CONFIDENTIAL - ADULT COUNSELING INTAKE FORM

DATE:_____

PATIENT NAME AND IDENTIFYING INFORMATION:

Last Name _____ First Name _____ Middle Initial _____ Nickname _____

Date of Birth _____/_____/_____ Age _____ Gender: Male _____ Female _____

Current Marital Status: Single _____ Engaged _____ Married _____ Separated _____ Divorced _____ Widowed _____

Spouse's Name: _____ Age _____ Years Married _____

Names of Children and/or Step Children and ages: _____

_____

Presently living with: Parents _____ Spouse _____ Roommate _____ Alone _____ Other:_____

Who referred you to Life Resources or how did you hear about us?_____

May we send a thank you for the referral? _____

OCCUPATIONAL/EDUCATIONAL INFORMATION:

Occupation: _____ Employer: _____ How long?_____

If Currently a Student: What school? _____ Field of Study? _____

Part time: _____ Full Time _____ Circle last year of school completed: 9 10 11 12 GED College: 1 2 3 4

Other: _____

Military Service (including branch of service and dates): _____

REASONS FOR SEEKING HELP: (use the back of this page if needed)

What concerns have led you to pursue counseling?_____

_____

_____

_____

Where is this impacting you the most? Check all that apply: Home ____ Work ____ Marriage____ God_____ Other_____

When did this begin to be a problem for you? _____

Please rate the severity of your present concerns: Mild _____ Moderate_____ Severe _____

What do you hope to gain from counseling?_____

_____

If other people are involved in your present problem, who are they and how could they help improve the situation?

_____

_____

_____

MEDICAL/HEALTH INFORMATION:

How would you rate your current health? Excellent _____ Good _____ Fair _____ Poor _____

Date of last physical exam: _____ Physician: _____

Are you currently experiencing any physical problems? (e.g. headaches, body aches, stomach problems):

Yes _____ No _____ if yes, please explain: _____

Describe any physical problem you or a member in your household have which require medical or physical care:

_____

Medications (Over-the-Counter or Prescription)	Dosage	Reason for Medication	Prescribing Physician

Have you ever had surgery? If yes, for what reason? _____

Are there chemical substance abuse issues in your family? Yes _____ No _____ Who? _____

If clean/sober, for what length of time? _____

Have you ever been hospitalized for mental illness or substance abuse? Yes _____ No _____

If yes, for what specific reason and where? _____

Have you ever participated in counseling before? Yes _____ No _____ If so, when and why? _____

_____ Name of Therapist: _____

Please indicate which of the following areas are currently problems for you. Check all that apply:

- ☐ Under too much pressure/feeling stressed
- ☐ Excessive anxiety or worry
- ☐ Feeling lonely
- ☐ Angry feelings
- ☐ Concerns about finances
- ☐ Feeling "numb" or cut off from emotions
- ☐ Angry outbursts
- ☐ Excessive fear of specific places/objects
- ☐ Difficulty making friends
- ☐ Feeling as if you'd be better off dead
- ☐ Feeling that people are "out to get you"
- ☐ Feeling manipulated or controlled by others
- ☐ Difficulty making decisions
- ☐ Loss of interest in sexual relationship
- ☐ Feeling sexually attracted to members of your own sex
- ☐ Concerns about physical health
- ☐ Loss of appetite/increased appetite
- ☐ Lacking self confidence
- ☐ Recent significant weight gain/loss
- ☐ Use of alcohol
- ☐ Use of non-prescription/prescription drugs
- ☐ Feeling distant from God
- ☐ Hallucinations
- ☐ Inability to concentrate while at school/work
- ☐ Crying spells
- ☐ Nightmares
- ☐ Loss of interest in usual activities/lack of motivation
- ☐ Obsessions or compulsions with specific activities or thoughts
- ☐ Inability to control thoughts
- ☐ Feeling trapped in rooms/buildings
- ☐ Hearing voices
- ☐ Blackouts or temporary loss of memory
- ☐ Sleeping too much or too little
- ☐ Feeling driven

Any other information that you feel is important to share that is not covered: _____

_____

_____

_____

_____

_____

_____

_____

ADDRESS AND CONTACT INFORMATION:

Mailing Address _____

City _____ State _____ Zip _____

Phone: Home _____ Cell _____ Work _____

Second cell phone: _____ belongs to? _____

Client email address: _____

Emergency Contact: Name _____ Relationship _____Phone _____

For confidentiality, in order to confirm and/or change appointments, may we contact you at:

Check all that apply: Home _____ Work _____ Cell _____Text _____ Email _____

Please list preferred days/times for your appointment availability: _____

_____

RELIGIOUS BACKGROUND:

Religious Affiliation: _____ Active_____ or Inactive _____

Do you attend a local church? Yes ____ No____ If yes, name of church: _____

How significant is your religion to your everyday life? _____

_____

_____

_____

_____

_____

Life Resources

POLICIES ♦ PROCEDURES ♦ DISCLOSURE STATEMENT ♦ CONSENT FOR TREATMENT

We are pleased that you have chosen to begin therapy with Life Resources and trust our relationship will be a pleasant and useful one. In order to provide you with the highest level of services, we must operate in a business-like manner. These guidelines are designed to keep services as efficient and inexpensive as possible.

APPOINTMENTS

All appointments are made through the administrative staff. Most appointments can be scheduled Monday - Thursday from 9:00 am to 5:00 pm. **Appointments should be cancelled 24 hours prior to the scheduled appointment time. You will be charged for appointments not cancelled 24 hours ahead of time - except in cases of valid emergencies.** Because Life Resources is not open on Fridays, Monday appointments must be cancelled by the previous Thursday at 3:00 p.m. to allow another client to be contacted to fill your appointment time. Since a specific block of time is set aside for you, Life Resources appreciates your every effort to keep your scheduled appointment. _____

(initial)

FINANCIAL POLICY AND INFORMATION

Life Resources accepts cash, checks, credit cards, debit cards and HSA cards and can keep your preferred card on file for your convenience. Life Resources participates in several insurance plans.

You are responsible to contact your provider for pre-authorization prior to your appointment or your insurance may not cover it and you will be responsible for full payment at the time of service.

Please check one: _____self pay _____insurance (Please note, we are not medicaid/medicare providers.)

Fee Structure for Life Resources as of December 1, 2014

Ph.D./ Psychologist:

New Intake (90 min)	$225
Individual session (50-60 min)	$150
Individual session (50-60 min)	$125
Individual session (75-90 min)	$225
Marriage/Couple Counseling (80 min)	$225

LPC / Licensed Professional Counselor:

New Intake (60 min)	$125
Individual session (50-60 min)	$125
Indiv. Intake session (90 min)	$175
Marriage/Couple/Family Counseling (60 min)	$175

LPC/I – Licensed Professional Counselor Intern

New Intake (90 min)	$125
Individual session (50-60 min)	$85
Individual session (75-90 min)	$125
Marriage/Couple/Family Counseling (80 min)	$125

(We **do not** file insurance for marriage counseling)

I understand that insurance may not cover some services or a 75-90 minute therapy appointment. I agree to be responsible for the balance in full for services not covered. _____

(Initial)

Payment is due at the time of service.

Self Pay

We are pleased to offer a scholarship program for individuals or families that may need financial assistance. The forms are available at the front office, upon your request. In special circumstances, a payment plan can be established where your credit card may be charged an agreed upon monthly amount and applied to your balance. Payment in full for remaining balance is due at the termination of therapy. You may apply for either of these services by speaking with an administrator.

Please initial the payment options you prefer:

_____Cash or check (Returned checks will be charged a $30 processing fee)

_____Credit card _____Keep my preferred credit card on file for convenience

_____I would like to pursue scholarship assistance

_____I would like to be considered for a payment plan via my credit card

Insurance

Primary Insurance - please provide a copy of your driver's license and insurance card.

Primary Company _____Policy Number _____Group ID# _____

Name of policy holder: _____

Date of birth for policy holder: _____

Social Security Number of policy holder: _____

Address of policy holder: _____

Please be aware that most insurance companies require you to authorize Life Resources to provide them with a clinical diagnosis. Sometimes, insurance requests additional clinical information such as treatment plans, or summaries.
This information will become a part of the insurance company files.
It is important to remember that you always have the right to pay for counseling services yourself if you do not wish to share such information with your insurance company.
If we are filing your insurance, please pay your co-pay **upon arrival** for your appointment.

Insurance/3rd Party Authorization

I authorize the release of any medical or other information necessary to process insurance claims or 3rd party payment for services rendered. I also request payment of medical benefits to Life Resources.

_____ _____
Client/Guardian Signature Date

890 Johnnie Dodds Blvd., Building 3, Suite A, Mount Pleasant, SC 29464
T 843-884-3888 F 843-884-8124 E admin@myliferesources.org
www.myliferesources.org

Services

Telephone calls are available on an as needed basis and as time permits. On occasions where calls are lengthy, it may be necessary to prorate your bill at the usual rate. Preparation time for documents provided for legal or other purposes will be charged at the hourly rate.

Confidentiality

Generally speaking, information provided by and to a client in a professional relationship with a counselor is legally confidential. By law, information can only be released with the written consent of the client and only to parties specifed by the client. There are specific exceptions to your right to confidentially which include:

- Any suspected incident of child or elder abuse or neglect
- Imminent danger to self or others.

When consulting with parents regarding minor children, specific content of therapy sessions with children or adolescents will be held in confidence unless their welfare requires that the parent(s) have access to such information. In most cases, joint meetings between children and/or adolescents, their parents and the therapist will be arranged as a part of the therapy process. Life Resources adheres to the Code of Ethics prescribed by South Carolina Code of Ethics for Mental Health Professionals.

The professionals of Life Resources participate in confidential therapeutic staffing where treatment may be discussed to insure quality of care received here. Please be assured that your identity will be concealed.

Referral Policy/Disclaimer

Clients will be referred to another counselor when treatment required is beyond the scope of care available. Life Resources will strive to be responsible and professional in the referral procedure; however, it is your full right and responsibility to select the professional of your choice. Life Resources is not liable for any services provided or not provided by the referred professional.

Contacting Your Counselor

For scheduling and canceling your appointments, or questions regarding payments you must contact Life Resources at 843-884-3888 or admin@myliferesources.org.

Please select one box and sign at the bottom of the page.

Standard email communication (Gmail, Yahoo, Hotmail, etc) is an easy and convenient way to communicate with Healthcare Providers. Skype and FaceTime provide additional means of communication that bridge the gap between an in person visit and phone or email. Texting is a quick way to communicate short and more time-sensitive messages. All these methods of communication are non-encrypted and therefore not considered fully secure, and do not meet the security requirements set forth by the Health Insurance Portability and Accountability Act (HIPAA). Phone and Fax are considered more secure, and TherapyAppointment can be used to contact Life Resources securely. However, because of their extreme convenience and wide availability, these non-secure methods are offered as an additional means of communicating with Life Resources.

I, the undersigned, have read and understood the above, and consent to non-secure electronic communication. ☐

I release Life Resources from any and all liability that may arise from use of non-secure communication. If at any time in the future I wish to revoke this consent, I will so inform Life Resources by fax or by secure message via TherapyAppointment. This revocation will not be retroactive, and will only affect communication going forward from the date of such revocation.

I, the undersigned, have read and understood the above, but choose to not consent to non-secure electronic communication. ☐

Signature: _____ Name: _____

Date: _____

Acknowledgement of Receipt of Life Resources

Notice of Privacy Practices (NPP)

This form is acknowledgement that you (the client or client's personal representative),

_____

have been offered a copy of Life Resources Notice of Privacy Practices ("NPP"). A copy of the HIPAA policy can be found in the waiting room and on the website. If you would like a copy, please let us know. When we use the term "you" below, it will mean the client (or your child, relative, or other person if you have written his or her name above).

When we assess, diagnose, treat, or refer you, we will be collecting what the law calls Protected Health Information ("PHI") about you. We need to use this information at Life Resources to decide what treatment is best for you and to provide treatment for you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment, or for other business or government functions.

By signing this form, you are acknowledging that Life Resources has provided you with a copy of Life Resources Notice of Privacy Practices (NPP). The Notice of Privacy Practices explains in more detail your rights and how Life Resources can share and use your information.

In the future we may change how Life Resources uses and shares your information and so may change our Notice of Privacy Practices. If Life Resources changes the Notice of Privacy Practices, you may obtain a copy from your therapist, our web site, or our privacy officer, whose contact information appears on the Notice of Privacy Practices.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations.

_____ _____

Signature of client or her/his personal representative Date

_____

Printed name of client or her/his representative

_____

Description of personal representative's authority

890 Johnnie Dodds Blvd., Building 3, Suite A, Mount Pleasant, SC 29464
T 843-884-3888 F 843-884-8124 E admin@myliferesources.org
www.myliferesources.org

Appointment Reminders
And Online Access

You can receive an appointment reminder to your email address, your cell phone (via text message), or your home/cell phone (via a voice message) the day before your scheduled appointment.

Once your account is established, you simply visit www.therapyappointment.com and click on 'Find Your Therapist' in the upper right hand corner of the screen to view your account.

Your name:_____

Requested login name: _|_|_|_|_|_|_| (6 maximum)
(Letters only – not case sensitive)

Requested password: : _|_|_|_|_|_|_| (6 maximum)
(Numbers only no special characters)

Your email address:_____

Your home phone number:_____

Your cell phone number:_____

Where would you like to receive appointment reminders: (**check only one**)

— Via a text message on my cell phone (normal text message rates will apply)
— Via an email message to the address listed above
— Via an automated telephone message to my home phone
— Via an automated telephone message to my cell phone
— **None of the above**. I'll remember my appointments on my own. (Missed appointment fees will still apply)

Please read the following two statements and sign for one.

By **selecting one method from the above options**, I understand that my appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

_____ _____
Signature Date

By selecting **none of the above**, I understand that my appointment information is considered to be "Protected Health Information: under HIPPA. Therefore, I would not like to receive any form of an appointment reminder.

_____ _____
Signature Date

Barbara S. Boatwright, Ph.D.
Executive Director & Founder
Licensed Clinical Psychologist

Dolores G. Hollen, LPC
Licensed Professional Counselor

Mary-Stewart Carpenter, LPC/I
Licensed Professional Counselor Intern

Meredith Little, LPC
Licensed Professional Counselor

Rachel Henry, LPC/I
Licensed Professional Counselor Intern

Nichole Dalzell, B.A.
Nationally Board Certified Teacher

Ginger Black, M.Ed.
Certified Reading Specialist

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Mt. Pleasant, SC 29464

phone: 843-884-3888
fax: 843-884-8124

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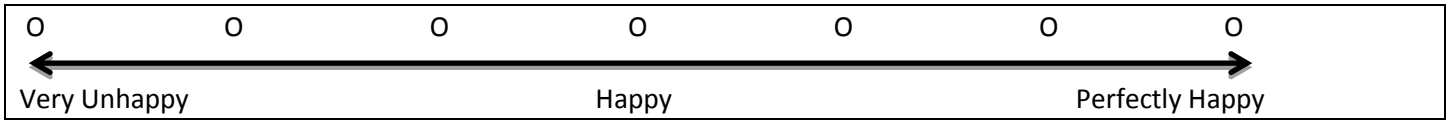
MARRIAGE ASSESSMENT

Life Resources

Lock-Wallace Marital Adjustment Test

Name: _____ Date: _____

1. Circle the dot on the scale arrow which best describes the degree of happiness, everything considered, of your present marriage:



State the approximate extent of agreement or disagreement between you and your mate on the following items. Put a check in the column that applies.

	Always Agree	Almost Always Agree	Occasionally Disagree	Frequently Disagree	Almost Always Disagree	Always Disagree
2. Handling Family Finances						
3. Matters of Recreation						
4. Demonstration of Affection						
5. Friends						
6. Sex Relations						
7. Conventionality (right, good or proper conduct)						
8. Philosophy of Life						
9. Ways of dealing with in-laws						

10. When disagreements arise, they usually result in:
    (a) husband giving in (b) wife giving in (c) agreement by mutual give and take

11. Do you and your mate engage in outside interests together?
    (a) all of them (b) some of them (c) very few of them (d) none of them

12. In leisure time do you generally prefer:
    (a) to be "on the go" (b) to stay at home

    Does your mate generally prefer:
    (a) to be "on the go" (b) to stay at home

13. Do you ever wish you had not married?
    (a) frequently (b) occasionally (c) rarely (d) never

14. If you had your life to live over again, do you think you would:
    (a) marry the same person (b) marry a different person (c) not marry at all

15. Do you ever confide in your mate?
    (a) almost never (b) rarely (c) in most things (d) in everything

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