



Helping People Return to Joy

Counselor: _____
Date: _____
www.lifetouchmin.org

GENERAL INFORMATION

Full Name: [Mr.] [Mrs.] [Ms.] [Miss] [Dr.] [Rev] _____
Age: _____ Date of Birth: _____ Sex: [Male] [Female]
Referred by: _____

CONTACT INFORMATION

Street Address: _____ Suite or Apt. #: _____
City: _____ State: _____ Zip Code: _____ May we send mail here: [Yes] [No]
Mailing Address or Post Office Box: _____
Home Phone: (_____) _____ May we leave a message here: [Yes] [No]
Mobile Phone: (_____) _____ May we leave a message here: [Yes] [No]
Work Phone: (_____) _____ May we leave a message here: [Yes] [No]
Email Address: _____ May we send a message here: [Yes] [No]

EMERGENCY CONTACT

Name: _____ Relationship: _____
Home Phone: (_____) _____ Mobile Phone: (_____) _____

EMPLOYMENT INFORMATION

Employer: _____ Length of Employment: _____
Occupation: _____ Average hours worked per week: _____
Annual Salary: [] \$0 to \$10,000 [] \$10,001 to \$20,000 [] \$20,001 to \$40,000
[] \$40,001 to \$50,000 [] \$50,001 to \$60,000 [] \$60,001 to \$80,000
[] \$80,001 to \$100,000 [] More than \$100,000

EDUCATION INFORMATION

Last Year of School Completed: [] 9 [] 10 [] 11 [] 12 [] GED College: [] 1 [] 2 [] 3 [] 4 [] Other: _____
Are you currently in school: [Yes] [No] Degree Pursuing: _____

RELATIONAL INFORMATION

Current marital status: Single Engaged Married Separated Divorced Widowed

Are you content with your current status: Yes No If no, briefly explain: _____

If married, how long: _____ Number of previous marriages for you: _____

If separated or divorced, how long: _____ If widowed, how long: _____

With whom do you currently live (*Check all that apply*): Alone Spouse Children

Parent(s) Sibling(s) Boyfriend Girlfriend Other: _____

PARTNER INFORMATION

Full Name: Mr. Mrs. Ms. Miss Dr. Rev. _____

How long have you known your partner: _____ Age: _____

Sex: Male Female Occupation: _____

Average hours worked per week: _____

What words would you use to describe this person: _____

CHILDREN

List your children (living or deceased) as well as children you have placed for adoption

Name	Sex	Current Age or Year of Death	Relationship to You (e.g. Natural, Step, Adopted)	Living with You?	Describe Him/Her

FAMILY OF ORIGIN

List Mother, Father, Brothers, Sisters, Step Family, and Any Other Family Members who Affected you Positively or Negatively

Name	Sex	Current Age or Year of Death	Relationship to You (e.g. Mom, Dad, Sibling, Step)	Occupation	Describe Him/Her

MEDICAL INFORMATION

Primary Physician: _____ Phone: (____) _____

Address: _____ City: _____ Zip: _____

Are you currently receiving medical treatment: Yes No If yes, please specify: _____

List any conditions, illnesses, hospitalizations, or traumas you've had (use back if necessary):

Have you ever had a miscarriage? Yes No

Have you ever had a medical abortion? Yes No

MEDICATION INFORMATION

List all current medications you are taking, including those you seldom use or take only as needed

Medication	Dosage	Improves, Prevents or Controls	Treating

Are you taking these medications(s) according to your doctor's recommendations: Yes No

If no, briefly explain: _____

PHYSIOLOGICAL SYMPTOMS

Please check any of the following physiological symptoms/sensations that apply to you presently or in the recent past:

- Headache Past Present Dizziness Past Present Stomach Trouble Past Present
- Sleep Trouble Past Present Visual Trouble Past Present Trouble Relaxing Past Present
- Tension Past Present Weakness Past Present Rapid Heart Rate Past Present
- Intestinal Trouble Past Present Difficulty Breathing Past Present Hearing Noises Past Present
- Tiredness Past Present Change in Appetite Past Present Pain Past Present
- Seeing Things Past Present Hearing Voices Past Present Other Past Present

Has your weight changed in the last 2-3 months? Yes No

RELIGIOUS BACKGROUND

Briefly describe the religious environment of your home as you were growing up: _____

Do you regularly attend a place of worship: Yes No If yes, where: _____

What is your level of involvement? _____

What denomination are you connected with, if any? _____

CURRENT STATUS

Please check any of the following problems that apply to you and/or your family:

- Panic..... You Family Anxiety..... You Family Guilt..... You Family
- Unhappiness..... You Family Depression/Sadness..... You Family Recent Death..... You Family
- Grief..... You Family Terminal Illness..... You Family Inferiority Feelings..... You Family
- Fears..... You Family Hopelessness..... You Family Loneliness..... You Family
- Friends..... You Family Marriage..... You Family Communication You Family
- Physical Abuse..... You Family Emotional Abuse..... You Family Verbal Abuse..... You Family
- Sexual Abuse..... You Family Temper..... You Family Anger..... You Family
- Aggressiveness..... You Family Nightmares..... You Family Concentration..... You Family
- Unwanted Thoughts..... You Family Violence..... You Family Impulsive Behavior..... You Family
- Memory..... You Family Loss of Control..... You Family Sexual Problem..... You Family
- Self-Control..... You Family Legal Matters..... You Family Pregnancy..... You Family
- Abortion..... You Family Drug Use..... You Family Trauma..... You Family
- Eating Problems..... You Family Appetite Change..... You Family Substance Use..... You Family
- Trouble with Job..... You Family Disturbing Memories.. You Family Physical Pain..... You Family
- Military Service..... You Family Sleep Disturbances..... You Family Weight Change..... You Family
- Paranoia..... You Family Flashbacks..... You Family Making Decisions..... You Family
- Recent Loss..... You Family Social Skill Struggles..... You Family Finances..... You Family
- Euphoria..... You Family Increased/Decreased Energy.. You Family
- Other..... You Family

What words would you use to describe yourself: _____

If God were to describe you, what would He say: _____

Do you have a personal support system: Yes No If yes, who: _____

LEVEL OF DISTRESS

Indicate how distressed you are by Placing an "X" on the scale below (1= Very Little Distress; 10=Extreme Distress)

1 2 3 4 5 6 7 8 9 10

Are you currently experiencing any suicidal thoughts: Yes No

If yes, what are the thoughts you are experiencing? _____

Have you experienced them in the past: Yes No

Have you ever attempted suicide: Yes No If Yes, when & how: _____

When was the last thought of suicide? _____ Self-harm? _____

Plan? _____ Intent? _____ Means? _____

Have any of your friends or family ever committed or attempted suicide: Yes No

If yes, when and who: _____

If you are struggling with these thoughts, do you have a trusted person you can rely on? _____

Have You Ever Been Homicidal? Yes No If Yes, When & How: _____

PRESENTING ISSUES AND GOALS

Please describe why you are coming to counseling at this time (i.e. what are your issues, problems?):

What do you hope to gain or change by coming for counseling: _____

How long do you believe counseling should last: _____

PREVIOUS COUNSELING

List any previous counseling, psychiatric treatment, or residential/in-patient care you have received (use back if necessary)

Therapist: _____ Location: _____ Dates: _____ Reason: _____

Therapist: _____ Location: _____ Dates: _____ Reason: _____

Therapist: _____ Location: _____ Dates: _____ Reason: _____



TERMS OF SERVICE

I understand that payment for professional services is due when rendered. I accept full responsibility for payment of any balance incurred for services.

Signed: _____ Date: _____

SESSIONS AND CANCELLATIONS: If you miss an appointment without cancelling or if you cancel less than 6 hours in advance, you will be billed for that session. Your cancellation fee will be determined by your sliding scale fee. In case of emergencies (i.e. unexpected weather, illness), you will not be charged.

Client Signature _____

Signature of LTMCC Staff Member _____

Date _____



Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this document carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations.

·*Treatment* means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc.

·*Payment* means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services.

·*Health Care Operations* include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information; to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

·The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

·The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.

·The right to request an amendment to your PROTECTED HEALTH INFORMATION.

·The right to receive an accounting of disclosures or PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.

·The right to obtain a paper copy of this notice for us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services

Office of Civil Rights

200 Independence Avenue, S.W.

Washington, D.C. 20201

877.696.6775 (toll-free)



www.lifetouchmin.org
574-269-7990
info@lifetouchmin.org

Acknowledgment of Receipt of Privacy Practice Notice

I, _____ (Full Name)
have received a copy LifeTouch Ministries & Counseling Center, a non-profit corporation notice of
privacy practices.

Name: _____

Street Address: _____ Suite / Apt. #: _____

City: _____ State: _____ ZIP Code: _____

Client
Signed: _____ Date: _____

Parent/Guardian
Signed: _____ Date: _____

Witnessed
Signed: _____ Date: _____



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Informed Consent & Release of Liability

The mission of LifeTouch Ministries & Counseling Center is to provide counseling with a distinctively Christian framework to the community of believers, and non-believers, at various churches and to the local community, as a whole.

The completion of an intake questionnaire and an informed consent and release of liability are required for counseling services to commence. Selected personality and/or vocational assessments may also be administered with your additional consent.

- 1. I understand that my counselor is a lay counselor, a mental health counselor, or a student intern...
2. I understand that my counseling records (files) are kept confidential...
3. In consideration of the benefits to be derived from the counseling...
4. I waive any right I may have otherwise had to seek to use my counseling records...

I have read and understood the preceding information and agree to the terms and conditions of LifeTouch Ministries & Counseling Center as stated herein.

Date: _____ Signed: _____

Signed: _____

Witness: _____



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Counselor:

Release of Confidential Information to Primary Care Physician

I, _____ hereby authorize LifeTouch Ministries & Counseling Center to disclose to my Primary Care Physician, _____
(Primary Care Physician Name) (Address)

all clinical information about me as may be necessary to permit my Primary Care Physician to monitor the continuity of my care and to inform my Primary Care Physician of health status.

This authorization may be revoked by me in writing at any time, with the exception of any actions already taken to coordinate my care. I understand this authorization does not extend to the release of any AIDS/HIV information unless I also place my initials here. _____

I further understand that the information authorized by this release will be released to the authorized representative only, for purposes noted above. I understand I am entitled to a copy of this authorization form for my records.

NOTE TO RECEIPIENT: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) and /or state law. In accordance with federal and state law requirements, this information received pursuant to this document is confidential and recipient is prohibited from making further re-disclosure of this information to any other person or entity, or to use it for any purpose other than as authorized herein, without the written consent of the person to whom it pertains or otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patients.



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Sliding Scale Fees

<u>Household Annual Gross Income</u>	<u>Fee per Session</u>
\$29,999 or below	\$2 / every thousand
\$30,000 - \$49,999	\$60
\$50,000 - \$79,000	\$70
\$80,000 - \$99,999	\$80
\$100,000 - \$119,999	\$90
\$120,000 or above	\$100

**Financial hardship cases will be considered with an alternative financial plan.

Payment: Payment for counseling is due at the beginning of each session. Checks should be made out to LifeTouch Ministries & Counseling Center. We also accept all major credit cards. Checks returned for non-sufficient funds are charged \$25.

I understand and agree to abide by my financial responsibilities, thus I agree to pay \$_____ per session.

Client Signature _____

Signature of LTMCC Staff Member _____

Date _____