

CLIENT DEMOGRAPHIC INFORMATION SHEET

Lifescapes Counseling Associates, PLLC

NAME: \_\_\_\_\_

CHART NO: \_\_\_\_\_  
 Intake Date: \_\_\_\_\_  
 Dx Code: \_\_\_\_\_  
 Clinician: \_\_\_\_\_

PHONE: Daytime: \_\_\_\_\_ OK to leave message: Y N  
 Evening: \_\_\_\_\_ OK to leave message: Y N  
 Other: \_\_\_\_\_ OK to leave message: Y N

ADDRESS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_  
 SS#: \_\_\_\_\_  
 SEX: M F

MARITAL STATUS:  Single  Married  Separated  Divorced  Widowed

EMPLOYMENT STATUS:  Full-Time  Part-Time  Student  Unemployed  Retired

PLACE OF WORK: \_\_\_\_\_  
 POSITION: \_\_\_\_\_

ETHNICITY: \_\_\_\_\_  
 YEARS OF EDUCATION: \_\_\_\_\_

RESPONSIBLE PARTY: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 \_\_\_\_\_

HOME PHONE: \_\_\_\_\_  
 WORK PHONE: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

**INSURANCE INFORMATION:**

Insurance Co. Name: _____	ID Number: _____
Claims Address: _____	Group Number: _____
_____	Policy Number: _____
Policy Holder Name: _____	Authoriz. No: _____
Address: _____	Employer: _____
_____	Date of Birth: _____
What is your relationship to the insured? _____	Home Phone: _____
Are you under your employer's health plan? _____	Work Phone: _____

*(If there is another health plan, please fill out another intake form and write "Secondary Insurer" on top of this form)*

CONSENT FOR TREATMENT

*I, the undersigned, have voluntarily applied for and agree to participate in counseling, psychological, and/or psychiatric services. I hereby authorize Lifescapes Counseling Associates, PLLC to release treatment and psychological information to my primary medical physician and health insurance carrier if necessary. I understand that I am fully responsible for all fees relating to my treatment which are not covered by my insurance plan, and I further agree to pay my co-payment at the time of each visit. In the event that I miss an appointment or cancel an appointment with less than 24 hours notification, I understand that I am solely responsible for paying a \$60 fee. Furthermore, if I fail to appear for three consecutive scheduled appointments, my case may be placed on inactive status.*

\_\_\_\_\_  
 Client signature

\_\_\_\_\_  
 Date

# Lifescapes Counseling Associates, PLLC

800 W. Williams Street, Suite 251  
Apex, NC 27502

## CONSENT & RELEASE FOR USE AND DISCLOSURE OF HEALTH INFORMATION

### SECTION A: Client giving Consent

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Email: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

### SECTION B: To the Client – Please read the following statements carefully

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office.

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to our Privacy Officer. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

### **Signature:**

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

If this Consent is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: \_\_\_\_\_  
Relationship to Client: \_\_\_\_\_

### **REVOCAION OF CONSENT**

*I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations (Please write explanation on the back of this form). I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.*

CLIENT CLINICAL INFORMATION SHEET - Child/Adolescent (page 1)

*Below is a list of concerns people sometimes have. Consider each one and decide how much each one has bothered your child or has been a problem for your child during the past month:*

	NONE 1	2	SOME 3	4	A LOT 5
Learning disabilities					
Other educational concerns					
Headaches					
Stomach problems					
Other health problems:					
<i>list:</i>					

Feeling depressed					
No appetite					
Difficulty sleeping					
Loss of energy					
Relationship concerns:					
<i>With whom?</i>					

Nightmares					
Weight loss					
Weight gain					
Suicidal thoughts					
Lack of friends					
Sexual concerns/behavior					
Legal involvement					
Self-esteem problems					

	NONE 1	2	SOME 3	4	A LOT 5
Family problems					
Over-activity					
Wetting or soiling self					
Anger					
Feeling inferior					
Oppositional behavior					
Speech problems					
Tantrums					
Anxiety, nervousness					
Withdrawn, isolated					
Self-control problems					
Violent behavior:					
<i>By your child</i>					
<i>By someone else</i>					
Misbehavior:					
<i>Describe:</i>					
Substance abuse:					
<i>Describe:</i>					
Destructive behavior:					
<i>Describe:</i>					
Other concerns:					
<i>Describe:</i>					

**Does YOUR CHILD have a history of...**

Substance abuse?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Abuse or trauma?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Criminal behavior?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Seizure?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Psychiatric hospitalization?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Suicide attempt?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Educational or learning problems?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Threatening or harming others?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

**Is there a FAMILY history of...**

Mental illness?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Substance abuse?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Domestic violence or abuse?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

**How often does YOUR CHILD...**

Smoke cigarettes (# packs/day) \_\_\_\_\_

Drink alcohol (# drinks/week) \_\_\_\_\_

Smoke marijuana (# times/mo.) \_\_\_\_\_

Use other drugs (# times/mo.) \_\_\_\_\_

Who is your child's primary care physician? \_\_\_\_\_

Please list any medications (& dosages) your child is taking: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list any chronic or serious medical problems: \_\_\_\_\_  
 \_\_\_\_\_

Please list any prior counseling experiences:

Name of agency or counselor: \_\_\_\_\_ Dates of service: \_\_\_\_\_ Reason for counseling: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## CLIENT CLINICAL INFORMATION - CHILD/ADOLESCENT (page 2)

**CURRENT HOUSEHOLD / IMMEDIATE FAMILY:** *Please list everyone who resides in your home, as well as other members of your immediate family not living at home. Include yourself in this listing. Include several "keywords" (quiet, angry, nurturing, etc...) to describe those listed below.*

NAME	RELATION TO SELF	LIVING AT HOME?	AGE	SEX	KEYWORDS
		Y N			
		Y N			
		Y N			
		Y N			
		Y N			
		Y N			
		Y N			

**EDUCATION:**

Does your child participate in any special education programs? Y N

Has your child been evaluated for ADHD or other learning disability? Y N

At school, is conduct/discipline a problem for your child? Y N

What is your child's estimated grade average? \_\_\_\_\_

List any school-based social or extracurricular activities in which your child participates: \_\_\_\_\_

**LIFESTYLE:**

List any hobbies, pasttimes, or enjoyable activities in which your child regularly takes part:

\_\_\_\_\_

\_\_\_\_\_

**SUPPORT SYSTEM:**

List all social and family sources of support (for instance, "sister, church, support group"):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What problems bring you in for counseling and how long have they been a concern?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What changes do you hope will be made as a result of counseling?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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## ATTENDANCE & CANCELLATION POLICY:

When you make an appointment with a therapist at our practice, we reserve that time especially for you. We do not overbook our appointments because we feel that our clients deserve to be seen in a timely manner. Just as you deserve your therapist's full attention during your appointment, we greatly appreciate knowing in advance when a client is unable to keep their appointment. When appointments are cancelled with less than 24 hours notice, it is almost impossible to fill that time slot with another client.

Also, please note that insurance companies do not pay benefits for missed and late-cancelled appointments. Therefore, missed appointments create a financial strain for our practice and make it difficult to serve the many clients on our waiting list. It is also important to note that consistency in attending counseling sessions is critical to effective counseling, and we want our clients to really benefit from our services.

For these reasons, your account will be charged a **\$60** fee if you miss a scheduled appointment or cancel an appointment with less than 24 hours notice. Please let our office staff know if there is an extenuating circumstance preventing you from being able to keep your appointment (ie, illness, death in the family, etc...) as we certainly recognize that unexpected situations can arise.

## FINANCIAL POLICY FOR MINOR CHILDREN OF SEPARATED/DIVORCED PARENTS:

It is our policy that the parent who consents to the treatment of a minor child is responsible for payment of the services rendered. Neither Lifescapes Counseling Associates, PLLC, nor its contracted therapists will be involved with separation/divorce disputes.

***By signing below, I acknowledge understanding that Lifescapes Counseling Associates charges a \$60 fee for no-shows and appointments cancelled with less than 24 hours notice, and I acknowledge understanding of the client billing policy as it affects treatment of minor children with divorced/separated parents.***

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

# Lifescapes Counseling Associates, PLLC

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## Notice of Privacy Practices – Brief Version

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.

### *Our Commitment to Your Privacy*

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. This pamphlet is a shorter version of the full, legally required Notice of Privacy Practices (“NPP”) and you may have a copy of this to read and refer to it for more information. However, we can’t cover all possible situations so please talk to our Privacy Officer (see the end of this pamphlet) about any specific questions or concerns.

We will use the information about your health which we get from you or from others mainly to provide you with treatment, to arrange payment for our services, and for some other business activities which are called, in the law, health care operations. After you have read this NPP we will ask you to sign a consent form to let us use and share your information in an appropriate manner. If you do not consent and sign this form, we cannot treat you.

If we or you want to use or disclose (send, share, or release) your information for any other purposes we will discuss this with you and ask you to sign an authorization form to allow this.

Of course we will keep your health information private but there are some times when the laws require us to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization who is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For Workers Compensation and similar benefit programs.

There are other situations like these but which do not occur very often. They are fully described in the longer version of the NPP.

### ***Your Rights Regarding Your Health Information***

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place which is more private for you. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.
2. You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.
3. You have the right to look at the health information we have about you such as your medical and billing records, with the exception of psychotherapy notes made by your therapist. You can even get a copy of these records but we may charge you. Contact our Privacy Officer to arrange how to see your records. See below.
4. If you believe the information in your records is incorrect or missing important information, you can ask us to make changes to (or amend) your health information. You have to make this request in writing and send it to our Privacy Officer. You must tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this NPP we will post the new version in our waiting area and you can always get a copy of the NPP from the Privacy Officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be made in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have questions regarding this notice or our health information privacy policies, please contact our Privacy Officer who is Jennifer Giambalvo and can be reached by phone at 303-0273 (please leave a message if she is unavailable).

The effective date of this notice is July 24, 2010 (the date of most recent revision).

Also, you may have other rights which are granted to you by the laws of our state and these may be the same or different from the rights described above. We will be happy to discuss these situations with you now or as they arise.

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## ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

*You may refuse to sign this acknowledgement*

On this date, I, \_\_\_\_\_ received a copy of the brief version of Lifescapes Counseling Associates, PLLC "Notice of Privacy Practices" to protect the privacy of my health information. I am aware that I may request the full length "NPP" to review at any time by requesting a copy from any staff member.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

### FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign.
- Communications barriers prohibited obtaining acknowledgement.
- An emergency situation prevented us from obtaining acknowledgement.
- Other (Specify) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_