5151 E Sam Houston Pkwy S
Pasadena, TX 77505
281-937-2977
www.clearhopecounseling.com

ADULT INTAKE FORM

GENERAL INFORMATION

Name:_____ Today's Date:_____

Your age: _____ Date of Birth (DOB):_____

Address:_____

_____

Spouse or Partner's Name (if applicable): _____

Emergency Contact: _____Emergency Contact Number: _____

Home phone:_____ May I leave a message? Yes No

Cell phone:_____ May I leave a message? Yes No

May I leave a ***text*** message? Yes No

Work phone:_____ May I leave a message? Yes No

Email: _____ May I email you? Yes No

Referred by:_____

What is the main reason you're seeking help?_____

_____

How long has this been an issue? _____

What are your goals for therapy?_____

_____

_____

MENTAL HEALTH INFORMATION

Have you previously seen a therapist or psychiatrist? If so, what year? Who did you see and for what reason? About how many meetings did you have? Was the experience helpful or not? How so?

_____

_____

Have you ever been hospitalized for mental illness? If so, list when, where, & reason:

_____

_____

Have you ever experienced any situation that you would consider traumatic for you?

_____

_____

When you were a child, did you struggle with any of the following:			Age
Learning disabilities	Yes	No	_____
Hyperactivity	Yes	No	_____
Bed wetting	Yes	No	_____
School fears	Yes	No	_____
Teasing/Bullying	Yes	No	_____
Eating disorders	Yes	No	_____
Witnessing violence in the home	Yes	No	_____
Sexual, physical or emotional abuse	Yes	No	_____

If so, by whom? _____

FAMILY PSYCHIATRIC HISTORY

In the section below identify if any members of your family and extended family has a history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

	Please circle		List Family Member(s)
Anxiety (general)	Yes	No	
Obsessive Compulsive Behavior	Yes	No	
Depression	Yes	No	
Suicide Attempts	Yes	No	
Bipolar/Manic Depressive	Yes	No	
Alcoholism	Yes	No	
Substance Abuse	Yes	No	
Domestic Violence	Yes	No	
Eating Disorders	Yes	No	
Obesity	Yes	No	
Schizophrenia	Yes	No	
Counseling or Psychotherapy	Yes	No	
Psychiatric Hospitalizations	Yes	No	

MEDICAL CONDITIONS & HISTORY

Do you currently have any medical problems? _____

_____

Have you ever been hospitalized for medical reasons? If so, list when, where and reason:

_____

_____

Do you have any unexplained aches, pains, nerve or joint pain?

_____

_____

Have you ever been treated for any of the following? If so please circle and describe:
Head injury, strokes, seizures, fainting, loss of consciousness, neurologic conditions (Multiple sclerosis, Parkinson's), cancer, headaches, diabetes/kidney, allergies, chronic fatigue, high fevers, surgeries, any other conditions:

_____

_____

_____

How many times a week do you exercise?_____What type and how many minutes? _____

_____

How would you describe your diet? _____

Do you have any concerns about your overall health? (If so, please describe)

_____

_____

MEDICATIONS & PHYSICIAN INFORMATION

Please list current prescription medications with dosage (psychiatric and general health):

_____

_____

_____

Please list any previous psychiatric medications (with dosage and dates): _____

_____

Who is your primary care physician? _____

Who is your psychiatrist (if applicable)? _____

When was your last complete physical exam (month/year)? _____

SUBSTANCE USE

Do you drink alcohol or use recreational drugs? If so, what kind and how often? _____

_____

_____

Do you or anyone close to you consider your use to be a problem? Yes No

FAMILY INFORMATION (Family of Origin)

Where were you born? _____

Where did you live most of your childhood? _____

	MOTHER	FATHER
Current age, or if deceased date, age, and cause of death.		
Country of Origin		
Religious/Spiritual Affiliation (if any)		
Use 3 adjectives or more to describe <u>each</u> parent.		
How did you and <u>each</u> parent get along when you were growing up? Give some examples of things that you did together & feelings you had.		
Use 3 adjectives or more to describe your parents' relationship.		
How did your parents get along? What were any things they disagreed over?		
Years married/together (parents)		
If divorced or not together, your age at divorce.		
Reason for divorce/split		
Describe your relationship with step-parents (if any).		
List anyone else who lived with you <u>or</u> regularly cared for you.		
Were you adopted? Age?	**If so, please write any relevant information about your biological parents.**	
List any issues in your family growing up:		

Siblings

Please list all of your brothers and sisters in the order of birth (if applicable).

First name	Biological (Yes/No)	Current Age	Male/ Female	Married or Partnered? (Yes/No)	Describe your relationship in a few words

Children

Please list your biological, adopted or stepchildren (if applicable).

First name	Biological, Adopted or Step	Current Age	School grade?	Male/ Female	Lives with you? (Yes/No)	Describe your relationship in a few words

INTIMATE RELATIONSHIPS & SOCIAL SUPPORTS

Are you currently married? Yes No How long?_____

Are you currently partnered/in a romantic relationship? Yes No How long? _____

Do you have any concerns about your current marital or romantic relationship that you would like to discuss?

If so, what are they?_____

_____

_____

_____

Are you currently separated or divorced? Yes No How long? _____

If you and your former spouse/partner have children together, please describe your current custody & visitation schedule (if any) and the status of your communication:

_____

_____

_____

_____

Please describe your social relationships. Do you have friends and/or extended family? Go out for fun? Socialize? To whom can you turn to for emotional and other forms of support?

EMPLOYMENT & EDUCATIONAL INFORMATION

Are you currently employed? Yes No Are you currently a student? Yes No

What was the highest grade of education you completed? _____

Please describe your current work or academic situation: _____

Do you enjoy your work/school? Is there anything stressful about it? _____

INTERESTS/ACTIVITIES/SPIRITUALITY

What are some of your interests/hobbies & activities? _____

Do you consider yourself spiritual or religious? Yes No

Is so, describe your spirituality/faith and you level of participation in a faith-based group (if applicable) :____

ADDITIONAL INFORMATION

Do you have any legal history or current legal problems or concerns you feel I should know about? For example, have you ever been charged with DWI/DUI, dealt with custody battles, legal issues related to crime, etc?

Have you experienced any unusually severe stresses during the last year? Yes No

If yes, please describe:_____

What do you consider to be your strengths?_____

What do you consider to be your areas of needed growth?_____

Is there any other information you'd like to add?

_____

_____

_____

_____

How much are each of the following areas currently a problem for you? Please circle.

	Not at all 1	**A little 2**	**Somewhat 3**	**Considerably 4**	**Terribly 5**
Anxiety	1	2	3	4	5
Physical Problems	1	2	3	4	5
Sleep Problems	1	2	3	4	5
Depression	1	2	3	4	5
Alcohol or Substance Abuse	1	2	3	4	5
Family Conflicts	1	2	3	4	5
Marital Conflicts	1	2	3	4	5
Social Relationships	1	2	3	4	5
Job/School	1	2	3	4	5
Sexual Problems	1	2	3	4	5
Spiritual/religious	1	2	3	4	5
Legal Problems	1	2	3	4	5
Eating Disorder/Struggles	1	2	3	4	5
Abuse (physical, emotional, sexual)	1	2	3	4	5

Financial Agreement Form and Privacy Disclosure

Please review the Financial Agreement and Privacy Disclosure.

I agree to:

1. To pay $145 for the initial assessment and $135 per 53-minute session thereafter.
2. Average treatment plans are 10-12 sessions in length and vary based on individual need.
3. To pay an hourly rate of $135 for time spent preparing and writing any formal or legal documentation including but not limited to court letters, disability determinations, assessments, and treatment summaries.
4. Payment is expected at the beginning or end of each session unless prior arrangements have been made.
5. Appointments not canceled or rescheduled 24 hours in advance may be charged a $75 no-show fee, which must be paid before the next session, and will be charged to the credit card on file.
6. Clients arriving more than 7 minutes late to their regularly scheduled appointment will need to be rescheduled and will be subject to the aforementioned $75 no-show fee.
7. A $25 service charge will be added to all returned checks and must be paid at the next session.
8. In the event a therapist is required to attend court proceedings, a retainer of $1000 per day is required before participation in legal proceedings. Charges will be incurred at the rate of $125 per hour + the allowable IRS mileage reimbursement rate.
9. Payments of fees are the full responsibility of the client. Insurance is billed as a courtesy and does not guarantee that any/all fees will be covered by insurance.
10. Benefit Check Disclaimer: While we try to be as accurate as possible when verifying benefits, your fees may change depending on your eligibility and benefits during the date of your sessions. This is an estimate as of today, and we won't know your exact fee until we bill your insurance and get your explanation of benefits back from your insurance company. You are also encouraged to call the number on the back of your insurance card and ask your member representative about your 'mental health, outpatient, office visit' benefits. Please let us know if you have any questions about your benefits.
11. In accordance with the No Surprises Act, a “Good Faith Estimate for Health Care Items and Services,” will be discussed and agreed upon with my therapist during the initial assessment.

Explanation of any alternative payment plan:

INSURANCE INFORMATION

Name of Insurance Company: _____

Insurance Company Address: _____

(City)_____ (State)_____ (Zip Code)_____

Phone Number: _____ Place of Employment:

_____ **Subscriber**

Name: _____ Date of Birth: _____

Policy ID:_____ Group Number: _____

I understand the above payment procedures and I agree to this plan of payment.

Client Signature _____ Date _____

I give Clearhope Counseling Center, permission to bill my insurance as indicated above.

_____ _____

Client Signature Date

I have received a copy and reviewed the Clearhope Counseling Center Privacy Disclosure: Your Information. Your Rights. Our Responsibilities.

Client Signature _____ Date _____

PRIVACY DISCLOSURE: YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

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.

YOUR RIGHTS	YOUR CHOICES	OUR USES AND DISCLOSURES
Your have the right to: • Get a copy of your paper or electronic medical record • Correct your paper or electronic medical record • Request confidential communication • Ask us to limit the information we share • Get a list of those with whom we've shared your information • Get a copy of this privacy notice • Choose someone to act for you • File a complaint if you believe your privacy rights have been violated	You have some choices in the way that we use and share information as we: • Tell family and friends about your condition • Provide disaster relief • Include you in a hospital directory • Provide mental health care • Market our services and sell your information • Raise funds	We may use and share your information as we: • Treat you • Run our organization • Bill for your services • Help with public health and safety issues • Do research • Comply with the law • Respond to organ and tissue donation requests • Work with a medical examiner or funeral director • Address workers' compensation, law enforcement, and other government requests • Respond to lawsuits and legal actions

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

- **Treat you**

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

- **Run our organization**

We can use and share your health information to run Clearhope Counseling Center, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

- **Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research We can use or share your information for health research.

Comply with the law We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Respond to organ and tissue donation requests We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- **We are required by law to maintain the privacy and security of your protected health information.**
- **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**
- **We must follow the duties and privacy described in this notice and give you a copy of it.**
- **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

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Credit Card Authorization Form

Payments are due at the time of service. Clearhope Counseling Center requires a credit, debit, or flex spending/HSA card on file in order to schedule sessions. The credit card on file can be used in order to pay for any copays, co-insurance, deductibles, no shows/late cancellations or out of pocket payments if no other payment method is used at the time of the session or if a late cancellation or no show is incurred (in which case, the credit card on file will be charged our full fee on the day of scheduled session). Clients may also pay by cash or check at each session. Your credit card will be stored in a HIPAA compliant electronic health system and this document will be safely destroyed.

Please check the box and sign below:

☐ Please charge my card for charges in full for sessions at the time of service.

Client Name:		
Cardholder Name:		
Credit Card Number:		
Expiration Date:	Billing Zip Code of Credit Card:	Security Code:
Cardholder's Signature:		Date:

I understand that by signing above, I am authorizing Clearhope Counseling Center to charge my card in the manner indicated by my initials above. These balances may include co-pays, co-insurance amounts, out of pocket payments, deductibles, no show or late cancel fees.

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AUTHORIZATION FOR RELEASE OF MENTAL HEALTH AND OTHER PERSONAL HEALTH INFORMATION

I,_____ hereby authorize _____
(Patient/Parent/Guardian/Power of Attorney) (Facility/Therapist/Counselor)

to exchange/release any and all records or information regarding _____
(Name of Patient)

The following items must be **checked** to be included in the use and/or disclosure of other health information:

☐ Diagnosis/Treatment Plan ☐ Mental health information ☐ Psychotherapy Notes

☐ Drug/alcohol diagnosis, treatment/referral

to_____
(receiving Agency/person) (Address)

for the purpose of (please check all that apply):

☐ Continuing (health and mental health) treatment or care and continuity of care ☐ Therapist transition

☐ Billing, payment and financial matters and arrangements ☐ Consultation, advise and representation

☐ Housing or other arrangements and services ☐ Other _____

This consent is valid until (calendar date)_____

I understand that I have the right to inspect and copy the information to be disclosed and may revoke this authorization at any time. Any such revocation will not affect materials disclosed prior to the revocation. The above-named person authorized to receive this information may use the information only for the purposes outlined above and may not redisclosed it without my written authorization.

I also understand that if I refuse to consent to this release of information the following may occur _____

_____ _____
(Minor recipient) (Signature of adult patient or parent)

_____
(Witness)

NOTICE TO PATIENT AND RECEIVING AGENCY:

Under the provisions of the Developmental Disabilities Confidentiality Act, HIPAA, and applicable Federal and State Alcohol and Substance Abuse Confidentiality Acts, there may not be redisclosure of any of the information provided pursuant to this release unless the patient, and/or parent of the patient who is a minor, specifically authorizes such disclosure. A separate release is required for psychotherapy notes.

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Consent & Statement of Understanding: Telehealth Video Sessions

Client Information

Name _____ Date of Birth_____

Home address_____ Zip_____

Phone: (Work)_____ (Home)_____ (Cell)_____

I hereby authorize Clearhope Counseling Center and its associates to use Google Meet, Zoom, Doxy.me, Vsee.com and other HIPPA compliant platforms for telecommunication as a means for psychotherapy. I further attest that since I have chosen this form of communication, I have been advised that it may not be covered by my insurance company and that I am responsible for any fees incurred during psychotherapy which incorporates telecommunication.

I understand that I may revoke this authorization at any time by giving written notice, except to the extent Clearhope Counseling Center has already taken action in reliance on it. I may specify the date, event, or condition on which this consent expires. If none is stated, and if no prior notice of revocation is received, this consent will expire one year after the date it was initiated.

_____ _____

Client's signature (age 12 and older) Date

_____ _____

Parent/guardian of minor OR of legally disabled recipient Date

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Notice of Compliance with The Consolidated Appropriations Act of 2021 and the “No Surprises Act”

Effective January 1, 2022, a ruling went into effect called the **"No Surprises Act"** which requires practitioners to provide a **"Good Faith Estimate"** about out-of-network care.

Under Section 2799B-6 of the Public Health Service Act (PHSA), health care providers and health care facilities are required to inform individuals who are not enrolled in an insurance plan or a Federal health care program, or not seeking to file a claim with their plan, that prior to service and upon request they are entitled to receive (both orally and in writing) a "Good Faith Estimate" of expected charges.

Note: The PHSA and GFE does not currently apply to clients who are using insurance benefits, including "out of network benefits" (i.e., submitting superbills to insurance for reimbursement). However, we are furnishing this information to all clients so that you may understand your estimated charges in the event that your health insurance expires, or you choose to become a cash pay client. These charges would also apply if you received services after the expiration of your health insurance plan and did not give us prior notification of the expiration.

Disclaimer

This Good Faith Estimate shows the costs of services that are reasonably expected for your mental health care needs. The estimate is based on information known at the time the estimate was created. The good faith estimate is not a contract and services can be discontinued at any time.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could require more sessions depending on your progress. Any changes to the treatment plan will be discussed with the therapist as needed.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill. You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call 800-985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 800-985-3059. Keep a copy of this Good Faith Estimate in a safe place.