INTAKE INVENTORY

Redemption CHRISTIAN COUNSELING

730 Emerson Dr. NE
Palm Bay, FL 32907
(321) 626-4095

TODAY'S DATE:	THERAPIST:	REFERRED BY:

GENERAL INFORMATION

Name:	Email:

Street Address: City, State, Zip:

Home Phone:	Cell Phone:	Work:
May we leave a message for you at home, cell, email or work?		**Do you check it frequently?**

Age:	Date of Birth:	Sex:
Last year of school completed:		
Degree pursued/accomplished:		
Are you currently in school:	If yes what level?	

Employer:	Length of Employment:
Occupation:	Hours per week:

RELATIONAL INFORMATION

Current marital status:		
Are you content with your current status:		
If no please explain:		
If you are married, for how long:	Previous marriages for you:	For your spouse:
If separated, for how long:	If widowed, for how long:	

With whom do you live (Circle all that apply):
Alone Spouse Children Parents Siblings Boyfriend Girlfriend Other_____

PARTNER INFORMATION

Name:		How long have you known your partner?
Occupation:	Age:	Education Level:
What words would you use to describe this person?		

CHILDREN:

NAME	SEX	CURRENT AGE OR YEAR OF DEATH	RELATIONSHP TO YOU NATURAL/ADOPTED/STEP	LIVING WITH YOU	DESCRIBE HIM/HER

FAMILY OF ORIGIN:

Please list mother, father, siblings, step-family relations or any other family member who had a significant effect upon your life, either positive or negative.

NAME	RELATIONSHIP TO YOU	CURRENT AGE OR YEAR OF DEATH	OCCUPATION	LIVED WITH YOU?	DESCRIBE HIM/HER

PHYSICAL HISTORY

Name of Physician:	Phone:
Specialty (Family Practice, OB/GYN, etc.)	
Address:	
Are you currently receiving any medical treatment: (If yes please explain):	

Please list any conditions, illnesses, treatments, or surgeries (including pregnancies, or related treatments) that might be relevant to your reason for seeking counseling:

Please list all current medications you are taking and the reasons (List even if you seldom use, or take only as needed.)

1.
2.
3.
4.
5.
6.

Are you taking these medication(s) according to the doctor's recommendations?

Please check the box next to any of the following physiological symptoms/sensations that apply to you currently, or in the recent past:

Headaches		Tension		Dizziness		Tiredness:	
Stomach Trouble		Intestinal Trouble		Difficulty Breathing		Visual Trouble	
Trouble with Sleep		Change in Appetite		Trouble Relaxing		Rapid Heart Rate:	
Weakness		Hearing Voices/Noises					
Pain(Specify):		Other:					

Current weight: Height:

Has your weight changed in the last 2-3 months, if yes, please explain:

CURRENT STATUS

Please mark any of the following problems, which pertain to you and/or your family.

STRESS	NERVOUSNESS	ANXIETY	PANIC
UNHAPPINESS	DEPRESSION	GUILT	APATHY
TERMINAL ILLNESS	RECENT DEATH IN FAMILY	GRIEF	HOPELESSNESS
INFERIORITY FEELINGS	DEFECTIVENESS FEELINGS	LONELINESS	SHYNESS
FEARS	FRIENDS	MARRIAGE	COMMUNICATION
PHYSICAL ABUSE	EMOTIONAL ABUSE	VERBAL ABUSE	SEXUAL ABUSE
TEMPER	ANGER	AGGRESSIVE BEHAVIOR	BAD DREAMS
CONCENTRATION	RACING THOUGHTS	UNWANTED THOUGHTS	MEMORY DIFFICULTIES
LOSS OF CONTROL	IMPULSIVE BEHAVIOR	SELF CONTROL	COMPULSIVITY
SEXUAL PROBLEMS	PREGNANCY	ABORTION	LEGAL MATTERS
TRAUMA/DISASTER	EATING PROBLEMS	DRUG USE	ALCOHOL USE
TROUBLE WITH JOB	CAREER CHOICES	AMBITION	MAKING DECISIONS
CHILDREN	BEING A PARENT	FINANCES	OTHER:

Please indicate by marking an X on the scale below how distressing your problem(s) are to you.

Very Little Distress Extremely Distressed

Are you currently experiencing any suicidal thoughts:
Have any of your friends or family ever committed or attempted suicide:
If so, briefly describe when and under what circumstances:

PRESENTING ISSUES AND GOALS

Please describe why you are coming to counseling:

What is it that you hope to gain or change by coming for counseling?

How long do you believe counseling should last?

What words would you use to describe yourself?

If I were to ask God to describe you, what would He say?

Please describe briefly the religious environment of your home as you were growing up

Complete the following thought. **GOD IS…….**

Do you regularly attend church, synagogue, or another religious institution?

If so, what is the name of your church, synagogue, etc.:

If so, what is the name of your pastor, priest, rabbi, etc.:

I understand that it is customary to pay for professional services when rendered. I accept full responsibility for payment of my balance incurred for services rendered. I further understand that without 72-hour notice of intention to cancel, I will be charged the full fee for professional service.

Signature: **Date:**

GENERAL PROCEDURES AND AGREEMENTS FOR COUNSELING

General Information

Counseling is a cooperative venture with the responsibility on both the counselor and the client. There are no guaranteed outcomes and often the healing process is tumultuous. In order to enable you and your counselor to work most effectively together, we ask that you carefully read the information below. If you have any questions, your counselor will be happy to discuss them with you.

Confidentiality

The preceding information is requested to assist us in becoming better acquainted with you, so that we may provide the help you need. All the information gathered is confidential and will remain in your file. No individual or institution will be contacted without your prior knowledge and consent. All sessions are ethically held in confidence, except where affected by state law such as in situations of child abuse or threats of physical harm to self or others.

Fees

The standard fee for a 50 minute session is $120. If you are undergoing a financial crisis you may qualify for a reduced fee. If this is the case, please ask your counselor for a scholarship form. If you have any questions regarding your fee before your visit please give us a call and we can give you the exact amount due for your session. Full payment by cash or check is required at each session unless both you and your counselor agree upon an alternative payment schedule.

Cancellations

We require a 72-hour notice be given to cancel an appointment. This courtesy on your part makes it possible to give your time to another client. The full fee will be charged for appointments canceled without 72-hour notice, except in cases of emergency.

Telephone Calls

There is no charge for professional advice given over the telephone, should a brief call be necessary outside of your scheduled session. However, a prorated fee will be charged for telephone conversations lasting longer than 10 minutes. Your counselor will make you aware of this at the time of the phone call as you reach the end of your allotted time. Telephone calls will be returned as the counselor's schedule permits. If you are in crisis, please make that clear in your message, including appropriate details, and your counselor will contact you as soon as possible.

Insurance

The counseling office of Redemption Christian Counseling will give a receipt, if requested by you, for counseling services. It is the responsibility of each client to file with their insurance company.

_____ _____

Signature of Adult Client **Date**

_____ _____

Signature of Minor Client's Guardian **Date**

NOTICE OF PRIVACY PRACTICES

Redemption CHRISTIAN COUNSELING

730 Emerson Dr. NE
Palm Bay, FL 32907
(321) 626-4095

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. If you have any questions about this notice, please contact our office at the number listed above. This notice is effective as of April 14, 2003.

OUR OBLIGATIONS

We are required by law to:
Maintain the privacy of protected health information.
Give you this notice of our legal duties and privacy practices regarding your health information.
Follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.
Without specific authorization, we are permitted to use and disclose your health care records for the purposes described as follows.

Treatment: We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care.

Payment: We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received.

Health Care Operations: We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. We may also share information with other entities that have a relationship with you for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health Related Benefits & Services: We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individual Involved in Your Care or Payment for Your Care: When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend.

Research: Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we use or disclose Health information for research, the project will go through a special approval process. Even without special approval we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS

As Required by Law: We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or to the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates: We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services.

Organ and Tissue Donations: If you are an organ donor we may use or release Health Information to organizations that handle organ procurement or their entities engaged in procurement; banking or transplantation or organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Worker's Compensation: We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Public Health Risk: We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report birth and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products that they may be using; inform a person who may have been exposed to a disease or may be at risk for contacting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We may also disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release Health Information if asked by a law enforcement official if the information is (1) in response to a court order, subpoena, warrant, summons, or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct on our premises; and 6) in an emergency to report a crime, the location of the crime or victims or the identity, description or location of the person who committed the crime.

National Security and Intelligence Activities: We may release Health Information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may release Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state, or to conduct special investigations.

YOUR RIGHTS

You have the following rights regarding your Health Information we have about you.

Right to Inspection and Copy: You have the right to inspect and/or request a copy of Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records other than psychotherapy notes. To inspect or request this information you must make your request in writing to Kimberly Fischer, M.A., LMHC.

Right to Request Restrictions: You have the right to request restriction or limitation of Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. To request restriction, you must make your request in writing to Kimberly Fischer, M.A., LMHC. We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You can ask that we contact you only by mail or at work. To request confidential communication you must make your request in writing to Kimberly Fischer, M.A., LMHC. Your request must specify how or where you want to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice. Even if you have agreed to receive this notice electronically you are still entitled to a paper copy of this notice.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and make the new notices apply to Health Information we already have as well as any information we receive in the future. We will have a copy of our current notice in our office that you may view at any time. The notice will contain the effective date on the first page.

COMPLAINTS

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices please contact:

The Privacy Officer
Kimberly Leslie, M.A., LMHC.
Redemption Christian Counseling
730 Emerson Dr. NE
Palm Bay, FL 32907
(321) 626-4095

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
1-877-696-6775 (toll free)

RECEIPT OF PRIVACY PRACTICES

730 Emerson Dr. NE
Palm Bay, FL 32907
(321) 626-4095

PLEASE SIGN AND RETURN THIS FORM ACKNOWLEDGING YOUR RECEIPT OF PRIVACY PRACTICES

I, _____ have received a copy of Redemption Christian Counseling notice of privacy with an effective date of April 14, 2003.

Name of Client:
Address of Client:
Signature of Adult Client: Date:
Signature of Minor Client's Guardian: Date:

INFORMED CONSENT AND RELEASE OF LIABILITY

730 Emerson Dr. NE
Palm Bay, FL 32907
(321) 626-4095

Redemption Christian Counseling is committed to provide counseling with a distinctly biblical framework. Counseling Services are provided by Christian Counselor practitioners who have earned a Master's Degree in Counseling from an accredited graduate program and who have been licensed by the State of Florida as Mental Health Counselors, Clinical Social Workers or provisionally licensed by the State of Florida as Registered Mental Health Counselor Interns.

In order to initiate counseling, please read the following agreement; your signature attests that you both understand and agree to the terms contained herein.

Our Registered Mental Health Counselor Interns (R.M.H.C.I.) allow us to provide quality Christian Counseling at a reduced rate. Your Counselor Intern has completed a Master's degree in counseling from an accredited graduate school and has been registered with the Florida Department of Health as an Intern.

1. Each R.M.H.C.I. works with a Licensed Mental Health Counselor supervisor who has additional training to provide clinical supervision to the R.M.H.C.I. and is licensed by the State of Florida to do so. The supervisor will periodically review and discuss your counseling sessions in an effort to ensure you receive the best care possible. This review may include discussion, notes and constructive feedback with your R.M.H.C.I. of any topics discussed in your counseling session. If a session has been video or audio taped (with your knowledge and permission) the supervisor will also be reviewing the tape.

Your R.M.H.C.I. may ask for your permission to record the session on occasion. Please initial here (_____) if you will allow your R.M.H.C.I. to occasionally record your session(s).

2. I understand that my counseling records are kept confidential, except where disclosure is required by law or by the professional ethics of the counseling profession (e.g. child/elder abuse, serious threats of harm, HIV/AIDS reporting requirements).

3. In consideration of the benefits to be derived from the counseling, the receipt whereof is hereby acknowledged, I hereby release and forever discharge and covenant not to sue or hold legally liable Redemption Christian Counseling, Melbourne Community Church, the licensed counselors, the registered intern, the supervisors, or the staff from any and all claims, demands, damages, actions or causes whatsoever related to the counseling process.

I waive any right I may otherwise have to seek to use the record of my counseling with Redemption Christian Counseling as evidence in any judicial proceeding or to compel the testimony of any licensed counselor, counselor intern, or supervisor providing counseling to me through Redemption Christian Counseling.

If you have any questions at this time, please discuss them with your counselor before signing.

I hereby read and understand the preceding information and agree to the policies of Redemption Christian Counseling, as stated. I understand that these comments are prerequisite to my receiving and continuing counseling through Redemption Christian Counseling.

_____
Printed Name of Client

_____ _____
Signature of Adult Client Date

_____ _____
Signature of Minor Client's Guardian Date

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Redemption CHRISTIAN COUNSELING

730 Emerson Dr. NE
Palm Bay, FL 32907
(321) 626-4095

I, _____, give my authorization to use or disclose my protected health information as described below.

I understand that I may revoke this authorization at any time by giving written notice to your Privacy Officer, Kimberly Fischer, M.A., LMHC.

I authorize the office to contact me in the following manner:

Home Phone:	Leave message with detailed information: Leave a call back number only:
Work Phone:	Leave message with detailed information: Leave a call back number only:
Cell Phone:	Leave message with detailed information: Leave a call back number only:

Home Address:

OK to receive mail at my home address: YES or NO

I understand that under the HIPPA regulations, my health information will be used and disclosed to any health care provider who is directly or indirectly involved with my medical treatment or services, my health insurance plan, and any medical billing clearinghouse who is involved with your insurance claims fulfillment or direct billing.
Under these new regulations the **following people must be authorized** by you to have access to your health information: your spouse, other family members, and friends; legal guardian or other person/organization who is not involved with your medical treatment, insurance plan or payment.

Below please list the people/organizations that you authorize to have access to your information:

1. Name: Contact Phone:

Relationship to client:

2. Name: Contact Phone:

Relationship to client:

I have reviewed and I understand this Authorization. I also understand that my health information will be used or disclosed to treatment team members and health care providers associated with my case. These providers will also keep your health information confidential.

Client Signature: _____ Date:_____

GOOD FAITH ESTIMATE

730 Emerson Dr. NE
Palm Bay, FL 32907
(321) 626-4095

You are entitled to receive this "good faith estimate" explaining the cost of your psychotherapy treatment.

While it is not possible for a psychotherapist to know in advance how many psychotherapy sessions may be necessary or appropriate for a given person, this form provides an estimated cost of services provided by our office. Your total cost of services will depend upon the number of psychotherapy sessions you attend, your individual circumstances, and your particular therapist's fee. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here. This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case and the estimated cost for those services depends on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment, and you may discontinue treatment at any time. The fee for a 50 to 55-minute individual, couple, or family psychotherapy session (in person or via telehealth) ranges from $100 to $175. Most clients will attend one psychotherapy visit per week, but the frequency of psychotherapy visits that are appropriate in your case may be more or less than once per week, depending upon your needs.

Services Provided By:

Kimberly Leslie, M.A. LMHC #MH15347

Services Provided At:

730 Emerson Dr. NE Palm Bay, FL 32907

Estimated Fee Schedule:

The following schedule provides you with a good faith estimate of what you can expect to pay for weekly therapy sessions over the course of the next twelve (12) months. $100 per session = $5200 per year $110 per session = $5720 per year $125 per session = $6500 per year $140 per session = $7280 per year $150 per session = $7800 per year $160 per session = $8320 per year $175 per session = $9100 per year

Questions or Concerns?

You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate. You may contact your provider at: Redemption Christian Counseling 730 Emerson Dr. NE Palm Bay, FL 32907 (321)626-4095 http://redemptionchristiancounseling.com

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

This Good Faith Estimate shows the reasonably expected costs for your non-emergency mental healthcare treatment. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. You have a right to initiate a dispute resolution process if the actual amount charged to you substantially exceeds the estimated charges stated in this Good Faith Estimate (which means $400 or more beyond the estimated charges). 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) from 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. Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call HHS at (800) 368-1019.

BY COMPLETEING THE SPACES BELOW I AM AGREEING THAT I HAVE READ AND UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____
Printed Name of Client

_____ _____
Signature of Adult Client Date

_____ _____
Signature of Minor Client's Guardian Date