Cedars Counseling, Inc.

Initial Client Intake

Please provide the following information for our records. Information you provide here is held to the same standards of confidentiality as our therapy.

Legal Name: _____
(First) (Middle Initial) (Last)

Parent/Guardian (if treating a minor): _____ Relationship to Minor: _____
(First) (Last)

Birth Date: _____/_____/_____ Age: _____ Social Security Number: _____

Gender: _____ Marital Status: _____ Number of Marriages _____ No of Children_____

Address: _____
(Street and Number) (City) (State) (Zip)

Home Phone: ( ) - May we leave a msg? Yes No

Cell/Work/Other Phone: ( ) - May we leave a msg? Yes No

E-mail: _____ May we e-mail you: Yes No
*Please be aware that e-mail might not be confidential.

Please indicate the primary reason for your visit today: _____

INSURANCE INFORMATION ***This MUST be completed even though we have a copy of your card.***

EAP ☐ No ☐ Yes If yes, through whom_____ Authorization Number _____

Primary Insurance _____ Contract/ID# _____

Subscriber Name _____ Group/Acct# _____

Subscriber Social Security Number _____

Subscriber Date of Birth _____ Client's relationship to Subscriber: ____Self ____Spouse ____Child ____Other

Emergency Information In case of emergency, contact:

Name _____ Relationship _____ Phone _____

Address _____City _____ State _____ Zip _____

OCCUPATIONAL INFORMATION:

Are you currently employed? Yes or No If yes, who is your current employer? _____

Current Position? _____ Please list any work-related stressors: _____

Highest grade completed: _____ Are you a veteran or currently active in the U.S. Military? Yes or No

Client Name: Medical Record:

Cedars Counseling, Inc.

MEDICAL INFORMATION:

Physician _____ Phone _____ City _____ State _____ Zip _____

Psychiatrist _____ Phone _____ City _____ State _____ Zip _____

List any major medical problems, surgeries, hospitalizations and/or allergies.

(1)	**(3)**
(2)	**(4)**

Current Medications_____ **Dosage:** _____

_____ _____

_____ _____

_____ _____

Mental Health Treatment History: Please list any previous psychological/psychiatric services & related information.

Type of Service	Dates of Service	Provider	Reason for Service

HEALTH AND SOCIAL INFORMATION:

1. How would you describe your physical health? ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

2. Current Symptom List: Please circle all that apply at present:

Poor Memory	Headaches	Nightmares	Stress	Shyness
Impulsiveness	Depression	Sexual Dysfunction	Anxiety	Rage/Anger
Hallucinations	Guilt/Shame	Excitability	Tension	Racing Thoughts
Worthlessness	Panic Attacks	Stomach Trouble	Bedwetting	Risky Behaviors
Fatigue	Intrusive Thoughts	Helplessness	Worry	Harm to Self/Others

3. Are you having any problems with your sleep habits? ☐ No ☐ Yes If yes, check where applicable:
   ☐ Sleeping too little ☐ Sleeping too much ☐ Poor quality sleep

4. How many times per week do you exercise? _____ Approximately how long each time? _____

5. Are you having any difficulty with appetite or eating habits: ☐ No ☐ Yes If yes, check where applicable:
   ☐ Eating less ☐ Eating more ☐ Binging ☐ Restricting

6. Have you experienced significant weight change in the last two months? ☐ No ☐ Yes

7. Do you regularly use alcohol? ☐ No ☐ Yes
   In a typical month, how often do you have 4 or more drinks in a 24 hour period? _____

Cedars Counseling, Inc.

8. How often do you engage in recreational drug use? ☐ Daily/Weekly ☐ Monthly ☐ Rarely ☐ Never

9. Have you had suicidal thoughts recently? ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

   Have you had them in the past? ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

10. Are you currently in a romantic relationship? ☐ No ☐ Yes If yes, how long have you been in this relationship? _____

    On a scale of 1-10, how would you rate the quality of your current relationship? _____

11. In the last year, have you experienced any significant life changes or stressors? _____

Have you ever experienced the following? Please circle all that apply.

Extreme depressed mood	Wild Mood Swings	Panic Attacks
Rapid Speech	Extreme Anxiety	Phobias
Sleep Disturbances	Hallucinations	Suicide Attempt
Unexplained losses of time	Memory lapses	Eating Disorder
Alcohol/Substance Abuse	Chronic pain	Repetitive behaviors
Body Image Problems	Repetitive Thoughts	Homicidal Thoughts

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following: (Circle any that apply and list family member, e.g. Sibling, Parent, Uncle, etc.):

Diagnosis	Family Member(s)	Diagnosis	Family Member(s)
Depression	_____	Bipolar Disorder	_____
Anxiety Disorders	_____	Panic Attacks	_____
Schizophrenia	_____	Substance Abuse	_____
Eating Disorders	_____	Trauma History	_____
Learning Disability	_____	Suicide Attempts	_____

THIS SECTION TO BE USED ONLY FOR MINOR CHILDREN

Are biological parents: Married Separated Divorced **Child resides with:**
Legal Guardian: **Parenting Plan?** __Yes __No **County of Jurisdiction:**
DCS Involvement? __Yes __No **Previous Abuse issues** __Yes __No ☐ Emotional ☐ Physical ☐ Sexual
Name of School: **Grade:**
Biological Mother's Name and Place of Employment
Biological Father's Name andPlace of Employment
Do you foresee needing our services for court? ☐ **Yes** ☐**No**

I assert that this information is correct to the best of my knowledge and ability.

_____ _____

Signature Date

Client Name: Medical Record:

Cedars Counseling, Inc.

Informed Consent to Treatment

I, _____, the undersigned, hereby attest that I have voluntarily entered into treatment or give my consent for the minor or person under my legal guardianship mentioned above, at Cedars Counseling, Inc. hereby referred as the Provider. Further, I consent to have treatment by a psychiatrist, psychologist, social worker, counselor, or intern in collaboration with his/her supervisor. The rights, risks, and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. Cedars Counseling encourages that this decision be discussed with the treating therapist. This will help facilitate a more appropriate plan for discharge.

Client's Rights and Responsibilities: I certify that I have received the Client's Rights Information and certify that I have read and understood the content.

Expectations: Counseling is based on the relationship you develop with your counselor. Every case is unique, but generally you can expect the following:

- Education: You can expect some information and education about what you are facing.
- Assignments: Homework is a vital part of making the most of your counseling process.
- Client Centered: You can expect to have topics that revolve around you and your concerns.
- Sharing: You will be asked questions, and there is an expectation that you will openly share your thoughts and feelings.
- Discovery: Expect to examine yourself through looking at your thoughts, feelings, and behaviors.
- Length of Treatment: Sessions last 45-50 minutes.
- Frequency of Appointments: One session per week is typical but can be adjusted to meet individual needs.
- Interruptions: It is in your best interest to have uninterrupted care. Time between sessions can substantially lessen the desired effects of treatment.

Non-Voluntary Discharge from Treatment: A client may be terminated from the Provider non-voluntarily, if: A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts on the premises of Cedars Counseling, and/or B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter.

Client Notice of Confidentiality: The confidentiality of patient records maintained by the Provider is protected by Federal and//or State law and regulations. Please refer to the Privacy of Information Policy which will address all matters of confidentiality.

Risks: Therapy is very safe, but there are some risks. The biggest risk is the result of change. Change can have an undetermined impact on your life and in significant relationships. Another risk is emotional pain or anxiety but should be alleviated with continued treatment.

Benefits: Change is also the most significant benefit of therapy. You will learn new ways of interacting, thinking, and behaving. Often changes will result in the reduction of problems and reported symptoms prior to therapy.

About your Counselor: As you review this form with your counselor, he/she should explain his/her individual counseling style. This should include qualifications, approach to therapy, school of thought, and other information. If you have any questions now or later, feel free to ask your counselor.

I consent to treatment and agree to abide by the above stated policies and agreements with Cedars Counseling, Inc.

_____ _____

Signature of Client/Legal Guardian Date

(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

_____ _____

Therapist Date

Client Name: Medical Record:

Cedars Counseling, Inc.

Client's Bill of Rights Notification

As a recipient of services at our facility, we would like to inform you of your rights as a client. The information contained in this document explains your rights and the process of complaining if you believe your rights have been violated.

Your rights as a patient:

- **Complaints:** We will investigate your complaints.
- **Suggestions:** You are invited to suggest changes in any aspect of the services we provide.
- **Civil Rights:** Your civil rights are protected by federal and state laws.
- **Cultural/ Gender Issues:** You may request services from someone with training or experiences from a specific cultural or gender orientation. If these services are now available, we will help you in the referral process.
- **Treatment:** You have the right to take part in formulating your treatment plan.
- **Denial of Services:** You may refuse services offered to you and be informed of any potential consequences.
- **Record Restrictions:** You may request restrictions on the use of your protected health information; however, we are not required to agree with the request.
- **Availability of records:** You have the right to obtain a copy and/or inspect your protected health information; however, we may deny access to certain records in which case we will discuss this decision with you.
- **Amendment of records:** You have the right to request an amendment in your records; however, this request could be denied. If denied, your request will be kept in your records.
- **Medical/Legal Advice:** You may discuss your treatment with your doctor or attorney.
- **Disclosures:** You have the right to receive an accounting of disclosures of your protected health information that you have not authorized.

Your rights to receive information:

- **Costs of services:** We will inform you of how much you will pay.
- **Termination of services:** You will be informed as to what behaviors or violations could lead to termination of services at our facility.
- **Confidentiality:** You will be informed of the limits of confidentiality and how your protected health information will be used.
- **Policy Changes:** You will be notified in advance of any policy changes.

Our ethical obligations:

- We dedicate ourselves to serving the best interest of each client.
- We will not discriminate between clients or professionals based on age, race, creed, disabilities, handicaps, preferences, or other personal concerns.
- We maintain an objective and professional relationship with each client.
- We respect the rights and views of other mental health professionals.
- We will appropriately end services or refer clients to other programs when appropriate.
- We will evaluate our personal limitations, strengths, biases, and effectiveness on an ongoing basis for the purpose of self-improvement. We will continually attain further education and training.
- We hold respect for various institutional and managerial policies, but will help improve such policies if the best interest of the client is served.

Client's responsibilities:

- You are responsible for your financial obligations to the facility as outlined in the Payment Contract for Services.
- You are responsible for following the policies of the facility.
- You are responsible to treat staff and fellow clients in a respectful, cordial manner in which their rights are not violated.
- You are responsible to provide accurate information about yourself.
- Therapy is an individual process for which you will need to assume responsibility for making changes.
- In order to receive the greatest benefit, you need to be actively involved in the treatment process. Goal setting, assignments, and talking are all important and critical to treatment success.
- Treatment is voluntary, and you may end counseling at any time without fear of penalty.
- You can expect to be treated with respect.

What to do if you believe your rights have been violated:

- If you believe that your client rights have been violated, contact Elysse Beasley, Srpe, LPC

Print Name: _____ Signature _____

Signed by: _____Client _____ Guardian _____Personal Representative Date _____

Cedars Counseling, Inc.

Payment Contract for Services

The following are fees associated with available services that may be provided at your request. Please indicate the services to which you wish to prescribe. Please be aware that ONLY the services indicated on this form, with your signature, will be provided. Any additional requests will require an updated form and signature.

Client Signature	Description of Service	Amount
	Initial Intake and Assessment Appointment	$135.00/Hr*
	Counseling Services, Individual, Family, Marriage	$125.00/Hr*
	Late Cancellations or No Show for Appointment**	$65.00 Each
	Phone Consultation (Client/Attorney/PO)	$25.00/15 min
	Court Documentation/Reports**	$150.00/Report
	Depositions**	$150.00/HR
	Court Appearance**	$150.00/Hr with a $750.00/Minimum
	Psychological Evaluations	Varies $50.00/Test fee**
	Hypnosis/Hypnotherapy**	$100.00/Hr.

*If you utilize insurance, the fee will be adjusted according to the contracted rate.
Required prepayment of services. Insurance **will not cover these costs.

Should your insurance fail to reimburse for our services, you will be responsible for the full amount due.

Your annual deductible is: _____ Your per visit co-pay is: _____

_____ _____
Client Signature Date

_____ _____
Therapist Signature Date

Client Name: Medical Record:

Cedars Counseling, Inc.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAFREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control protected health information. "Protected health information" is information about you, including demographic information, that may identify you and relates to your past, present, or future physical or mental health or condition and related care services.

I. Uses and Disclosures of Protected Health Information Requiring Authorization

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

II. Treatment

We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

III. Payment

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission. If claims are denied, you are responsible for all costs of the services provided. There is a 2% interest charge on all outstanding balances over 60 days. In the event that your account goes into court for collection, there will be an additional charge to cover any attorney or legal fees and post-judgment interest at the rate of 2% per month.

IV. Health Care Operations

We may use or disclose, as needed, your protected information in order to support the business activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to a medical school student that sees patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments.

We may use or disclose your protected health information in the following situations without your authorization. These situations include, as required by law. Under the law, we must make disclosures to you and, when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization and opportunity to object unless required by law.

You may revoke this authorization at any time in writing except to the extent that your physician or the physician's practice has taken an action previously on the use or disclosure indicated in the authorization.

Client Name: Medical Record:

YOUR RIGHTS: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or health care operation. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you request. If the provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communication from us by alternative means or an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to this notice alternatively (i.e. electronically).

You may have the right ot have your provider amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

V. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

VI. Effective Date

This notice shall go into effect April 14, 2003 and will remain so unless new notice provisions effective for all protected health information are enacted accordingly. We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objects to this form, please ask to speak with our HIPAA Compliance Office in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this notice of our Privacy Practices.

Print Name: _____

Signature: _____ Date: _____

Signed by: ___client ___ guardian ___personal representative

Cedars Counseling, Inc.

Authorization to Disclose Protected Health Information

Section 1: The Client

First Name	Middle Initial	Last Name
Address	**Date of Birth**	**Phone**

I hereby authorize the disclosure of protected health information about the individual named above and declare that I am:
____the individual named above OR ___ a personal representative because the patient is a minor, incapacitated or deceased.

Section 2: Person/Agency Disclosing Information

Name	Address	Phone
Cedars Counseling, Inc.	**319 W. McKnight Drive, Murfreesboro, TN 37129**	**615-896-9160**

Section 3: Recipient of Information

Name of Recipient	Address	Phone

Section 4: Information That Will Be Disclosed

_____ Medical Records

_____ Psychiatric Records

_____ Alcohol and Drug Records

_____ PCP Communication

_____ Emergency Contact

_____ Other (specify)_____

_____ Appointment Summary

_____ Initial Assessment

_____ Verbal Communication

_____ Progress Notes

_____ Discharge Summary

Section 5: The Purpose of the Disclosure

_____ Treatment and Evaluation

_____ Continuity of Care

_____ Other (specify)_____

_____ Legal Purposes

_____ Employment

My signature indicates my willingness to have my information released to the above recipient.

Print Name: _____ Date: _____

Signature: _____ Signed by: ___client ___guardian ___personal representative

Cedars Counseling, Inc.

Consent for Psychological Evaluation

I have received a copy of HIPAA Notice of Privacy Practices. I understand that, in most cases, my treatment and all records are confidential. In the event of a threat of imminent harm to myself or another, or the necessity of reporting abuse of a minor or of an elderly person, this confidentiality is waived by law.

I understand that I have a right to know about my evaluation and to understand what evaluations are being used and for what purposes. I give my consent to be treated.

Signature _____ Date _____

Please initial the following statements:

Would you like our office to submit the charges for your evaluation to your insurance company? ☐ Yes ☐ No

If yes, please continue and initial:

_____Our office will determine to the best of our ability your co-pay/co-insurance prior to testing. I understand that this is not a guarantee of coverage and the insurance company has the final determination of covered expenses.

_____ I understand that there is a $50.00 test-scoring fee which is not a covered service by insurance. This fee is due at the time of the evaluation.