

Counseling Intake Form



Please Submit Completed Forms to JAKS Counseling Services:

Fax to: 775-295-5087
 Email to: info@jaksounseling.com
 Mail to: 10702 Manchester Rd., Ste. 201
 Kirkwood, MO 63122

Main Office:
314-529-1595

DEMOGRAPHIC INFORMATION

Name _____ D.O.B. _____ Male ___ Female ___
 Legal Guardian if client is a minor _____ Relationship _____
 Address _____ City _____ State _____ Zip _____
 Phone (H) _____ (M) _____ Email _____
 Black _____ White _____ Hispanic _____ Other (list) _____

INSURANCE INFORMATION

Name of Insured _____
 Insured's Workplace _____
 Primary Insurance Company _____ Phone _____ Co-Pay Amt. _____
 ID# _____ Group ID# _____
 Secondary Insurance Company _____ Phone _____ Co-Pay Amt. _____
 ID# _____ Group ID# _____

MEDICAL INFORMATION

Primary Care Physician _____ Phone _____
 Psychiatrist _____ Phone _____
 Description of past medical problems _____

Please list current medications/dosage	Reason Prescribed
_____	_____
_____	_____

BACKGROUND INFORMATION

(Please check all that apply.)

- | | | |
|---------------------|----------------------------------|--------------------------------|
| Anger Management | Anxiety | Abuse/Violence |
| Depression | Inattentiveness | Self Esteem |
| Hyperactive | Trauma | Financial Stressors |
| Family Concerns | Withdrawn | Eating Disorder |
| Substance Abuse | Grief & Loss | Attachment Issues |
| Divorce/Separation | Sexuality/Homosexuality Concerns | Suicidal/Homicidal |
| Work/School-Related | Adoption/Foster-Care | Crisis Intervention |
| Transition Issues | Adjustment Issues | |
| Peer Issues | Sibling Rivalry | Relationship Concerns |
| Sleeping Problems | Chronic Pain/Illness | Recent Weight Loss/Weight Gain |

Additional Information:

HIPAA Notice of Privacy Practices

I have received or been provided the opportunity to review a copy of HIPAA Notice of Privacy Practices. I understand JAKS Counseling Services may use and disclose my protected health information (PHI) to carry out treatment, payment, and health care operations.

This authorization permits JAKS Counseling Services to use and/or disclose individually identifiable health information about me.

1. JAKS Counseling Services is authorized to disclose my individually identifiable health information to partnering counseling therapists/agencies.
2. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign this authorization will not affect my ability to obtain treatment, or eligibility for benefits unless allowed by law.
3. I understand that I may inspect or copy the information to be disclosed.
4. I understand that I may revoke this authorization at any time by notifying JAKS Counseling Services in writing, except to the extent that: (a) JAKS Counseling Services has taken action in reliance on this authorization; or (b) If this authorization is obtained as a condition for obtaining insurance coverage. Other law provides the insurer with the right to contest a claim under the policy.

Financial Responsibilities

(1) The client (or client's guardian, if a minor) is responsible for the payment for all services rendered. (2) The client is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated. (3) Clients are responsible for the payment of co-pays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service.

Child Custody Issues

JAKS Counseling Services does not make recommendations for custody of children in disputed cases. Such recommendations are beyond the scope of our services.

Supervision Disclosure Statement and Recording Consent

I understand that in addition to Licensed Professional Therapists; JAKS contracts with Provisionally Licensed Therapists who are working toward completing their full licensure in the State of Missouri. These individuals have passed the appropriate board examinations and are either in the process of receiving or have received their provisional license to practice therapy in the State of Missouri.

I understand that JAKS offers placement, training and supervision for Master's Level Counseling interns.

I understand that all Provisional Practitioners and Interns who provide counseling services to clients do so under the clinical supervision of a licensed professional therapist who is fully credentialed in the State of Missouri who is also contracted with the JAKS.

I give my consent for JAKS Counseling Services to record my counseling sessions for educational purposes. I understand counseling sessions may be taped and reviewed by the therapist/supervisor and/or team members in effort to provide the most beneficial services.

X

Signature of client/Legal guardian if client is under 18

Relationship to Client

Client's Name

Date

Consent for Evaluation & Treatment

1. **Consent to Evaluate/Treat:** I voluntarily consent that I will participate in a mental health status evaluation and/or treatment by staff from JAKS Counseling Services. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
 - a. The benefits of the proposed treatment
 - b. Alternative treatment modes and services
 - c. The manner in which treatment will be administered
 - d. Probable consequences of not receiving treatmentThe evaluation or treatment will be conducted by a licensed professional counselor, licensed clinical social worker, a psychologist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Missouri Law for Psychological, Social Work, Professional Counseling, or Marriage and Family Counseling.
2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.
3. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.
4. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and/or treatment is contained in a confidential medical record at JAKS Counseling Services, and I consent to disclosure for use by JAKS Counseling Services staff for the purpose of continuity of my care. Per Missouri mental health law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.
5. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.
6. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

Client Name

Signature of client/Legal guardian if client is under 18

Date

The client/legal guardian acknowledges receipt of the *JAKS Counseling Services Policies and Procedures Handbook* on the date shown below.

The client/legal guardian understands that the *JAKS Counseling Services Parent/Guardian Policies and Procedures Handbook* is current as of the time given and supersedes any previous manual or single copies of policies or procedures.

From time to time, new situations may develop that may require changes, additions, or eliminations of the policies or procedures in this manual. The client/legal guardian will be notified in writing of these changes and understands that he/she is responsible for all amendments.

In addition, JAKS Counseling Services reserves the right to amend or to terminate any of the policies and/or procedures.

ACKNOWLEDGEMENT

I ACKNOWLEDGE ALL OF THE ABOVE:

SIGNATURE: _____

PRINT NAME: _____

DATE: _____