Kimberly Peterson, MS LPC *Individual, Couple, & Family Counseling*

1830 N Lakes Place
Meridian, ID 83646
Tel: (208) 649-4806
kimpeterson@myboisetherapy.net

INDIVIDUAL INTAKE FORM

Welcome! Please take a few minutes to fill out this form. The information will help me to better understand your situation as well as potential solutions in helping you get your life back on track. Please note - the information is confidential, for our use only, and will not be released to anyone without your written permission.

Personal Information

Client Name: ________________________Date of Birth: _____________ Age: ______ SSN: _____________

Street Address: ____________________________ City/State:____________________ Zip Code: _________

Sex: ☐ Female ☐ Male Religious Affiliation (if any): ___________________

Home Phone___________________ Is it okay to leave a message? ☐ Yes ☐ No

Work Phone___________________ Is it okay to leave a message? ☐ Yes ☐ No

Cell Phone____________________ Is it okay to leave a message? ☐ Yes ☐ No

Email Address: _____________________________May we e-mail you? ☐ Yes ☐ No

In an emergency, who do we call? Contact Name: ___________________ Contact Phone: _______________

Employer: ____________________ Length of Employment: _________Occupation:___________________

Highest Level of Education Completed: _____________________

Insurance Information:

Name of Insurance Company:_________________ Insurance Co. Phone # (Mental Health):______________

Policy Owner's Name: _______________________ Policy Owner's Date of Birth: _____________________

Policy Owner's SS#: _____________ Insurance ID #:__________________Policy or Group#:_____________

Policy Owner's Address (only if different than above): ____

Secondary Insurance (if applicable):

Name of Insurance Company:_________________ Insurance Co. Phone # (Mental Health):______________

Policy Owner's Name: _______________________ Policy Owner's Date of Birth: _____________________

Policy Owner's SS#: _____________ Insurance ID #:__________________Policy or Group#:_____________

Policy Owner's Address (only if different than above): ____

Please be prepared to provide our office staff with your insurance card so that we may make a copy.

Social / Family Information

Which best describes you? Choose all that apply: ☐Never Married ☐ Married ☐ Separated ☐ Divorced

☐ Widowed ☐ Engaged ☐ Living Together ☐ Same-Sex Partners

If you are currently in a romantic relationship, for how long?____________. On a scale of 1 to 10 (with 10 being best), how would you rate your satisfaction with your current relationship? ______.

Do you have children? If so, please provide names and ages: ___________________________________

____

If you have listed children, with whom do they live? ____

Do you have any pets in the home? If so, what type? ____________________

List any other individuals living in your home (other than you and any children listed above):____________________

____

Medical and Mental Health History / Information

Are you currently being treated by a physician for any medical conditions? If so, please describe:

____

____

Are you currently taking prescription, over-the-counter or herbal medication? ☐No ☐ Yes; Medication name/dose:

____

____

____

Have you ever seen a Psychiatrist or other mental health provider? ☐No ☐ Yes; If yes, when? ____________

What was the focus of treatment? ____________________ Was it helpful? ☐ Yes ☐ No

Counseling Concerns

What are the issues for which you are currently seeking assistance? Please be as specific as possible.

1. ____________________ 3. ____________________

2. ____________________ 4. ____________________

What have you previously tried in order to resolve these issues (e.g. religious counseling, talking with family/friends)? Has anything been helpful?

____

____

What are some of your coping strategies?

____

____

What do you consider to be your strengths?

____

____

Counseling Goals

Goals are very important in counseling. They provide us with a focus and direction that will help me to help you. Please list the goal(s) that you hope to address and achieve in counseling. Please be as specific as possible.

1. ____________________ 2. ____________________

3. ____________________ 4. ____________________

Risk Assessment

Is there any family history of mental illness or substance abuse? If so, please list relationship & diagnosis:

____

____

Please list family, friends, support groups and community groups which are or have been helpful to you:

____

____

List any personal history of emotional, physical, and/or sexual abuse:

____

____

Has a family member or close friend ever committed suicide? ☐No ☐ Yes, (who)____________________

Have you been having any thoughts of harming yourself or others?

☐Yes ☐ No ☐ Self ☐ Other(s)

Have you ever been involved in any significant legal actions, currently or in the past (e.g.: lawsuit, probation, parole)? If so, please state who and under what circumstances:

____

____

Alcohol / Substance Use Survey

How often do you have a drink containing alcohol?

☐Never ☐ 1/month or less ☐ 2-4/month ☐ 2-4/week ☐more than 4/week

How many drinks containing alcohol do you consume on a typical day that you are drinking?

☐1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐10 or more

Do you use marijuana or other “street drugs”? (Remember, this information is confidential)

☐No ☐ Yes; what type/quantity/frequency of use:__________________________

If you prefer not to answer in writing and choose to discuss this privately with the therapist, check here ☐

Referral Source

How did you learn about this office? (Please check one and provide name as indicated):

☐Insurance Co.______________ ☐ Physician ___________ ☐ Advertising (source) ______________

☐ Internet__________________ ☐ Friend _____________ ☐ Other ______________

Thank you for taking the time to fill out this form.

Client 1 Name (please print): ____

Client 1 signature: __________________________________ Date: _____/_____/______

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Client Services Agreement

Name of Client: __________________________ Name of Responsible Party (if different): ___________________

TREATMENT:
I understand that I must be committed to attend sessions on a consistent basis in order to receive the greatest benefit from therapy. Although I may stop therapy at any time, I agree to inform my therapist of my decision **prior** to my last visit. If my therapist believes that I can receive more effective treatment elsewhere, I will be given referrals. I understand that I may not attend a session if I am under the influence of alcohol or drugs, or if I am in possession of a dangerous weapon. My signature below indicates my desire and consent to receive mental health services from Kimberly Peterson, MS LPC.

PAYMENT & INSURANCE REIMBURSEMENT:
I understand that I (the client) am fully responsible for the payment of all fees for services provided regardless of any insurance coverage I may have. I understand that it is policy that the fee for any session is payable on the day of service. *All sessions are 45 - 60-minutes in length*. The fee for an initial intake session is $140.00. Follow up session fees for individuals, couples or families is $120.

I understand that if I have insurance, Kimberly Peterson, MS LPC and/or Wellspring Counseling Services will either file the claim on my behalf or will provide me with the necessary information so that I can file the claim. I understand that I am ultimately responsible for any therapy fee(s) not covered by my insurance carrier. Co-pays and non-covered services are payable at time of service unless other arrangements have been made. In the event that insurance is billed on my (the client) behalf, I authorize payment of mental health benefits to Kimberly Peterson, MS LPC/ Wellspring Counseling Services.

CANCELLATIONS AND MISSED APPOINTMENT POLICY
I understand that unless a verifiable emergency exists, I must cancel or re-schedule my appointment **24 hours in advance**. Same-day cancellations will incur a $20 fee applied to my account and my failure to attend a scheduled appointment without cancellation (a “no-show”) will incur a $120 fee to my account. I can expect an invoice to be mailed directly to me if I do not show up or timely cancel a scheduled appointment. If I cancel appointments on a consistent basis or miss appointments consistently without reasonable cause, Kimberly Peterson, MS LPC reserves the right to refer me elsewhere for services. I understand that this policy is not meant to be punitive, but instead is to request consideration for the professionals who are providing me a valuable service. My appointment time is reserved for me at the exclusion of others who may be waiting to see the therapist. Since Kimberly Peterson, MS LPCs practice is fee for service, my late cancellation or failure to show for an appointment may result in a loss of income for the therapist.

My signature below indicates that I have read, understand, and agree to the statements made above regarding Treatment, Payment & Insurance Reimbursement, and Cancellations and Missed Appointment Policy.

Client (or responsible party’s) signature: ___________________________ Date: ______/_____/_____

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Consent for Counseling Services

Client Name: ________________________

I, ____________________________, understand that I have the right to agree to, or to refuse mental health services provided by Kimberly Peterson, MS LPC. By signing below, I am indicating my desire to receive Mental Health services from (therapist name):________________________.

Limits of Confidentiality

I understand that the contents of a counseling, intake, or assessment session are protected under the confidentiality laws of the State of Idaho. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of this office not to release any information about a client without a signed release of information. Noted exceptions are as follows:

- Signed authorization to release information to a specific individual or organization.
- Therapist determination that you may harm yourself or someone else
- Disclosure of abuse, neglect, or exploitation of a child, the elderly, or disabled
- Disclosure of professional misconduct of another mental health professional
- Court order or requirement by law to disclose information
- Prenatal exposure to controlled substances
- In the event of a client's death (the spouse or parents of a deceased client have a right to access their child's or spouse's records)
- Minors/Guardianship (parents or legal guardians of non-emancipated minor clients have the right to access the client's records)
- Insurance Companies (only information required for billing purposes)

By signing my initials next to the statements below and signing this document, I agree to the following statements:

________ I am consenting to receive mental health services from Kimberly Peterson, MS LPC.

________ I understand my right to confidentiality and the above noted exceptions.

Client 1 Name (please print): ____

Client 1 signature: ____ Date: _____/_____/______

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Consent to Use and Disclose Your Health Information (HIPPA)

This form is an agreement between you, and Kimberly Peterson, MS LPC/Wellspring Counseling Services. When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here:

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When we consult, evaluate, diagnose, treat, and/or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read this notice and are aware our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information is available to you upon request.
If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, the new information will be available In our office or you can request a copy by calling us at 208-908-6320.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will need to submit any limitation requests in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do accept them, we commit to abide by the limitations that you have requested. After you have signed this consent, you have the right to revoke it by submitting a written request to our Office Manager. Upon receipt of your request, we will discontinue using or sharing your PHI. However, please be advised that we may have already used or shared some of it, and that information cannot be retracted.

____________________________________ __________________

Signature of client or personal representative Date

____________________________________ ____________________________________

Printed name of client or personal representative Relationship to the client