologist, or psychiatrist □ YES □ NO
If yes, who?_____

Have you ever had counseling before? □ YES □ NO
If so, when and why? _____
_____

Was it helpful? □ YES □ NO If not, why not?_____

Have you ever had medication prescribed for psychiatric or emotional difficulties? □ YES □ NO
If so, please list:
_____
_____

Have you ever been physically, sexually, or emotionally abused? □YES □ NO
If yes, briefly describe:
_____
_____

Have you ever been hospitalized for mental or nervous problems? □YES □ NO
If yes, when and where: _____

Are you experiencing any issues related to sexuality (i.e. sexual identity, compulsive pornography use, desire, performance, etc.)? □ YES □ NO
If yes, please explain:_____
_____
_____

Have you ever attempted suicide? □ YES □ NO
If yes, how and when:_____
_____
Are you suicidal now? □ YES □ NO

How often do you drink alcohol? _____
Have you ever been arrested for driving under the influence (DUI)? □ YES □ NO

Do you smoke or use tobacco? □ YES □ NO
If yes, how much?_____

Do you use recreational drugs? □ YES □ NO
If yes, what drugs do you use and how often?_____

Do you have any concerns about alcohol/drug usage by members of your family? □ YES □ NO
If yes, please explain:_____
_____

Are you currently involved or expected to be involved in any court related matters? □ YES □ NO
If yes, please describe:_____
_____

Have any of your biological relatives had concerns similar to yours, or had any other psychiatric or emotional difficulties? □ YES □ NO
If yes, which relatives and what kind of concerns/difficulties:_____
_____

Religious and Spiritual
Do you consider yourself spiritual? □ YES □ NO Religious? □ YES □ NO
Comment?_____

Do you currently express this spirituality through religious practice? □ YES □ NO
Comment?_____

Would you like spirituality included in your counseling? □ YES □ NO

Church affiliation_____

Demographic Information (optional…may skip this section and go to next page)

This information is confidential and used for statistical purposes. Providing demographic information is voluntary.

Ethnicity: ____Caucasian/White ____American Indian/Alaska Native ____Middle Eastern
____African American/Black ____Native Hawaiian/Pacific Islander ____Asian
____Hispanic/Latino ____Other _____

Education of Adults in Household (put initials of each adult if more than one):
____Some High School ____Associate's Degree ____Doctorate
____High School Graduate ____Bachelor's Degree ____Trade/Specialty
____Some College ____Master's Degree ____Other _____

Presenting concerns: (check all that apply – if attending couples or family counseling please put initials of each person next to the concerns that apply.)

___very unhappy
___insecurity
___irritable/critical
___no joy
___withdrawn/isolation
___tiredness
___frustration
___moody
___depression
___memory loss
___short attention span
___concentration difficulty
___crying spells
___lack of energy
___lacks motivation
___difficulty making decisions
___emotional abuse
___sexual abuse
___physical abuse
___homicidal thoughts
___suicidal thoughts

___impulsive
___obsessive/compulsive
___nervousness
___panic attacks
___racing thoughts
___fearful
___shyness
___worry
___health problems
___self-harming
___stressed out
___destructive
___excessive daydreaming
___hair pulling
___mean to others
___distractible
___paranoia
___strange thoughts
___strange behavior

___undependable
___intense headaches
___ temper outbursts
___employment problems
___repetitive/ritualistic behaviors
___seizures
___financial stress
___legal problems
___problems w/ex-spouse
___sexual problems
___relationship issues
___affair
___divorce/separation
___significant alcohol use
___problems with friends
___parenting problems
___stomach/bowel problems
___chronic pain
___problems w/parents

___self-control
___ stealing
___bullying
___loneliness
___grief
___lying
___flashbacks
___nightmares
___eating problems
___sleeping problems
___bed wetting
___school issues
___ work/career issues
___pornography use
___drug use
___social problems

Explain:_____
_____
_____
_____
_____

What are your goals for treatment (what do you want to accomplish with counseling?)
1)_____
_____
2)_____
_____
3)_____
_____

Is there anything else that you feel is important for your therapist to know?
_____
_____

Informed Consent and Counseling Agreement

Gary Armour, Licensed Clinical Marriage and Family Therapist

Thank you for giving me the opportunity to serve you in your counseling needs. I pledge to give you the best care that I can and will deliver to you the highest quality of service. In order to meet your needs the following information is provided for your consideration. Please read this carefully and ask any questions that you may have.

Credentials – I am a Licensed Clinical Marriage and Family Therapist in the state of Kansas, and hold a professional Master's degree in the practice of ministry. I am not a physician and do not have authority to prescribe medication.

Benefits and Risks – Any time individuals seek therapy to work on difficulties within themselves or in their personal relationships, there are potential benefits and risks. Benefits may include the ability to handle specific concerns and/or interpersonal relationships in a healthier way. Clients may also gain a greater understanding of personal, interpersonal, or family issues. This new understanding may lead to greater maturity and happiness as an individual or family. There may also be other benefits that come as clients work at resolving specific concerns.

However, therapy is also sometimes challenging and uncomfortable. Reviewing and resolving unpleasant issues may result in intense feelings of anxiety, anger, depression, or frustration. As clients work to resolve personal issues or issues between family members, peers or other persons, they may experience discomfort and an increase in conflict. Changes in relationships that were not originally intended may also result.

I will discuss with each individual/family the benefits and risks involved in their specific situation. Clients are encouraged to discuss with me concerns they may experience at any time.

Confidentiality – It is my policy and desire to protect the rights of my clients to confidentiality as defined in State and Federal statutes. All staff at Lifeline Counseling Center have been educated in the principles of confidentiality. You may rest assured that your records are being kept, handled, and monitored in the most professional ways possible. No information from your records will be released to anyone without your prior written consent. Exceptions to this include:
-suspected abuse or neglect of someone;
-duty to warn of homicidal intent;
-civil detention to prevent suicide;
-when ordered by a court of law;
-when either you or I initiate legal action regarding the counseling process;
-when I am in a civil or criminal lawsuit pertaining to my counseling practice;
-when you sign a release for disclosure of the contents of your records or of pertinent needs/progress to any person such as a doctor or other co-treater, family member or pastor;
-when I bill third party providers such as an insurance company, Employee Assistance Program, or a church;
-occasional collaboration or consult with professional colleagues (these persons are also required to keep your information confidential);
-Parents have a right to have a reasonable account of their minor child's therapy. Occasionally when a child/adolescent reveals information in therapy, they wish it to remain confidential. Usually their request will be honored unless it involves dangerous behavior such as drug/alcohol use, risky sexual behavior, suicidal ideation, or running away;
-If you and your partner decide to have individual sessions as part of the couple's therapy, what you say in those individual sessions will be considered to be a part of the couples therapy, and can and probably will be discussed in our joint sessions. Do not tell me anything that you wish kept secret from your partner. I will remind you of this policy before beginning such individual sessions.

Court Fees – Should it be requested or required that I appear in court, there will be a $250 court appearance fee, as well as a $120/hourly fee assessed for my time. Additional fees may apply for copying of files or report writing.

Scheduling of Appointments – I will make every effort to schedule your appointments at times most convenient for you. My sessions last approximately 50 minutes. It is your responsibility to arrive on time. If you are running late please call and let me know. **If you have not called and are not here by 15 minutes past the scheduled start time, I will cancel the appointment and bill you the full fee for the session. I must have 24 hours advance notice if you cannot attend your scheduled appointment.**

How to reach me – Should you need to reach me, please call 913-764-5463 ext #132. If I do not answer, please leave a message with your phone number. Use the emergency number on my LifeLine voice mail only if your call is urgent and demands immediate action. Most calls do not warrant the emergency number.

I may not immediately be able to speak with you when you try to contact me if it is between the hours of 9am and 8pm due to being in sessions with other clients. I will gladly return your call as soon as I am able. On occasion you may experience a time when speaking to me briefly outside a session would be helpful. As I receive notice of your need and am able to respond, I can provide at most two ten-minute phone crisis sessions per week without charge. Phone calls lasting 15 minutes or more will be billed in 15 minute increments at my standard hourly fee.

Children – Please do not bring your children unless they are a part of our session. I also ask that you do not leave children unattended in the waiting area. If you have any questions or concerns regarding children, please discuss those with me.

Record Keeping – I keep very brief records, noting only that you have been here, what interventions happened in session, and the topics we discussed. Under the provisions of the Health Care Act of 1992, you have the right to a copy of your file at any time. You have the right to request that I correct any errors in your file. You have the right to request that I make a copy of
your file available to any other health care provider at your written request. I maintain your records in a secure location that cannot be accessed by anyone else.

On occasion I may be asked to fax or email information regarding your treatment. This request could be made by an insurance company or another health care provider.

I **authorize** the fax or email transmission of information from my records. _____
Client initials

I **do not** authorize the fax or email transmission of information from my records. _____
Client initials

If I am away from my office, I may use a cell or cordless phone to communicate with you. These calls are not always guaranteed to be 100% secure. I need permission to talk with you on a cell or cordless phone.

I **authorize** phone calls via cell or cordless phone. _____
Client initials

I **do not** authorize phone calls via cell or cordless phone. _____
Client initials

_____

Privacy Notice – Please read the Privacy Notice, which is mandated by federal law and the Health Insurance Portability and Accountability Act (HIPAA), and initial here _____. The notice explains HIPAA and how it applies to your personal health information. By initialing this agreement you are acknowledging the receipt of the privacy act.

_____

Insurance Billing – I am a provider on some insurance panels, please be advised of the following:

1. Some, but not all, insurance companies will pay a portion of counseling fees. I cannot guarantee that your company will do such.
2. You are responsible for knowing your insurance benefits.
3. I will bill your insurance company in a timely manner and will expect payment in such. Most companies reimburse within 30 days of receiving a claim. If your insurance company delays payment, you may be asked to contact the company to expedite payment.
4. You are expected to make applicable co-payments at the time of each visit.
5. Your insurance company will not pay for any missed appointments. **You are responsible for paying my fee for these according to the rate your insurance company has contracted with me.**

Finances - My fee per session is **$120 for the first session and $90 for all following sessions.** Counseling fees are due and payable before the session begins. If you desire any other arrangement, please talk to me in advance. I accept cash, check, Discover, MasterCard and Visa and some HSA cards. There is a $15 charge for a returned check.

My signature below indicates that:

1. I have read, understand, and agree with the therapist's policies and give informed consent to receive therapy services.
2. I understand that there can be risks and benefits associated with therapy. I also understand that no promises have been made to me as to the results of treatment.
3. I understand that I may leave therapy at any time and agree to discuss the termination of therapy at a regular therapy session rather than by phone.
4. I acknowledge receipt of a copy of this Informed Consent.
5. I authorize the release of my/our name only to our referral source to thank them for our referral.
6. I agree to allow disclosure of necessary information for the processing of insurance claims on my behalf.
7. I have read and agree to the above Finance and Insurance Billing sections. I agree to pay $_____(fee/copay; *circle one*) I also agree to pay for missed appointments or for appointments I cancel without giving the required advance notice.

Client Signature _____ Date_____

_____Date_____

Therapist Signature _____Date_____
Gary Armour, LCMFT

KANSAS NOTICE FORM

Notice of Policies and Practices to Protect the Privacy of Your Health Information
Effective July 1, 2007

This notice describes how I may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO). It also describes your rights to access and control your protected health information. “Protected Health Information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related healthcare services. Please review it carefully. You have the right to a paper copy of this Notice; you may request a copy at any time.

How I may use and disclose health information about you:

I may use and disclose your health information for the following purposes without your express consent or authorization. I will obtain your express written authorization before using or disclosing your information for any other purpose. You may revoke such authorization, in writing, at any time to the extent I have not relied on it.

Payment. I may use and disclose your health information as necessary to obtain payment for services provided to you.

Health Care Operations. I may use and disclose your health information for internal operations. These uses and disclosures are necessary for the day-to-day operations and to make sure clients receive quality care. I may disclose health information about you to a health care provider or health plan with which you also have had a relationship for purposes of that provider’s or plan’s internal operations.

Creation of de-identified health information. I may use your health information to create de-identified health information. This means that all data items that would help identify you are removed or modified.

Uses and disclosures required by law. I will use and/or disclose your health information when required by law to do so.

Disclosures for public health activities. I may disclose your health information to a government agency authorized (a) to collect data for the purpose of preventing or control disease, injury, or disability; or (b) to receive reports of child abuse, elder abuse or neglect. I also may disclose such information to a person who may have been exposed to a communicable disease if permitted by law.

Disclosures about victims of abuse, neglect, or domestic violence. I may disclose your health information to a government authority if I reasonably believe you are a victim of abuse, neglect, or domestic violence.

Disclosures for judicial and administrative proceedings. Your protected health information may be disclosed in response to a court order or in response to a subpoena, discovery request, or other lawful process if certain legal requirements are satisfied.

Disclosures for law enforcement purposes. I may disclose your health information to a law enforcement official as required by law or in compliance with a court order, court-ordered warrant, a subpoena, or summons issued by a judicial officer; a grand jury subpoena; or an administrative request related to a legitimate law enforcement inquiry.

Disclosures regarding victims of a crime. In response to a law enforcement official's request, I may disclose information about you with your approval. I may also disclose information in an emergency situation or if you are incapacitated if it appears you Ire the victim of a crime.

Disclosures to avert a serious threat to health or safety. I may disclose information to prevent or lessen a serious threat to the health and safety of a person or the public or as necessary for law enforcement authorities to identify or apprehend an individual.

Disclosures for specialized government functions. I may disclose your protected health information as required to comply with governmental requirements for national security reasons or for protection of certain government personnel or foreign dignitaries.

Your rights regarding your health information.

Right to Inspect and Copy. You have the right to inspect and copy health information maintained by me. To do so, you must submit in writing the information needed to process your request. If you request copies, I may charge a reasonable fee. I may deny you access in certain limited circumstances. If I deny access, you may request review of that decision by a third party and I will comply with the outcome of the review.

Right to Request Amendment. If you believe your records contain inaccurate or incomplete information, you may ask me to amend the information. To request an amendment, you must submit request in writing including the reason that supports your request.

Right to an Accounting of Disclosures. You have the right to request a list of disclosures of your health information I have made, with certain exceptions defined by law. To request this list, you must submit request in writing.

Right to Request Restrictions. You have the right to request a restriction on the uses and disclosures of your health information for treatment, payment, or health care operations. You must submit request in writing.

Right to Request Alternative Methods of Communication. You have the right to request that I communicate with you in a certain way or at a certain location. You must submit the/a request in writing, and I will accommodate all reasonable requests.

Breach Notification. I am required to provide you with written notice concerning any breach of your health information. You will receive such notice via first-class mail, unless you agree to an alternative form of notice or I do not have a current address for you. If you have any concerns regarding any possible unauthorized use or disclosure of your health information and/or any breach notification please contact me.

Complaints

If you believe your rights with respect to health information have been violated, you may file a complaint with Marcie Wheatley, Director of Lifeline Counseling Center, or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

I reserve the right to change the terms of this Notice and to make the revised Notice effective with respect to all protected health information regardless of when the information was created.

PHYSICIAN RELEASE/WAIVER

By Kansas statute I am required to consult with your primary care physician or psychiatrist to determine if there is a medical condition or medication which may be contributing to your symptoms. You are required to provide me with the name and mailing address of your physician, or sign a waiver stating you do not wish for me to contact your physician.

Please contact my physician: Dr. _____

address_____

_____ _____
Client signature date

I waive my right for you to contact my physician. I do not wish for you to consult my physician.

_____ _____
Client Signature date

I authorize payment of insurance benefits to Gary Armour, M.Div., LCMFT for counseling services.

_____ _____
Client signature date