Coralville Family Counseling

2431 Coral Court Ste. 4
Coralville, IA 52241
319-338-1052 (phone)
319-382-3109 (fax)

Katie Barreras, LISW
Farrah Bonde, LISW

Adult Intake Assessment

<table>
<tr><td colspan="2">First Name:</td><td colspan="2">Last Name:</td></tr>
<tr><td>Date of Birth:</td><td>Age:</td><td>Gender Identity:</td><td>Today's Date:</td></tr>
<tr><td colspan="4">Home Address:</td></tr>
<tr><td colspan="2">Cell Phone:</td><td>Home Phone:</td><td>May we identify ourselves?
[ ] Yes [ ] No</td></tr>
<tr><td colspan="2">Work Phone:</td><td>Email:</td><td>May we identify ourselves?
[ ] Yes [ ] No</td></tr>
<tr><td colspan="4">Coralville Family Counseling respects your right to not disclose the following information. Please use your discretion and level of comfort when answering the following questions. We have provided a self-identify (Self-ID) option in each relevant category to allow for your unique identity to be included.</td></tr>
<tr><td colspan="2">Race/Ethnicity (check all):
☐ African American/Black
☐ Asian/Pacific Islander
☐ Caucasian
☐ Hispanic/Latino(a)
☐ Native American
☐ Self-ID: _______________</td><td>Relationship Status:
☐ Single
☐ Dating
☐ Partnered, not married
☐ Married
☐ Divorced/separated
☐ Widowed
☐ Self-ID: ____________</td><td>Sexual Identity:
☐ Lesbian
☐ Gay
☐ Heterosexual
☐ Bisexual
☐ Questioning
☐ Self-ID: _____________</td></tr>
<tr><td colspan="2">Cultural preferences:</td><td>Language preference:</td><td>Religious Affiliation/ Spiritual Identity:</td></tr>
<tr><td colspan="2">Highest level of education:</td><td>Current employer:</td><td>Occupation:

Hours worked per week:</td></tr>
<tr><td colspan="3">Primary Care Physician:</td><td>Clinic:</td></tr>
<tr><td colspan="3">Psychiatrist's Name</td><td>Clinic:</td></tr>
<tr><td colspan="3">Are you being treated by any other behavioral health provider(s)?</td><td>Clinic:</td></tr>
<tr><td colspan="4">Behavioral/Mental Health Treatment History</td></tr>
<tr><td colspan="2">Agency/ Professional's name:</td><td colspan="2">Date of treatment:</td></tr>
</table>

Client Name: ____

Outcome/Response to treatment and interventions used:		
Agency/ Professional's name:	**Date of treatment:**	
Outcome/Response to treatment and interventions used:		

Current medications and dosages		
Medication and prescriber:	**Dose (per day):**	**Date prescription initially started:**
Medication and prescriber:	**Dose (per day):**	**Date prescription initially started:**
Medication and prescriber:	**Dose (per day):**	**Date prescription initially started:**
Is the medication regime followed? [ ] YES [ ] NO **Is the medication working? [ ] YES [ ] NO**	**Any problematic side effects?**	
List all allergies, adverse reactions/sensitivities to food, drugs, and other substances:		
List family medical history concerns/issues:		
List all previous medical and mental health diagnoses:		
List dates of diagnosis and providers of previous medical treatment:		
List current medical concerns and current treating clinicians:		

History				
	Yes	**No**	**Uncertain**	**Explanation:**
Have you ever been in trouble legally, or are you experiencing legal concerns now?				
Any family history of chemical dependency?				
Any family history of mental illness?				

Client Name: ____

Have you ever been physically abused?				
	Yes	**No**	**Uncertain**	
Have you ever been sexually abused?				
Have you ever been emotionally abused?				
Have you ever experienced a traumatic event?				
Have you been diagnosed with a disability?				
Have you ever been hospitalized for psychiatric issues?				
Have you ever been hospitalized for substance use issues?				**Date(s), substance type, outcome:**
Have you ever seriously considered/attempted harming yourself?				**Date(s), method, access:**
Have you ever seriously considered/attempted harming someone else?				**Date(s), method, access:**
Have you ever abused another person?				

Substance use				
	Yes	**No**	**Amount**	**Have you in the past?**
Do you currently use alcohol?				
Do you currently use nicotine?				
Do you currently use caffeine?				
Do you currently abuse non-prescription medication?				

Client Name: ____

Do you currently abuse prescription medications?				
Do you currently use illicit drugs?				
If an active smoker, are you ready to quit or reduce tobacco use?				

<table>
<tr><td colspan="2" align="center">Substance abuse treatment history/ if applicable</td></tr>
<tr><td colspan="2">Date and type of treatment(s) participated in:</td></tr>
<tr><td colspan="2">Length of current relapse, if applicable:</td></tr>
<tr><td colspan="2" align="center">Other people living in your home?</td></tr>
<tr><td>Name: ___________________________________
Gender identity:___________
Age: ________________
Relation: __________________________</td><td>Name: ___________________________________
Gender identity:___________
Age: ________________
Relation: __________________________</td></tr>
<tr><td>Name: ___________________________________
Gender identity:___________
Age: ________________
Relation: __________________________</td><td>Name: ___________________________________
Gender identity:___________
Age: ________________
Relation: __________________________</td></tr>
<tr><td colspan="2" align="center">Please answer the following questions</td></tr>
<tr><td colspan="2">Describe your relationship with your spouse/ significant other:</td></tr>
<tr><td colspan="2">Describe your relationship with your family and/or children:</td></tr>
<tr><td colspan="2" align="center">Personal short answer</td></tr>
<tr><td colspan="2">What event (s) prompted you to seek treatment at this time?</td></tr>
</table>

Client Name: ____

List additional family stressors or concerns at this time (Mental, physical, emotional health of other family members, employment, housing, financial, recent losses, etc.):
What changes would you like to see in yourself?
What changes would you like to see in your significant other and/or family?
Please list your strengths, skills and abilities:
What is your current motivation level?
Are you having any educational concerns or struggles?
What risk factors would prevent you from making changes? **(Please check ALL that apply)** **[ ] Noncompliance with treatment** **[ ] Number of multiple behavioral diagnosis** **[ ] Immediate risk of harm to self** **[ ] Immediate risk to harm someone else** **[ ] Immediate risk of harm to animals** **[ ] Immediate risk of harm to children** **[ ] Suicidal/homicidal thoughts** **[ ] Substance abuse** **[ ] Elopement potential** **[ ] Other, please explain:**
Resources and Referrals
List current resources (e.g. - family, friends, non-profit organizations, support groups, social services, school based services, government assistance, etc.):
Referrals needed (e.g. – housing, food, psychiatry, support groups, relapse prevention, gambling intervention, stress management, wellness programs, lifestyle changes, academic, etc.):
Emergency Contact- Do Not Leave Blank
Name:

Client Name: ____

Phone:	
Home address:	
Provide Insurance Information or Insurance Card(s)	
Primary insurance: **Insurance Phone #:** **Employer of Insured:**	
Policy holder name: **DOB:**	
ID#	**Group #**
Secondary Insurance: **Employer of Insured:**	
Policy holder: **DOB:**	
ID#	**Group #**

In consideration of the health care services provided to the client,

I ________________________ assign and authorize my insurance company, or other third party payor to make payments directly to Coralville Family Counseling.

Specific authorization for release of information

I specifically authorize Coralville Family Counseling to submit medical information regarding diagnoses, treatment, consultations, prescriptions, and medical history to my insurance company, or other third party payor or its authorized agents or representatives for the purpose of determining benefits and facilitating payment. I may revoke this specific consent to release information at any time by sending a written notice to Coralville Family Counseling, 2431 Coral Court, Suite #4, Coralville, Iowa 52241. I understand that the information to be released may include mental health related information unless I specifically deny the release.

Printed Name:	
Signature:	**Today's Date:**

Acknowledgment of Notice of Privacy Practices

I acknowledge that I am aware the Provider's Notice of Privacy Practices is available in the lobby at Coralville Family Counseling for me to review. The Notice of Privacy Practices describes how identifiable health information may be used and disclosed and states my rights with respect to my medical information.

I understand that Coralville Family Counseling has the right to revise these polices and to amend the Notice of Privacy Practices. I understand that in the event that the notice is revised, the revised notice will be available at Coralville Family Counseling. At any

Client Name: ____

time, upon request, I may obtain a copy of the Privacy Practices. *If for a child, your signature indicates that you have legal guardianship to sign for this minor.*	
Print Client's Name:	Date of Birth:
Signature of Client /Legal Representative:	Today's Date:
Staff Member/ Witness:	Date:

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Consent for Treatment

Before you start counseling there are some things that you should know. Legally this information is called "Informed Consent." Informed Consent will help you understand better what to expect and will explain some limitations about what we will be doing.

Confidentiality

Of course, all of our work together—our conversations, your records, and any information that you give us—is protected by something called privilege. Our office respects your privacy, and we intend to honor your privilege. However, there are some limits to your legal privilege, some expectations you should understand before we start. If we believe there is a risk that you might harm yourself or someone else, we may be required to contact the authorities or the other person to give them the opportunity to protect you or the other person. If you are abusing children or elderly people, we are required by law to notify the authorities, so they can protect others from harm. Also, if you become involved in any lawsuit in which your mental health is an issue—for example, a child custody dispute or an injury lawsuit in which you claim compensation for emotional pain and suffering –then the court or the lawyers may insist upon, and may obtain your information from us. Similarly, you would lose the protection of your privilege if you file a complaint against our office with the state licensing board.

The financial part of our relationship also imposes some confidentiality limits. If you are using insurance or another third party payer, our office must share certain information with them, including (but not necessarily limited to) your diagnosis and the times of your visits. If there is a managed care company, they may require us to provide additional information, such as your symptoms and your progress. You should also understand that insurance and managed care information is often stored in national computer databases. If we find ourselves in a dispute with you over billing, our office may only provide the information necessary to clarify and to collect any outstanding balance. Coralville Family Counseling will use good faith efforts to protect the patient's right to confidentiality in providing health information to payors.

Risks

You or your child may be suffering from a condition(s), which requires Mental Health services, diagnosis, and or treatment; you voluntarily consent to and authorize services, including psycho education, EMDR therapy, play therapy, cognitive behavioral therapy, narrative therapy, guided imagery, and services that the therapist may deem necessary. You acknowledge that as the patient or as the participant/guardian of a child in services you are aware that there are risks to participating in mental health treatment. You acknowledge that no guarantees have been made to you or anyone else on your behalf, as to the results of such services and procedures. You acknowledge that you have received information regarding the service(s) descriptions and have had all of your questions regarding the service answered to your satisfaction.

You should know that counseling is not always easy. You may find yourself having to discuss very personal information. You could find those conversations difficult and embarrassing, and you might be very anxious during and after such conversations. As you learn more about yourself, you might encounter increased conflict with friends, co-workers, and family members. It is possible that you might become somewhat depressed. Counseling is intended to alleviate problems and improve level of functioning, but sometimes, especially at first, and as you get to the root of some things, you may feel them even more acutely than in the past. We may also ask you to do some things that might, at first, make you feel awkward or uncomfortable. Sometimes counseling requires trying new ways of doing things. You will always be free to move at your own pace. We will challenge you and your old ways of thinking and doing things, but we cannot offer any promise about the results you will experience. Your outcome will depend upon many things.

You acknowledge that during treatment, you/your child may have new insights and or new disturbing information may come to the patient's attention in the form of images, thoughts, affect, or sensations. You understand that it is your responsibility to share these reactions with the therapist and your physician.

If we believe that your problems require knowledge that we do not have, we may refer you for a consultation or treatment with someone with specific training or experience. We will discuss any such referral with you before we act. At the very beginning we will create a treatment plan with you. That is, we will look at what you would like to change, what we will do to change it, how we will know you are succeeding, and how long it will take. Every now and again, we will review that plan to see if it needs to be updated.

By signing we are stating that we understand and agree to the process and to the above mentioned information.

Print Client's Name:	Date of Birth:
Signature of Client / Guardian/ Representative:	Today's Date:
Staff Member/ Witness:	Date:

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Client's Responsibilities & Rights

Client's Responsibilities: Regarding your care during mental health treatment, you are responsible for:

- Providing accurate and comprehensive information about all matters pertaining to your health, including medications and past or present medical problems.
- Reporting changes in your condition or symptoms to your therapist and primary care physician.
- Following the instructions and advice of your health care team.
- Identifying and discussing any safety concerns that may affect your care.
- Informing your therapist or physician if you do not understand information about your care or treatment.
- Informing your mental health therapist if you are not satisfied with any aspect of your care.
- Participating in the planning of your care, including discharge planning.
- Keeping your scheduled appointments or cancelling appointments with 24-hours advanced notice; patient may be discharged after two missed appointments without 24-hour advanced notice.
- By providing your e-mail address to our staff you assume risks regarding confidentiality that may arise by using electronic correspondence. You must provide written notice to Coralville Family Counseling if you do NOT want e-mail correspondence at your work or home e-mail accounts (when the e-mail address is given to staff or staff receives e-mails from you).
- Providing supervision or childcare arrangements to appropriately supervise any child that needs to wait in the lobby while the parent/legal guardian/legal representative is participating in services in another room.
- Paying all charges, copayments, deductibles and co-insurance not covered by insurance or third party payor or as a result of lack of insurance coverage.
- Paying for all non-covered services as a result of failure to obtain pre-authorization for treatment as required by your insurance.
- Paying for Therapist's attorney fees in the event you wish to resist a subpoena for your records.

Client's Rights:

- As a client, you have the right to receive information from your mental health therapist about that therapist's education, training, experience, and credentials. As a client, you have the right to be informed about the options available for treatment interventions and the effectiveness of the recommended treatment.
- As a client, you have the right and responsibility to fully participate in all decisions related to your health care. Clients who are unable to fully participate in treatment decisions have the right to be represented by parents, guardians, legal representatives, or family members. You have the right to change your mental health therapist at any time. You have the right to a second opinion if you should choose to do so.
- As a client, you have the right to request and receive information about the methods you may use to submit complaints or grievances regarding provision of care by your mental health therapist. Clients using services, and their guardians, have the right to appeal the application of policies and procedures, or any staff action that affects the individuals utilizing the services. If you wish to appeal or file a grievance, you may file a written grievance or appeal to your direct mental health therapist. The Coralville Family Counseling staff has 30 days to provide a response to the appeal or grievance. Clients who express a concern or complaint, or file a grievance, will not have their future access to care compromised in any way. To share a concern or complaint, please contact any staff member or your direct mental health therapist who can speak with you about your concern.
- Recommendations regarding mental health treatment shall be made only by a licensed mental health therapist in conjunction with you and your family as appropriate. As a client, you have the right to make final decisions regarding your treatment. If a client misses a session and/or doesn't return for 30 days, we will assume your therapy has been terminated.
- Our telephone is answered twenty-four hours a day by a mechanical answering system. Through the day, we check messages regularly, and whenever possible we try to return phone calls the same day. If we have not returned your call within twenty-four hours, please try again as your message may have been lost. If you have an emergency and are unable to reach us, call 911, or go to an emergency room.
- Quality mental health services should be provided to you without regard to race, color, religion, national origin, gender, age, sexual orientation, or disability. You have the right to considerate, respectful care from all staff members of Coralville Family Counseling at all times and under all circumstances. An environment of mutual respect is essential to maintain a quality treatment relationship.

Advanced Directives

- During the client's initial intake appointment, all clients/guardians/legal representatives of clients have been given the opportunity to discuss their desire for information regarding an Advanced Directive. All client's that wish to be given more information about advanced directives will be given information on how to develop or obtain an Advanced Directive.
- It is necessary for you to sign that you have read and received this notice of Responsibilities and Rights and return this form to us.

By signing this, I acknowledge receipt and understanding of the above stated information regarding my responsibilities and rights. If I need clarification on any item, I will contact Coralville Family Counseling at (319) 338-1052 for clarification, before signing.

Print Client's Name:	Date of Birth:
Signature of Client / Guardian/ Representative:	Today's Date:
Staff Member/ Witness:	Date:

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CONSENT FOR TELEHEALTH & DIGITAL COMMUNICATION

I understand that my therapist has agreed to engage in telehealth sessions with me.

I acknowledge that the video conferencing technology that will be used to conduct therapy will not be the same as direct client/provider visits as I will not be in the same room as my therapist.

I understand that a telehealth session has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.

I understand there are potential risks to this technology, including but not limited to interruptions, unauthorized access, limits to confidentiality, and technical difficulties. I understand that my provider or I can discontinue the telehealth session if it is felt that the video connections are not adequate for the situation.

I understand telehealth is NOT an Emergency Service. In the event of an emergency, I will use a phone to call 911.

I agree to be in a quiet, private space that is free from distractions during the session.

I know I should use a secure internet connection rather than public or free Wi-Fi.

It is important to be on time. If I need to cancel, I will give at least 24 hours' notice to cancel or reschedule my appointment.

I understand that I should confirm with my insurance company that the video sessions will be reimbursed, if they are not reimbursed, I am responsible for the full payment.

I acknowledge, my therapist or myself may deem telehealth services as not appropriate and these services may be terminated and face to face sessions may be recommended instead.

I will not share my telehealth appointment link with anyone unauthorized to attend the appointment or record the session without the permission from the provider.

By signing this form, I certify:

That I agree to the above-mentioned policies and procedures.

That I fully understand its contents including the risks and benefits of these services.

That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Client Name: ____________________________________ Date: ______________________

Signature of Client/Client's Legal Representative: ____________________________________

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

____________________________________ ____________________
Name of patient *Patient Date of Birth*

I, ______________________________, hereby give permission to Coralville Family Counseling to:
Name *of patient/legal representative*

__ **Disclose information to:** AND/OR __**Obtain information from:**

____
(Name of agency, attorney, school counselor, therapist, etc.)

____
Street *City* *State* *Zip Code*

____
Phone

I do______ /I do not ______ authorize the release of my/my child's protected mental health information.

I authorize release of my and/or the patient's: ___ **ENTIRE RECORD; OR**
___ **Only the following information:** (Patient must initial each item to be released/obtained)
___ Substance Abuse Information
___ Treatment Recommendations
___ Attendance Records Only
___ Psychological Testing or Evaluations
___ Other (specify): ______________________
___ Diagnosis / Assessment
___ Treatment Plan
___ Progress Report of Treatment
___ Educational Reports/Testing

I understand that the time frame within which this release of information is applicable is one year from the date signed unless otherwise specified here: ____________

In consideration of this consent, I hereby release the source of the records from any and all liability arising there-from.

I understand that no services will be denied to me and/or the patient solely because I refuse to consent to this release of information, and that I am not in any way obligated to release these records. I do release them because I believe that they are necessary to assist in the development of the best possible treatment plan for me and/or the patient. The information disclosed may be used in connection with my and/or the patient's treatment. I understand that I can request to view the information that is disclosed.

I have been informed of the risks to privacy and limitations on confidentiality of the use from electronic means of information transfer, and I accept these.

I affirm that everything in this form that was not clear to me has been explained. I also understand that I have the right to receive a copy of this form upon request.

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it. I fully understand all of the above information and my consent on this form is freely given.

____
Signature of patient/parent or legal guardian Date

____
Witness Date

NOTICE TO RECIPIENT OF INFORMATION
This information has been disclosed to you from mental health records; the confidentiality of which may be protected by federal and/ or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

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Credit Card Policy and Authorization

Our office policy is that a credit card is on file in our office as a backup for any unpaid charges. No charges will be made to your card if you pay in full during your appointment. Any charges incurred and not paid at the time of the appointment will result in a charge to your credit card. Additionally, if you "no show" to an appointment or fail to cancel two appointments with at least a twenty-four-hour notice, your card will be charged a fee of $50 for each missed session. You have a right to see a summary of charges to your account and will be provided a copy of the receipt upon request.

Client Name: ____________________________________ Date of Birth: ________

Card Type: ____ Visa ____ Mastercard ____ Discover
Card Number: ____________________ Expiration: ______ Security Code: _____
Name as it appears on card: ____
Billing Address: ____
State: ______________ Zip Code: __________ Phone: ______________________

I (printed name) ____ authorize Coralville Family Counseling to charge payments for services to the credit card indicated on this form.

This charge card will be used for the unpaid balance of the client charges unless other payment arrangements are made.

____ ______________________
Signature of Cardholder/Responsible Party Date