

CLIENT 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
 Domestic Partnership

EMPLOYMENT STATUS: Full-Time Part-Time Student Unemployed Retired
 Disabled/unable to work

PLACE OF WORK: _____
POSITION: _____

ETHNICITY: _____
YEARS OF EDUCATION: _____

RESPONSIBLE PARTY: _____
ADDRESS: _____

HOME PHONE: _____
WORK PHONE: _____

REFERRED BY: _____

COMMUNICATION PREFERENCES

With whom may we share information about:

1. APPOINTMENT SCHEDULING: Spouse Child Parent Other
Name: _____
2. BILLING OR INSURANCE ISSUES: Spouse Child Parent Other
Name: _____
3. TREATMENT, CLINICAL, DIAGNOSTIC INFORMATION RELATED TO YOUR THERAPY: Spouse Child Parent Other
Name: _____

How would you prefer to receive appointment confirmations? Text Phone Email

CONSENT FOR TREATMENT

I, the undersigned, have voluntarily applied for and agree to participate in counseling, psychological, &/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. This information may be disclosed via mail, fax, phone, direct communication, or electronic transmission.

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.

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

	NONE 1	2	SOME 3	4	A LOT 5
Job related concerns					
Educational concerns					
Relationship concerns					
Health concerns					
Sexual concerns					
Behavioral concerns					
Financial concerns					
Spiritual concerns					
Identity concerns					
Parenting concerns					
Legal concerns					
Family concerns					
Difficulty sleeping					
Poor judgement					
Concentration problems					
Substance abuse					
Impulsive behavior					
Self-control problems					
Mood swings					
Lack of friends					
Self-esteem issues					
Grief, loss, or mourning					
Problems with trust					
Violent/aggressive behavior					
Problems making decisions					
Memory problems					
Confusion					

	NONE 1	2	SOME 3	4	A LOT 5
Headaches					
Stomach problems					
Chronic pain					
Anxiety, nervousness					
Preoccupation with thoughts					
Chronic worry					
Fear or phobia(s)					
Difficulty relaxing					
Panic attacks					
Perfectionistic personality					
Nightmares					
Intrusive thoughts					
Feeling depressed					
Feeling overwhelmed					
Irritability					
Lack of enjoyment					
Feeling lonely					
Feeling isolated/withdrawn					
Loss of energy					
Poor appetite					
Overeating					
Lack of sexual interest					
Suicidal thoughts					
Weight gain					
Weight loss					
Feeling hopeless					
Poor motivation					

Do YOU 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 do you...

Smoke cigarettes (# packs/day) _____

Drink alcohol (# drinks/week) _____

Smoke marijuana (# times/mo.) _____

Use other drugs (# times/mo.) _____

Who is your primary care physician? _____

Please list any medications (& dosages) you are 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: _____

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			

RELATIONSHIPS: Are you currently in a committed relationship? **Y N**
 Have you previously been involved in committed relationships? **Y N**
 If yes, how many times? _____
 How many times have you been married? _____

LIFESTYLE: List any hobbies, pastimes, or enjoyable activities that you regularly take part in:

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 to make as a result of counseling?

Lifescapes Counseling Associates, PLLC

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Apex, NC 27502

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 services rendered. Neither Lifescapes Counseling Associates, PLLC, nor its contracted therapists will be involved with separation/divorce disputes. Divorced parents bear the responsibility for splitting the cost of therapy. The parent who brings a minor client to appointments is expected to pay the full copay due.

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

800 W. Williams St, Suite 251

Apex, NC 27502

ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

You may refuse to sign this acknowledgement

On this date, I, _____ received a copy of the Lifescapes Counseling Associates, PLLC "Notice of Privacy Practices" to protect the privacy of my health information. I am aware that I may direct questions about our privacy practices to the Privacy Officer listed in the NPP.

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) _____

Lifescapes Counseling Associates, PLLC

Peakway Market Square
800 W. Williams Street, Suite 251, Apex NC 27502
919 303 0273

CREDIT CARD PAYMENT AGREEMENT

For your convenience, we offer our clients the option of arranging to pay all session fees and account balances with a credit card. With this arrangement, we keep your credit card information on file, and you do not have to spend additional time paying each time you come in. We accept Visa and Mastercard.

Please complete the following information:

NAME OF PERSON RECEIVING TREATMENT: _____

FULL NAME PRINTED ON CARD: _____

CREDIT CARD ACCOUNT NO.: _____

EXPIRATION DATE: ___ / ___ / ___ SECURITY Code: _____ TYPE: Visa MC

AGREED (Signature): _____ DATE: _____