HGCC ADULT INTAKE PACKET

It is the policy of Healing Grace to provide services to all persons without regard to race, ethnicity, nationality, religion, gender, sexuality, age or ability status. No person shall be excluded from participation in, be denied the benefits of any service, or be subjected to discrimination because of race, ethnicity, nationality, religion, gender, sexuality, age or ability status.

CLIENT INFO

Client Legal Name: ____________________________________ Preferred Name:_______________________

Date of Birth: ____ / ____ / _____ Social Security # (For Billing Purposes): _________________

Address: _____________________________________ City/State: ____________________ Zip: __________

Email:____

*please note we do not send email reminders

Biological Sex:

□ Male □ Female □ Intersex

Gender:___________________________

Preferred Pronouns:_________________

TEXT REMINDERS

For your convenience, Healing Grace now offers appointment text reminders. This electronic communication will only relate to scheduling and will not, under any circumstances relate to therapy itself. These are automated text reminders sent out from our HIPPA compliant scheduling software not from your therapist. You are not able to cancel replying to this text message. All cancellations must be done by phone directly to your therapist. Please be aware this is considered an unsecure form of communication and there is a potential chance that a third party may be able to intercept these messages

Do we have your permission to send appointment text reminders? YES NO (please circle)

Cell Phone # for Test Reminders (only 1 # allowed per our system):___________________________

Are you required by a court of law to receive counseling as part of a legal proceeding? Yes / No

Have you ever received counseling services from HGCC or any other organization? Yes / No If yes, where/when?

INVOLVEMENT IN CARE

I hereby request the following person(s) to be allowed to participate in my care and/or payment decision-making process. I understand these person(s) may be given health or payment information about me.

NAME	RELATIONSHIP	PHONE NUMBER	TYPE OF INFO (Billing, Scheduling, Clinical, All)

HGCC will make a reasonable effort to provide only the necessary information for the person(s) to make an informed decision or to receive printed/verbal protected health information.

EMERGENCY CONTACT INFO

Notify: ______________________________ Phone: ________________________

Relationship to client: ___________________________________

HEALTH & MEDICAL

Primary Care Physician: ______________________________ Phone: ________________________

Psychiatrist: ______________________________ Phone: ________________________

Please list any medical problems: ____

____

Please list any current medications: ____

PAYMENT POLICY

Insurance – The insurance benefits quoted by your insurance company and/or HGCC are not a guarantee of payment. Benefits can change periodically and may affect the amount that your insurance company will pay. The final confirmation of your benefits and copay will appear on the Explanation of Benefits you receive from the insurance company. You are financially responsible for any and all charges not covered by your individual policy.

Out of Pocket – All fees, including copays are due at the time of service. Our billing staff is not authorized to split payments or to run a specific dollar amount on certain days of the month. We accept cash, checks, (payable to Healing Grace) major credit cards, debit cards and health saving cards.

PAYMENT INFO

How will you be paying for services (✓which applies):

☐ **Seeing Cash Rate Provider** ☐ **Using Insurance**

(online scholarship application must be completed if seeing cash rate provider)

Primary Insurance Company: ________________________Policy Holder ID #: ______________________________

Group #: ____________________________________ Policy Holder's Name: ________________________________

Date of Birth: ____ / ____ / ____ SS#: _____________________ Relationship to Client: _____________________

Secondary Insurance Company: _______________________Policy Holder ID #: ______________________________

Group #: ____________________________________ Policy Holder's Name: ________________________________

Date of Birth: ____ / ____ / ____ SS#: ______________________ Relationship to Client: ____________________

CANCELLATION POLICY

Effective October 1st, 2022

Therapy sessions are scheduled in advance and are a time reserved exclusively for our clients. When a session is canceled without adequate notice, we are unable to fill this time slot by offering it to another current client, a client on the waiting list, or a client with a clinical emergency.

For these reasons, we kindly ask for *at least* 24-hour cancellation notice by phone, directly to your therapist extension. If you cancel or no show after the 24-hour period, no matter what the reason is for cancellation, you **will** be charged a missed flat rate fee of **$100.00,** regardless of what you currently pay per session. The missed fee is your responsibility and cannot be billed to your insurance company.

You can avoid a cancellation/missed session fee by:

- Have a Telehealth session instead - this is where a counselor provides psychological counseling and support over video conferencing or a telephone call. This is especially beneficial during inclement weather, transportation issues, sick kids, etc. This is **not** our preferred method of therapy, however within good reason, can be approved by a supervisor. Remember to keep in mind the state that your therapist is licensed in, as they are not *all* licensed to provide therapy in states other than Missouri. Please note: Internet, a computer or mobile device, an integrated or external microphone and camera are required for video conferencing.

The information I have given is true and correct. I have read all the above policies and by signing below agree to its terms and conditions. I also agree to notify Healing Grace staff if address, insurance, or any other changes occur during my therapy.

Client's Signature: ______________________________ Date: ____________

(if applicable)

Parent/Guardian: ______________________________ Date: ____________

Spouse Signature: ______________________________ Date: ____________

Client Name

Consent for Treatment

We are committed to providing you with the best possible care. Please read and initial each item:

_____1. Therapy

I understand there are no guarantees made to me regarding therapy treatment. My decision is voluntary, and I understand that I may terminate these services at any time. I understand that during treatment I may need to discuss material of any upsetting nature in order to resolve my problems. I also understand it cannot be guaranteed that I will feel better after completion of treatment.

_____ 2. Compliance with Treatment Plan

I agree to participate in the development of an individualized treatment plan. I understand that consistent attendance is essential to the success of my treatment. Frequent "no shows" and/or late cancellations may force Healing Grace to transfer my care to a different counseling practice.

_____ 3. Payment

I understand all fees are due at the time of session. If I choose to use insurance, I authorize my insurance carrier to pay HGCC for billed services. I understand any and all charges not covered by my insurance are my financial responsibility and are subject to collections.

_____ 4. Confidentiality

All information shared in session is confidential except in circumstances governed by Federal and State law, including 1) to warn others of life-threatening concerns should it become necessary, 2) to notify appropriate state agencies of any suspicion of child or dependent adult abuse and 3) to provide information in legal cases when under court order.

_____ 5. Release of Information

I authorize the release of any medical or other information necessary to process claims, or otherwise collect payment on my account. All other medical records requests require a separate signed authorization document and records cannot be released until we receive that form.

_____ 6. Minor Children

We require at least one parent signature to authorize treatment for a minor. (Missouri law states any person under the age of 18 is considered a minor). Please be aware additional signatures/authorizations may be required depending on custody or other legal disputes. I agree to read the Parental Agreement document provided and bring a signed copy to my first session.

_____ 7. No Harm Agreement

I agree that I will not engage in self harm and/or harm to others. I agree I will take the following actions if I violate this agreement. 1) I will call 911 if I believe that I am in immediate danger of harming myself/ or others. 2) I will call any or all 24-hour suicide prevention lines (1-800-SUICIDE) and I will continue talking on the phone for as long as necessary until the suicidal thoughts have subsided. For non-life-threatening, clinical emergencies, please call 816-246-4465 and leave a message on your therapist voicemail box.

_____ **8. Services <u>not</u> provided**

HGCC therapists are not qualified as legal experts in court cases. HGCC does not provide custody evaluations, sexual abuse investigations, or anything related to such matters.

_____ **9. Privacy Practices**

A list of patient rights and responsibilities are available upon request to all patients. They are also posted in our waiting room.

______________________________________ ______________________

Print Client Name   Date of Birth

______________________________________ ______________________________ __________

Client/Parent/Guardian Signature   Therapist Signature   Date

____

Parent/Guardian Signature   (Both signatures are required for divorced parents who have joint custody)

Informed Consent for Telehealth

This Informed Consent for Telehealth contains important information focusing on doing psychotherapy using the phone or the video conferencing through the Internet. Please read this carefully and let us know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telehealth

Telehealth refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telehealth is that the client and clinician can engage in services without being in the same physical location. This can be helpful if bad weather is expected, if the client or clinician moves to a different location, has transportation issues, or is otherwise unable to meet in person. It is also more convenient and takes less time. Telehealth, however, requires technical competence on both parts to be helpful. Although there are benefits of telehealth, there are some differences between in-person psychotherapy and telehealth, as well as some risks. For example:

Risks to confidentiality I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telehealth. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

Issues related to technology There are many ways that technology issues might impact telehealth. If the session is interrupted for any reason and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the telehealth platform on which we agreed to conduct therapy. If you do not receive an attempt to reconnect within two (2) minutes, then call me using the telephone.
If a technological connection fails, and you are having an emergency, do not call me back; instead, call 911, or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

Informed Consent

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature below indicates you understand the risk of telehealth and agree to engage in therapy through the means of video conferencing or telephone.

Print Client Name____

____ ________________
Client Signature Date

Client Name

Symptoms Assessment

So we can better serve you, please give us an accurate account of what your symptoms are. If you have any questions or concerns, we invite you to discuss them with your therapist.

(✓your concerns)

I AM EXPERIENCING…	NEVER	SELDOM	OFTEN	ALWAYS	FOR HOW LONG?
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					
Phobias: unusual fears about specific things					
Panic Attacks: sweating, trembling, shortness of breath, heart palpitations					
Recurring, distressing thoughts about a trauma					
"Flashbacks" as if reliving the traumatic event					
Avoiding people/places associated with trauma					
Nightmares about traumatic experience					

I AM FEELING…	NEVER	SELDOM	OFTEN	ALWAYS	FOR HOW LONG?
Decreased interest in pleasurable activities					
Social Isolation, Loneliness					
Suicidal thoughts					
Bereavement or feelings of loss					
Changes in sleep (too much or too little)					
Normal, daily tasks require more effort					
Sad, hopeless about future					
Excessive feelings of guilt					
Low self-esteem					

I NOTICE…	NEVER	SELDOM	OFTEN	ALWAYS	FOR HOW LONG?
I am angry, irritable, hostile					
I feel euphoric, energized and highly optimistic					
I have racing thoughts					
I need less sleep than usual					
I am more talkative					
My moods fluctuate: go up and down					

I HAVE…	NEVER	SELDOM	OFTEN	ALWAYS	FOR HOW LONG?
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					
Obsessive Thoughts					
Been hearing voices when alone					
Problems with my speech					

I HAVE…	NEVER	SELDOM	OFTEN	ALWAYS	FOR HOW LONG?
Risking taking behaviors					
Compulsive or repetitive behaviors					
Been acting without concern for consequence					
Been physically harming myself					
Been violent toward other(s)					
Been hearing voices when alone					

I USE THE FOLLOWING…	NEVER	SELDOM	OFTEN	ALWAYS	FOR HOW LONG?
Alcohol					
Nicotine (Cigarettes)					
Marijuana					
Cocaine					
Opiates					
Sedatives					
Hallucinogens					
Stimulants					
Methamphetamines					

MY EATING INVOLVES…	NEVER	SELDOM	OFTEN	ALWAYS	FOR HOW LONG?
Restriction of food consumption					
Binging and purging					
Binge eating					
A lot of weight loss or gain					

I HAVE…	NEVER	SELDOM	OFTEN	ALWAYS	FOR HOW LONG?
Concern about my sexual function					
Discomfort engaging in sexual activity					
Questions about my sexual orientation					

Personal and Family History

□ Yes □ No

Have you or a close relative ever been hospitalized for a psychiatric illness?

□ Yes □ No

Does anyone in your family have a mental illness?

□ Yes □ No

Has anyone in your family ever attempted or committed suicide?

□ Yes □ No

Does anyone in your family have a substance abuse problem?

□ Yes □ No

Have you ever taken previous medications for emotional or behavioral problems?

□ Yes □ No

Have you ever suffered from any physical abuse or neglect?

□ Yes □ No

Have you ever been a victim of sexual abuse?

□ Yes □ No

Have you ever been arrested?

If "yes" to any of the above, please briefly explain (who, when, etc.): ____________________

____

____

____

____

1) (✓) How well you are doing on your job:

0 □	1 □	2 □	3 □	4 □	5 □	6 □	7 □	8 □	9 □
Not Working	Cannot Function		Serious Problems		Moderate Problems	Mild Problems		No Problems	

2) (✓) How well you are doing in your marital/significant other relationship:

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐

N/A Cannot Function Serious Problems Moderate Problems Mild Problems No Problems

3) (✓) How well you are doing in your family relationships:

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐

N/A Cannot Function Serious Problems Moderate Problems Mild Problems No Problems

4) (✓) How well you are doing in relationships with people outside your family:

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐

N/A Cannot Function Serious Problems Moderate Problems Mild Problems No Problems

5) (✓) Please rate your current physical health:

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐

Very Poor Excellent

6) (✓) Please rate your general happiness and well-being:

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐

Very Poor Excellent

Presenting Problem: Please describe the problem(s) that prompted you to seek help: ______________________________

____

____

____

Please describe any changes or events that might have contributed to the problems' development: ____________________

____

____

____

Therapy Goals: ____

____

____

____

UD: 12/27/21

Credit/Debit Card Authorization Form

CLIENT NAME(S) we are authorized to use this card for ______________________________

Phone Number for Billing Questions ____________________

Cardholder's Name (As Shown On Card) ______________________________

Billing Address ____

Street   City   State   Zip Code

Credit/Debit Card Number______________________________________

(We accept Visa, MasterCard, Discover, & American Express)

Expiration Date ____________   CVV ____________

(3-4 digit code on the back)

PLEASE READ AND SIGN BELOW

My signature below authorizes Healing Grace billing department to keep my credit card on file and charge my credit/debit card account for any outstanding balances, including, but not limited to: deductible, co-pay, coinsurance, and private pay fees; missed appointment or late cancellation fees; along with any other outstanding balances.

I acknowledge that Healing Grace does not need any further authorization, such as phone calls or emails, prior to charging my card.

All information entered on this form will be kept strictly confidential by Healing Grace Counseling Center and stored on our HIPAA compliant software.

If you have any further questions, please feel free to contact our billing staff at 816-944-3251.

Cardholder Signature ____ Date ____________

Email Receipt to ____