

Family Christian Counseling Center Inc.

2200 Chambliss Ave NW, Cleveland, TN 37311 Phone: 423.599.9347 Fax: 832.369.7679

Gary R. Lynn, M.Ed., LPC, NCC ~~~ Daniel J. Walker, DMin, LPC, NCC ~~~ Karen H. Lynn, MEd, CEC

Minor Intake Form

Minor Counselee Name: _____ /_____/_____
(Last) (First) (Initial) (Nickname) (Date)

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

Social Security Number: _____ - _____ - _____ Male Female Age: _____ Birth date: ____/____/____

Parent/Guardian Name: _____ SS#: _____ - _____ - _____ Birth date: ____/____/____

Phone Numbers: Home: (____) _____ Work: (____) _____ Cell: (____) _____

E-mail: _____ Marital Status: Single Married Divorced Separated Other

Employer: _____ Full Time Part Time Self Unemployed

Spouse's Name: _____ Birth date: ____/____/____

Spouse's Employer: _____ Spouse's SS#: _____ - _____ - _____

Referred By: _____ Home Church: _____ Do not attend at this time

Why have you decided to seek counseling for your child? _____

What goals do you hope to accomplish? _____

Previous Counseling

Counselor Name: _____ From Mo. ____ Yr. ____ to Mo. ____ Yr. ____ Number Sessions: _____
Counselor Name: _____ From Mo. ____ Yr. ____ to Mo. ____ Yr. ____ Number Sessions: _____
Counselor Name: _____ From Mo. ____ Yr. ____ to Mo. ____ Yr. ____ Number Sessions: _____

Current Doctors

Family Doctor: _____ Date of First Visit: _____ Date of Last Office Visit: _____
Psychiatrist: _____ Date of First Visit: _____ Date of Last Office Visit: _____
Specialist: _____ Date of First Visit: _____ Date of Last Office Visit: _____
Specialist: _____ Date of First Visit: _____ Date of Last Office Visit: _____

Current Medications

Name: _____ Treatment for: _____ Dosage: _____ per _____ Date Began: _____
Name: _____ Treatment for: _____ Dosage: _____ per _____ Date Began: _____
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Background History

(Please share any information you consider important)

Describe any major physical or emotional problems: _____

Traumatic life events: _____

Personal alcohol and/or illicit drug use? _____

Physical, emotional, and/or sexual abuse during developmental years? _____

Share your religious upbringing and current religious status: _____

Describe your current family status and support network? _____

Briefly share your employment history including any military service: _____

Are you experiencing any of the following physical symptoms?

(A - Always B - Often C - Sometimes)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Violent behaviors | <input type="checkbox"/> Sleeping too much | <input type="checkbox"/> Recurrent thoughts or worries |
| <input type="checkbox"/> Restlessness | <input type="checkbox"/> Guilty conscience | <input type="checkbox"/> Outbursts of anger | <input type="checkbox"/> Feeling compelled to do things |
| <input type="checkbox"/> Overeating | <input type="checkbox"/> Seizures or convulsions | <input type="checkbox"/> Inability to sleep | <input type="checkbox"/> Trouble getting along with others |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Anxiety or nervousness | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Avoiding people/social situations |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Feelings of unreality | <input type="checkbox"/> Financial difficulties | <input type="checkbox"/> Neglected hygiene/appearance |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Heart irregularities | <input type="checkbox"/> Difficulty making choices | <input type="checkbox"/> Weight loss by vomiting/laxatives |
| <input type="checkbox"/> Upset bowels | <input type="checkbox"/> Feelings of sadness | <input type="checkbox"/> Uncontrolled crying spells | <input type="checkbox"/> Loss of interest in usual activities |
| <input type="checkbox"/> Heart Racing | <input type="checkbox"/> Addicted to pornography | <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Difficulty thinking/distractions |
| <input type="checkbox"/> Lack of energy | <input type="checkbox"/> Feelings of worthlessness | <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Preoccupation w/ bodily functions |
| <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Suicidal thoughts/attempts | <input type="checkbox"/> Involuntary body trembling | <input type="checkbox"/> Difficulties at work or school |
| <input type="checkbox"/> Stomach troubles | <input type="checkbox"/> Always "on guard" | <input type="checkbox"/> Loss or decrease of sex drive | <input type="checkbox"/> Constant focus religious thoughts |
| <input type="checkbox"/> Indecisiveness | <input type="checkbox"/> Excessive guilt or shame | <input type="checkbox"/> Tingling or numbness | <input type="checkbox"/> Moodiness, changeable moods |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Unusual sexual behavior | <input type="checkbox"/> Excessive sweating | <input type="checkbox"/> Feeling as if reliving past trauma |
| <input type="checkbox"/> Self mutilation | <input type="checkbox"/> Feelings of sadness | <input type="checkbox"/> Sensitivity to criticism | <input type="checkbox"/> Excessive fear of persons, places |
| <input type="checkbox"/> Poor memory | <input type="checkbox"/> Headaches | <input type="checkbox"/> Fear of "going insane" | <input type="checkbox"/> Feelings of doom or death |
| <input type="checkbox"/> Chest pains | <input type="checkbox"/> Periods of "going blank" | <input type="checkbox"/> Fear of being alone | <input type="checkbox"/> Recurring distressing dreams |

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Payment/Cancellation Policies

It is required that payments or co-payments for appointments be paid at the time of service. If your insurance will cover the services, you must satisfy any deductible before payments can be reduced to your co-payment. For your convenience, we accept Visa, MasterCard, Discover and American Express. Any alternative arrangements must be discussed with the counselor.

The cancellation of your appointment less than 24 hours prior to the scheduled time or failure to keep your will result in being charged a NO SHOW fee of \$60.

Preferred Method of Payment: _____ Cash _____ Check _____ Credit Card

Signature: _____

Date: ____/____/____

Please complete the below Credit Card Authorization ONLY if you intend to pay by credit or debit card on a continuing basis.

Credit Card Authorization

I authorize this clinic to keep my signature on file and to charge my listed credit card for the:
(Initial and fill in necessary information)

_____ Deductibles and co-payment for each appointment visit.

_____ Balance of charges not paid by insurance within 90 days and not to exceed \$_____.

I understand this form is valid for one year unless I cancel the authorization through written notice to this provider.

Patient's Name: _____ Cardholder Name: _____

Billing Address: _____
(Street) (City) (State) (Zip)

_____ - _____ - _____ - _____ / _____
(Account Number) (Expiration Date) (Security Code)

Cardholder Signature: _____ Date: ____/____/____

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Insurance Information

Do you have insurance that you want billed for this service? ___ Yes ___ No

Present your insurance card for photo copy or fill information below.

Primary Insurance Company: _____ Phone: (____) ____-_____

Insured's Name: _____ Social Security Number _____-____-_____

Birth date of Insured: ____/____/____ Relationship: Self Spouse Parent Other

Insurance ID Number: _____ Group Number: _____ Plan: _____

Assignment of Insurance Benefits

I hereby authorize and request my insurance to pay directly to the clinic the amount due on my claim for services rendered to me and/or my dependents. I further agree that should the amount be insufficient to cover the entire medical expense, I will be responsible for payment of the difference; and if the nature of the disability be such that it is not covered by the policy, I will be responsible for payment of the entire bill.

I also authorize the release of any medical information that may be requested by my insurance company in order to assist in processing any claim for payment.

Signature: _____

Date: _____

(Patient/Insured)

Please read and initial the following statements indicating you understand them:

_____ I have sought counseling on my own initiative and am under no obligation to accept the counsel that I receive.

_____ I am aware that counseling sessions will address emotional issues and therefore, I may experience increase of emotional pain.

_____ I understand that counsel I receive will include **discussion and/or teaching of principles from the Christian Bible.**

_____ I assume complete responsibility for my health and well-being.

_____ I understand that my counselor assumes no responsibility for me or my emotional condition.

_____ I understand my responsibility in the payment process.

Signed: _____
(Patient)

(Parent/Guardian/Insured)

_____/_____/_____
(Date)

FAMILY CHRISTIAN COUNSELING CENTER, INC. P.O. BOX 3475 CLEVELAND, TN 37320 | 9950 CYPRESSWOOD, SUITE 260, HOUSTON, TX 77070 | FAX: 832.369.7679 | EMAIL: OFFICE@MYFCCC.COM TENNESSEE - PH. 423.599.9347 | TEXAS - PH. 281.890.6234

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. AFTER YOU HAVE READ THIS NOTICE WE WILL ASK YOU TO SIGN A CONSENT TO LET US USE AND SHARE YOUR INFORMATION IN THESE WAYS. IF YOU DO NOT CONSENT AND SIGN THIS FORM, WE CANNOT TREAT YOU.

Our commitment to your privacy

Our practice is dedicated to maintaining the confidentiality and security of your personal health information as part of providing professional care. We are also required by law to keep your information private. HIPAA is the federal Health Insurance Portability and Accountability Act of 1996. The primary goal of the law is to make it easier for people to keep health insurance, protect the confidentiality and security of protected health information and help the healthcare industry control administrative costs.

Patients protected health information

HIPAA protects an individual's health information and his/her demographic information. This is called "protected health information" or "PHI". Information meets the definition of PHI if, even without the patient's name, if you look at certain information and you can tell who the person is then it is PHI. The PHI can relate to past, present, or future physical or mental health of the individual. PHI describes a disease, diagnosis, procedure, prognosis, or condition of the individual and can exist in any medium- files, voice mails, email, fax, or verbal communications. HIPAA defines information as protected health information if it contains the following information about the patients, the patient's household members, or the patient's employers:

- Names
- Dates relating to a patient, i.e. birthdates, dates of medical treatment, admission and discharge dates, and dates of death.
- Telephone numbers, addresses (including city, county, or zip code) fax numbers and other contact information
- Social Security numbers
- Medical record numbers
- Photographs
- Finger and voice prints
- Any other unique identifying number

How we use and disclose your protected health information with your consent

We will use the information we collect about you mainly to provide you with treatment, to arrange payment for our services, and for some other business activities that are called, in the law, health care operations. If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask to you to sign an authorization for to allow this.

How we use and disclose your protected health information without your consent

There are some times when the law requires us to use or share your information. For example:

- 1. Duty to Warn and Protect:** When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client. They will only share information with persons who are able to help prevent or reduce the threat.
- 2. Abuse of Children and Vulnerable Adults:** If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.
- 3. Prenatal Exposure to Controlled Substances:** Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.
- 4. Minors/Guardianship:** Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records

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5. Insurance Providers (when applicable): Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes types of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries. This includes workers' compensation and similar benefit programs.

6. Judicial or Statutory Decree: The mental health professional is required to disclose specific information when mandated in legal or court proceedings.

Patients' rights

A health provider can disclose an individual's PHI without the patient's authorization if the disclosure deals with treatment, payment, operations, or if the information is mandated by law. Otherwise, for most other uses, the patient will need to authorize the provider to make the disclosure. HIPAA stipulates the following patient's rights under its privacy rule:

- Patients have a right to receive a notice of the privacy practices of any health care provider, health clearing house, or health plan.
- Patients have a right to see their PHI and get a copy.
- Patients have a right to request that changes be made to correct errors in their records or to add information that has been omitted. These requests must be in writing and include reasons for the changes.
- Patients have a right to see a list of some of the disclosures that have been made of their PHI.
- Patients have a right to request that special treatment is given to their PHI.
- Patients have a right to request confidential communications and treatment records. Specifically,
 - o Upon release from a client or the clients authorized representative, the therapist or the therapist's representatives shall provide a complete copy of the client's records or summary of such records which were maintained by the provider;
 - o It shall be the .provider' s option as to whether copies of the records or a summary will be given to the client;
 - o Requests for records shall be honored by the provider in a timely manner; and
 - o The individual requesting the records shall be responsible for payment of a reasonable fee to the provider for copying and mailing of the records.
- Patients have a right to complain.
- Patients have a right to request us to communicate with them in a particular way or at a certain place that is more private for them. For example, a patient can ask us to call them at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.
- Patients have a right to request that the health provider limit what information shared people involved in care or the payment for care, such as family members and friends.
- Patients have the right to file a complaint if they believe their privacy rights have been violated. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way. We will be happy to discuss these situations with you now or as they arise. If you have any questions regarding this notice or our health information privacy policies, please call the office.
 - o Complaints can be made in writing to our corporate privacy officer:

Privacy Officer
P.O. Box 3475
Cleveland, TN 37320

- o Complaints can be made with the Sec. of U.S. Department of Health & Human Services in writing:

U.S. Department of Health & Human Services
61 Forsyth Street, SW, Suite 3870
Atlanta, GA 30323
Or telephonically:
(404)562-7886; (404)331-2867 (TDD)
Or via facsimile:

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LIMITS OF CONFIDENTIALITY AND HIPAA

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

- 1. Duty to Warn and Protect:** When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.
- 2. Abuse of Children and Vulnerable Adults:** If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.
- 3. Prenatal Exposure to Controlled Substances:** Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.
- 4. Minors/Guardianship:** Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records
- 5. Insurance Providers (when applicable):** Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes types of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries. This includes workers' compensation and similar benefit programs.

I agree to the above limits of confidentiality and understand their meanings and ramifications. I have also been given a copy my HIPAA rights and agree to these terms.

Client Name (Print Name)

Date

Client Signature (*Client's Parent/Guardian if under 18*)

Date

Signature of Witness

Date