Day Shepherd, LPC

CLIENT INFORMATION SHEET

Date: _____

CLIENT NAME: _____ M / F Date of Birth: _____

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

Marital Status: M S D W Soc. Sec. #: _____ Home Phone: _____

E-mail Address: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Emergency Contact:_____ Cell Phone: _____
Name Relationship

Home or Work Phone: _____

POLICY HOLDER INFORMATION (If you are not the policy holder)

Name: _____ Soc. Sec. #: _____ D.O.B. _____

Relationship to client: _____ Home Phone: _____

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

E-mail Address: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

RESPONSIBLE PARTY INFORMATION (Guardian, Custodial Parent)

Name: _____ Soc. Sec. #: _____ D.O.B.: _____

Relationship to client: _____ Home Phone: _____

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

E-mail Address: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

~~~~~~~~~~~~~~~~~~~~ INSURANCE INFORMATION - FOR OFFICE USE ONLY ~~~~~~~~~~~~~~~~~~

Company: _____ Certificate #: _____ Group #: _____

Authorization #: _____ # Visits: ____ CPT: _____ Expires: _____

Authorization #: _____ # Visits: ____ CPT: _____ Expires: _____

Copayment amount: _____ Deductible: _____ Deductible met? Yes No N/A

Axis I _____ Axis I _____ Axis II _____

Day Shepherd, LPC

4044 Central
Kansas City, Missouri 64111
Ph: 816-213-1551
Fax:

If the information on this form cannot be provided at the Intake Appointment, Please obtain by the end of today.
Your insurance company will NOT backdate authorizations for service.
Please fax to the number circled below.

TODAY'S DATE _____

STAFF LAST NAME _____

PATIENT NAME _____

PATIENT DOB _____

AUTHORIZATION PHONE # _____
(On Ins. Card)

PREAUTHORIZATION NUMBER _____**

AUTH. BEGIN DATE _____ END DATE _____

NUMBER/APPTS/YR _____

EFFECTIVE DATE OF COVERAGE _____

DEDUCTABLE AMOUNT : Individual Total _____ Paid to Date _____

Family Total _____ Paid to Date _____

COPAY AMOUNT ($$.$$) _____
and/or
COINSURANCE (%) _____

CLAIMS MAILING ADDRESS (for MENTAL HEALTH vs. medical claims)

Company Name _____

Street Address _____

P. O. Box _____

City/State/Zip _____

FAX TO:

**Clients please note: To avoid unnecessary costs, please be sure to obtain preauthorization for services, as you are responsible for all fees not covered by insurance.

For Office Use: Date Received: _____ Staff Initials: _____

CLIENT REPORT OF PROBLEM

Name:_____ Today's Date:_____

Client/parent statement of problem:

Briefly describe your reason(s) for seeking help:

How long have you had the problem(s)?

Why did you decide to seek help now?

What other ways have you tried to deal with this problem?

History of treatment for emotional problems and family history:

Outpatient counseling (Therapist name, dates, did it help):

Inpatient treatment (Where, when, and for how long):

Family history of emotional problems (Who and their relationship to you):

Check any of the following items that apply:

____ Thoughts of suicide or death

____ Nervousness/anxiety

____ Thoughts of harming others

For Children:

____ History of attempts to kill yourself your temper

____ Cutting or otherwise hurting yourself

____ Depressed mood

____ Feelings of hopelessness

____ Large weight gain or loss

____ Trouble getting to sleep

____ Waking during the night

____ Waking early every day

____ Inability to make decisions

____ Excessive guilt

____ Frequent crying

____ Loss of energy

____ Feeling worthless don't

____ Mood swings thoughts

____ Trouble concentrating

____ Phobias

____ Panic attacks

____ Irritability

____ Feeling overwhelmed

____ Loss of appetite

____ Tingling or numbness

____ Forgetfulness

____ Excessive worrying

____ Feeling tense

____ Reliving traumatic events

____ Intrusive distressing thoughts you can't control

____ Seeing things others

____ Complains of aches and pains

____ Trouble controlling

____ Violence toward others

____ Hearing voices

____ Feeling empty

____ Memory problems

____ Financial problems

____ Problems at work

____ Legal problems

____ Health problems

____ Family problems

____ History of sexual abuse

____ History of physical abuse

____ Aggressive

____ Problems with drugs or Alcohol

____ Problems with attention

____ Problems at school

____ Hyperactivity

____ Behavior problems

____ Impulsiveness

____ Excessive fears

____ Problems with peers

____ Sad/unhappy

____ Oppositional or defiant

____ Anxious - Worried

____ Withdrawn

____ Irritable

____ Racing

Health status

List any medical problems or physical problems and when they were diagnosed:

1.
2.
3.

List any major (where you were put to sleep) surgeries you have had and date:

1.
2.
3.

List any serious illness or injuries especially anything involving the head:

1.
2.
3.

List any allergies to foods or drugs:

Date of last physical examination:_____ Date of last physician visit:_____

List all of the prescription and over-the-counter drugs you are taking

List all vitamin AND herbal supplements you take. Please list amounts of each.

Drug and alcohol information: Check substances that you use in any amount at all:

How much do you use per

	Age first used	Weekday	Weekend	Month	Last used
❑Beer	_____	_____	_____	_____	_____
❑Liquor	_____	_____	_____	_____	_____
❑Wine	_____	_____	_____	_____	_____
❑Marijuana	_____	_____	_____	_____	_____
❑Cocaine/Crack	_____	_____	_____	_____	_____
❑Methamphetamine	_____	_____	_____	_____	_____
❑Heroin	_____	_____	_____	_____	_____
❑Barbiturates (Downers)	_____	_____	_____	_____	_____
❑PCP, LSD (Hallucinogens)	_____	_____	_____	_____	_____
❑Tobacco in any form	_____	_____	_____	_____	_____
❑Other _____	_____	_____	_____	_____	_____

To be completed by adults (18 yr.s and older)

Have you ever felt like you should cut down on your drug or alcohol use?
❑ Yes ❑ No

Has a friend or relative expressed concerns about your use?
❑ Yes ❑ No

Have you ever felt guilty about your drinking or drug use?
❑ Yes ❑ No

Have you ever had to take a drink or use a drug the next day to steady your nerves?
❑ Yes ❑ No

Are you a recovering alcoholic or a recovering drug addict?
❑ Yes ❑ No

Is there a history of problems with drug or alcohol use in your family?
❑ Yes ❑ No

To be completed by adolescents (12 yr.s to 17 yr.s)

Have you ever used alcohol or drugs before or during school?
❑ Yes ❑ No

Have you ever missed school (or been truant) because of use or just to use?
❑ Yes ❑ No

Have you ever avoided non-users?
❑ Yes ❑ No

How often do you get drunk/high?

About how often do you use more than one drug when you get high?

Is there a history of problems with drug or alcohol use in your family?
❑ Yes ❑ No

CLIENT TREATMENT AGREEMENT AND CONSENT TO TREAT

Please read this document which contains important information about our professional services and business policies. A Notice of Privacy Practices for use and disclosure of Protected Health Information (PHI) is also posted in the reception area.

The law requires that I obtain your signature acknowledging that I have provided you with this information and that you have agreed to its terms. When you sign this document, it will represent a contract between us. You may revoke this contract in writing at any time. That revocation will be binding on me unless I have already taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or monies owed in connection with treatment.

I am a provider who works independently in an office that I sublet. The other individuals in the office are not associated with my practice and do not have access to your private medical records. On occasion we may refer to each other but each practioner is responsible solely for their own practice.

Payment of Services

Payment is required at the time of each visit and I accept cash and checks as forms of payment. There will be up to a $25.00 charge for any returned check. You will be responsible for the fees that are charged in connection with your treatment. Our fee is $150.00 per hour or our contracted rate with your insurance provider. I will submit claims directly to insurance companies, their mediators and Employee Assistance Programs (EAP), for which I am a contracted provider.

I cannot guarantee payment by your insurance company. If your claim is not paid it will be your responsibility. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon in advance, I have the option of using legal means to secure the payment. This may involve employing the services of a lawyer or agency for collection purposes. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of the services and the amount due or other PHI allowed by HIPAA (Health Insurance Portability and Accountability Act).

Insurance companies may require access to your PHI. By signing this form, you will be authorizing me to release information about you that is required by your insurance company or EAP for payment of services.

Fees for other services not included in your insurance/EAP

Your insurance company or EAP does not typically reimburse me for activities that are not a part of direct individual, family or group counseling. The following is a list of activities where an additional fee (time spent based on $150/hour) is required to be paid in advance.

1. Copying your clinical record. (rate based on the prevailing community standard)
2. Completion of any disability or other form at your request. (time spent based on $150/hour)
3. Preparation of a letter or report at your request. (time spent based on $150/hour)
4. Time spent away from the office to testify in court. (time spent based on $150/hour)
5. Consultation with other entities, including but not limited to attorney, school, disability insurers, workmen's compensation. (time spent based on $150/hour)
6. There will be a $10 service charge if I have to send you a bill for services rendered.

Professional Records

The laws and standards of my profession required that I keep Protected Health Information (PHI) about you in your clinical record. Your records will be maintained properly and consistent with HIPAA regulations, state law and the requirements of your insurance plan.

Confidentiality
The law protects the privacy of all communications between client and counselor, psychologist, social worker or psychiatrist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. Your signature on this agreement provides consent for release of information consistent with HIPAA and state law. A summary of the circumstances in which I may disclose PHI without your consent follows on page 2 of this document.

HIPAA (Health Insurance Portability and Accountability Act) Confidentiality
Confidential treatment of your clinical record. The following are cases where your information may be disclosed without your consent.

1. If there is a situation that is potentially life threatening.
2. When child abuse is known or suspected. (Reporting required by state law)
3. When the abuse of an elderly or dependent person is known or suspected. (Reporting required by state law)
4. I you commit a crime against a staff member or another person on the premises.
5. If you bring charges against, or sue, your clinician.
6. When ordered by the court.
7. In some cases, details of your treatment may be discussed with another clinician for the purpose of consultation. When this is done, no identifying information will be included (ie, the client is anonymous).
8. In some cases your records may be audited by the quality improvement activity of your insurance company or EAP. When this is done, no identifying information is included (ie, the client is anonymous).
9. If it becomes necessary to refer your account to a collection service. Only information necessary to pursue collection will be released.

Minors and Parents

Clients under 18 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's treatment records. Parents will need to sign a permission to treat form for services provided to a minor. In divorce families, clients under 18 need the consent of the custodial parent(s). A copy of the divorce decree may be requested prior to initiating evaluation and treatment.
I verify that I do have legal custody of this child _____ (initials)

Information Regarding Psychotherapy

1. Psychotherapy may involve remembering unpleasant events and can arouse intense emotions.
2. Psychotherapy is not always effective and may, in some cases, result in deterioration rather than improvement of a clients psychological functioning.
3. There are numerous forms of psychotherapy which vary not only in underlying theory and methods employed but also in terms of time commitment and cost. We will attempt to provide treatment plans that are realistic in both areas. In addition, we will discuss other possible treatment interventions.
4. Unless it is part of your treatment plan, your treatment will be terminated if you have not contacted your therapist in more than 60 days.

Appointments, Scheduling and Cancellation of Appointments

Individual appointments for counseling and psychotherapy services are typically scheduled for no more than 45 – 50 minutes. Scheduling and cancellation of appointments is done through your therapist directly. If you find it necessary to cancel a scheduled appointment, we require advance notice of at least 24 hours. You will be charged $75.00 for the missed appointment if it is not cancelled at least 24 hours prior to the scheduled appointment time. Please schedule or cancel your appointments with me directly by calling my voicemail at 816-213-1551. Your calls to me are recorded with a time and date stamp.

Our clients have the right to:

1. Be treated by a licensed mental health professional and with respect for their individual needs, preferences, feelings and requirements;
2. Confidential treatment of their treatment records. Information from those records will not be released without their prior written consent, except in an emergency, as required by law or as noted (page 2);
3. Have an individualized treatment plan and participate with their therapist in treatment planning decisions;
4. Be given the information necessary to give informed consent prior to the start of any treatment or procedure;
5. Refuse treatment and to be informed of the consequences of refusal;
6. Continuity of care. Should transfer or discharge become necessary, clients will be given the reasons and plan, as well as reasonable advance notice;
7. Participate in the formulation of a discharge plan when the termination of treatment is therapeutically indicated;
8. View their treatment and financial records.

Our clients have the responsibility to:

1. Provide to the extent possible, information that their therapist needs to provide appropriate care;
2. Participate in the development of treatment plan goals;
3. Communicate openly and honestly with their therapist;
4. Ask questions so that they understand the care and instructions given;
5. Actively participate in his or her own treatment and to carry out therapeutic homework assignments;
6. Take medications prescribed as part of their treatment plan and as instructed;
7. Keep their appointments or call at least 24 hours in advance, if possible, to cancel visits;
8. Inform their therapist of any changes in insurance coverage;
9. Pay their co-payments, deductibles, other fees and/or bills for services rendered in a timely manner.

Client Consent to exchange Information with my Primary Care Physician / Psychiatrist

HIPAA policy allows collaboration between health care providers regarding your care. A space for this information is provided. You have the right to withhold this information. By my initials below I either authorize or withhold exchange of information with my/my child's primary care physician/psychiatrist. I place no limits on dates, history of illness, diagnostic and therapeutic information, including treatment for alcohol and/or drug abuse.

Authorize___ Withhold___ Physician Name	Address	Phone #	Fax#	
Authorize___ Withhold___ Psychiatrist Name	Address	Phone #	Fax #	

If any of these policies or procedures cause problems or seem confusing, please speak with me, so that I may clarify them for you. I make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. By signing this Agreement, you agree that I can provide the necessary information to your insurance carrier, employee assistance program and other designated third party payors such as Medicare or Medicaid, to process claims and for quality assurance activities.

AGREEMENT

By signing this 4 (four)-page agreement below I am acknowledging that I have reviewed:

1) Client Agreement and Consent to Treat Policies

2) Practices to Protect the Privacy of Your Health Information displayed in the office and you may obtain a copy for yourself on request

3) Notice of Client Rights and Responsibilities (page 3) .

I have read these policy statements and having been informed to my satisfaction, I give consent to treatment and/or evaluation by _____ and Day Shepherd, LPC. I understand that by signing this agreement I am acknowledging that I understand the content on this form and agree to comply with all aspects of it.

_____ _____

Signature of client/parent/guardian Date **Print Client Name**

_____ _____

Relationship of above to client **Witness Date**

My Private Practice Social Media Policy

This document outlines my office policies related to use of Social Media. Please read it to understand how I conduct myself on the Internet as a mental health professional and how you can expect me to respond to various interactions that may occur between us on the Internet. If you have any questions about anything within this document, I encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may be times when I need to update this policy. If I do so, I will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

FRIENDING
I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

INTERACTING
Please do not use messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact me. These sites are not secure and I may not read these messages in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with me in public online if we have an already established client/therapist relationship. Engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. Text messaging for appointment times is allowed but as standards by the American Counseling Association change, may also be revised.

Email Security
Due to recent developments with the Health Insurance Portability and Accountability Act (HIPAA) and the Affordable Care Act, many aspects of health information are required to be protected by providers. Emails are unsecured unless certain precautions are provided by your email and my email provider. Therefore anytime you send anyone including clinicians information via email, it is not secure. Sites such as Hushmail offer secure email but this requires both clinician and client to sign up for an account. When you send me an email, you risk the release of private health information and confidentiality breaches. Please do not send me clinical information via email.

If you need to contact me between sessions, the best way to do so is by phone. Direct email for quick, administrative issues such as changing appointment times still indirectly could indicate that you are a client.

USE OF SEARCH ENGINES

It is NOT a regular part of my practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions *may* be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone, or email) there *might* be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if I ever resort to such means, I will fully document it and discuss it with you when we next meet.

GOOGLE READER

I do not follow current or former clients on Google Reader and I do not use Google Reader to share articles. If there are things you want to share with me that you feel are relevant to your treatment whether they are news items or things you have created, I encourage you to bring these items of interest into our sessions.

BUSINESS REVIEW SITES

You may find my psychology practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client.

Of course, you have a right to express yourself on any site you wish. But due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. I urge you to take your own privacy as seriously as I take my commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with me about your feelings about our work, there is a good possibility that I may never see it. If we are working

together, I hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. None of this is meant to keep you from sharing that you are in therapy with me wherever and with whomever you like. Confidentiality means that I cannot tell people that you are my client and my Ethics Code prohibits me from requesting testimonials. But you are more than welcome to tell anyone you wish that I'm your therapist or how you feel about the treatment I provided to you, in any forum of your choosing. If you do choose to write something on a business review site, I hope you will keep in mind that you may be sharing personally revealing information in a public forum. I urge you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection. If you feel I have done something harmful or unethical and you do not feel comfortable
discussing it with me, you can always contact the Board for Professional Counselors, which oversees licensing, and they will review the services I have provided.

Missouri Board for Professional Counselors
3605 Missouri Boulevard
P.O. Box 1335
Jefferson City, MO 65102-1335
Telephone: (573) 751-0018

LOCATION-BASED SERVICES

If you used location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. I do not place my practice as a check-in location on various sites such as Foursquare, Gowalla, Loopt, etc. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client based on your location.

CONCLUSION
Thank you for taking the time to review my Social Media Policy. If you have questions or
concerns about any of these policies and procedures or regarding our potential interactions on the Internet, do bring them to my attention so that we can discuss them.

By signing below I understand that I have read and accept the D&M Shepherd – Day Shepherd, LPC Social Policy

_____ _____
Signature of Client Date

Thank you to Dr. Kolmes for creating the Social Media Policy in its original form. I have adapted it to fit my practice.

PLEASE COMPLETE FOR CHILDREN AND ADOLESCENTS

Did mother use drugs, smoke or consume alcohol during pregnancy: _____

Problems during pregnancy or delivery: _____

Birth defects? (If yes, specify): _____

Ages at which child: Sat up _____ Crawled _____ Stood alone _____ Walked _____ First words _____

Age at which potty trained _____ Length of time to train _____ Once potty trained did your child ever revert

to soiling or wetting themselves? ❑ Yes ❑ No If yes, describe how and when: _____

_____

Current soiling or bedwetting? ❑ Yes ❑ No If yes, how long: _____

Cruelty toward animals ❑ Yes ❑ No Fire setting ❑ Yes ❑ No Stealing ❑ Yes ❑ No

List any history of seizures, prolonged high fevers, head injuries, poisoning, serious illness or injury:

_____

List any prolonged separations from mother or traumatic events in childhood: _____

_____

School: _____ Grade _____ Academic performance/grades: _____

_____

Problems / special services from school: _____

_____

Does your child show an unusual interest in sex for their age? ❑ Yes ❑ No
Are you concerned about sexual behavior on your child's part? ❑ Yes ❑ No
Do you have any reason to suspect that your child has been physically or sexually abused? ❑ Yes ❑ No

How would you rate your child's social adjustment (e.g., Poor, Fair, Good, Excellent):

_____

~~~ If the child is 12 years or older, please complete the following additional information~~~

Is your child sexually active? Yes ❑ No ❑ Do not know ❑
If yes, do they know about safe sex? Yes ❑ No ❑ Do not know ❑

Does your child smoke or use tobacco in any form? Yes ❑ No ❑ Do not know ❑
If yes, how much: _____ Cigarettes _____ Snuff _____ Chewing tobacco

Do you suspect that your child is abusing drugs or alcohol? Yes ❑ No ❑ Do not know ❑