Generations Counseling

5988 Mid Rivers Mall Drive
Saint Charles, Missouri 63304
(636) 229-5679

CLIENT INFORMATION *(Please Print)*

Last Name:	**First:**	**Middle:**	**Gender** ❑ Male ❑ Female	**Marital status** (circle one) Single / Mar / Div / Sep / Wid / Remarried

Is this your legal name? ❑ Yes ❑ No	**If not, what is your legal name?**	**(Former or Maiden name):**	**Birth date:** / /	**Age:**	**Sex:** ❑ M ❑ F

Street address:	**Home phone:** ( )	**Cell phone:** ( )

P.O. box:	**City:**	**State:**	**ZIP Code:**

Email address:	**Please indicate preferred method of contact:** ❑ Cell Phone ❑ Email ❑ Home Phone ❑ Mail	**Is it okay to leave a voice message?** ❑ Yes, you may call and leave a message ❑ You may call, but do not leave a message ❑ No, please do not call unless in an emergency

Do you attend church? Please choose the option which best describes your situation:

❑ I attend a local church:_____ ❑ No, I do not attend a church

Employer:	**Position:**	**How long employed?**

Emergency Contact:	**Relationship:**	**Contact Phone:**

Were you referred to Generations Counseling? If so, by whom?

Are you currently seeing (or have you in the last two months) a counselor or therapist? ❑ Yes ❑ No

If yes, please tell me a bit about it:

PARTNER/PARENT INFORMATION

Last Name:	**First:**	**Middle:**	**Gender** ❑ Male ❑ Female	**Email Address:**

Home Phone: ( )	**Cell phone:** ( )	**Business phone:** ( )	**Birth date:** / /	**Age:**	**Sex:** ❑ M ❑ F

Do you attend church? Please choose the option which best describes your situation:

❑ I attend a local church:_____ ❑ No, I do not attend a church

Employer:	**Position:**	**How long employed?**

Children (please list names and ages):

What is your current struggle? Please check **all** that apply.

❑ Anxiety
❑ Depressed Mood/Sadness
❑ Eating Disorder
❑ Sexual Issues
❑ Substance Abuse
❑ Marriage Issues
❑ Children Issues
❑ Family Issues
❑ Victim of Abuse (past)
❑ Victim of Abuse (current)
❑ Spiritual Confusion
❑ Vocational Issues
❑ Financial Issues
❑ Other: _____

What is happening in your life that has caused you to seek counseling?

Please tell us about your symptoms by indicating how severe they have been over the last week.					
	None	Mild	Moderate	Severe	Worst I can imagine
Depression					
Anxiety					
Panic Attacks					
Thoughts of Suicide					
Drug/Alcohol Use					
Marital Distress					
Compulsive Behavior Issues					

Is there anything else you would like to tell us about your situation?

SERVICES AND PAYMENT POLICIES

As you come in for counseling, you probably have preliminary questions about services, costs and billing. Those questions are appropriate, respectful, and welcome.

Please initial next to each statement.

____ **Services and Payment:** Counseling sessions usually run 50 minutes, allowing 10 minutes for the necessary administration of your records and account. Payment is expected at the beginning of the session and will be accepted in the form of **cash, check or credit card**. Except in cases of an emergency, your counselor will provide at least 24 hours advanced notice should an appointment need to be canceled or rescheduled. If the fee is a hindrance to you, please ask about scholarships that may be used to help.

____ **Missed Appointments:** Your cooperation in keeping scheduled appointments is not only appreciated, but also necessary and expected. If you cannot be present for an appointment, please notify your counselor at least 24 hours in advance to avoid being charged for the appointment.

____ **Emergency Contact:** I give permission for my counselor to contact my emergency contact and notify them of any possible threat I may pose to either myself or others.

CONSENT FOR TREATMENT & CONFIDENTIALITY

We are committed to do everything possible to guard any information our clients entrust to us. However, there are times when we are legally required to share information with others. Some exceptions to confidentiality include, but are not limited to the following:

1. We are informed of alleged or suspected child/elder abuse or neglect committed by or experienced by the client or by a specifically identified individual.
2. The client is a perceived threat to themselves or others. Every effort will be made to resolve these issues before such a violation of confidentiality takes place. Every effort will be made to prevent an attempted suicide or a dangerous action against another person.
3. The counselor is subpoenaed and ordered by a judge to testify or release client information.
4. The client or parent/legal guardian of the client provides a valid, written consent to release information to a third party.
5. The parent/legal guardian of an individual under the age of 18 requests information about the child.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have. Where possible, we attempt to discuss the situation with our clients and obtain informed consent to release information before any action is taken. We may also confidentially consult with appropriate professional colleagues to seek greater wisdom in order to provide our clients with the best possible counsel.

Professional Consultation: In following ethical and professional standards, our therapists consult with other professionals to gain other perspectives and ideas on how to best serve you. We may confidentially consult with appropriate professional colleagues to seek greater wisdom in order to provide our clients with the best possible counsel. Unless you have signed a release, no identifying information is shared during these consultations. **Please Note:** Counselors who are pursuing licensure in the state of Missouri are required to consult regularly with their supervisor.

CONSENT TO COUNSELING

By signing below, I understand that I am signifying that I have read the information in this document and agree to abide by its terms during the professional relationship with my counselor. If I am not benefiting from counseling my counselor will provide me with one or more referrals that may better serve my needs. I understand that I am free to leave counseling at any time.

I understand my counselor is in supervision with _____.

I am entering counseling relationship with _____.

I agree to a counseling fee of **$**_____ per hour.

_____ _____
Client Signature Date

_____ _____
Client Signature Date

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Counselor Signature Date

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NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Protecting your confidential health information is important to me.

Federal and state law requires that your health care information remain private and protected. The law also requires me to give you this Notice about my privacy practices, my legal duties, and your rights concerning your health care information. I must follow the privacy practices described in this Notice while it is in effect. This Notice takes effect July 2, 2014, and will remain in effect until I replace it. Additional copies of this Notice are available upon request.

I reserve the right to change my privacy practices and the terms of this Notice at any time, provided that applicable laws permit the changes. Before I make any significant changes to my privacy practices, I will provide a new Notice to you for your information and consent.

I. Definitions

- Protected Health Information (PHI): Your health care record and any information that could be used to identify you.
- Treatment: When I provide, coordinate, or manage your health care and other services related to your health care, such as when I consult with another health care provider.
- Payment: When I obtain reimbursement for your health care, including if I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility for coverage.
- Health Care Operations: Activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits and administrative services, and case management and care coordination, when applicable.
- Uses: Applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- Disclosure: Applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.
- Authorization: Written permission above and beyond the general consent that permits only specific disclosures of your PHI.

II. Uses and Disclosures of Health Information

I use and disclose health care information about you for treatment, payment and health care operations.

Uses and Disclosures Requiring Authorization

I may use or disclose your PHI for purposes outside of treatment, payments, or health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization to already disclose your PHI, or (2) your insurer has a legal right to your PHI that you authorized me to disclose in order to contest a claim under the policy.

Uses and Disclosures Requiring neither Consent nor Authorization

I may use or disclose your PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If I have reasonable cause to suspect that a child has been or may be subjected to abuse or neglect, or if I observe a child being subjected to conditions that would reasonably result in abuse or neglect, I must immediately report such information to the Missouri Division of Family Services. I must also report suspected sexual abuse or molestation of a child less than 18 years of age to Family Services. I may also report child abuse or neglect to a law enforcement agency or juvenile office.
- *Adult and Domestic Abuse* – If I have reasonable cause to suspect that an eligible adult (defined below) presents a likelihood of suffering physical harm or is in need of protective services, I must report such information to the Missouri Department of Social Services. "Eligible adult" means any person 60 years of age or older, or an adult with a handicap (substantially limiting mental or physical impairment) between the ages of 18 and 59 who is unable to protect his or her own interests or adequately perform or obtain services which are necessary to meet his or her essential human needs.
- *Health Oversight Activities* – The Missouri Attorney General's Office may subpoena records from me relevant to disciplinary proceedings and investigations conducted by the Missouri Board of Healing Arts.

- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and I will not release information without written authorization from you or your personal or legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. I will make all reasonable efforts to inform you in advance if this is the case.
- *Serious Threat to Health or Safety* – When I judge that disclosure is necessary to protect against a clear and substantial risk of imminent serious harm being inflicted by you on yourself or another person, I must disclose your relevant confidential information to the appropriate professional workers, public authorities, the potential victim, his or her family, or your family.
- *Workers' Compensation* – If you file a worker's compensation claim, I must permit your record to be copied by the Missouri Labor and Industrial Commission or the Division of Worker's Compensation of the Missouri Department of Labor and Industrial Relations, your employer, you and any other party to the proceedings.

III. Patient's Rights

You have the following rights as a patient:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- *Right to Alternative Communications* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know that you are seeing me. Upon your written request, I will send your bills to another address and will accommodate all reasonable requests about communicating with you for the purposes of scheduling or canceling sessions.
- *Right to Inspect and Copy* – You have the right to inspect and obtain a copy of your PHI in my mental health and billing records used to make decisions about your care for as long as the PHI is maintained in the record. However, I may deny your access to your PHI under certain circumstances, but in some cases, you may have this decision reviewed. Upon your written request, I will discuss with you the details of the request and denial process. If you request a copy of the information, I may charge a fee for the costs of copying, mailing or other associated supplies.
- *Right to Amend* – You have the right to request an amendment of your PHI for as long as the information is kept in my records. However, I may deny your request. Upon your written request, I will discuss with you the details of the amendment process.
- *Right to an Accounting of Disclosures* – You have the right to receive an accounting of disclosures of your PHI. Upon your written request, I will discuss with you the details of the accounting process.
- *Right to This Notice* – You have the right to a paper copy of this Notice. You may request a copy of this Notice at any time.

IV. Questions and Complaints

If you have questions or concerns about your privacy rights, or if you disagree with the decisions I have made about access to your health care records, please contact me.

Notice of Privacy Practices – Written Receipt and Agreement

Your signature below indicates that you have read this agreement and agree to its terms. Your signature also serves as an acknowledgement that you have received this HIPAA Notice.

Client: _____ Date: _____

Client: _____ Date: _____

Parent/Legal Guardian_____ Date: _____

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CONSENT TO EMAIL & TEXT COMMUNICATIONS

I recognize that e-mail & text is not a secure means to transmit data. I voluntarily wave my rights provided by federal and state laws regarding confidentiality in order to send to, or receive communications (and / or invoices) from Generations Counseling via e-mail.

I voluntarily give my permission and will not hold Generations Counseling or my counselor _____ legally responsible for the transmission of this data.

Name (Print): _____ _____

Signature: _____ Date: _____

Counselor Signature: _____ Date: _____

CONSENT FOR RECORDING COUNSELING SESSIONS

I, _____, hereby give consent to my counselor, _____, at the Generations Counseling to audiotape our counseling sessions.

I give consent for my Counselor's supervisor to observe or listen to recordings of my sessions with my Counselor, even if my Counselor's supervisor is not employed by Generations Counseling. These recordings will be used to aid the counseling process and to gain further understanding of important aspects of the treatment and will be used solely for educational and training purposes.

I understand that any and all written notes and audio recordings of my sessions with my Counselor will be kept in a secure place within Generations Counseling and that access will be limited to counselors associated with Generations Counseling.

I understand my counselor will give notice of recording and that I can object or refuse to be recorded at any point during a counseling session.

I have discussed this procedure with the counselor, including the Generations Counseling Center's policy on confidentiality and I understand that refusal to sign this form will not affect my eligibility for receiving services at this agency.

Signature: _____ Date: _____

Counselor Signature: _____ Date: _____