Demographic/Registration Form

NAME: (SELF OR CHILD): _____ TODAY'S DATE: _____
CLIENT DATE OF BIRTH: _____
HOME ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
SS#: _____ EMPLOYER: _____
PHONE: _____ WORK PHONE: _____
SEX: **FEMALE MALE OTHER** MARITAL STATUS: **SINGLE/PARTNER MARRIED DIVORCED WIDOWED**

RESPONSIBLE PARTY: _____ SS#: _____
ADDRESS: _____ CITY/STATE: _____ ZIP: _____
PHONE: _____ WORK PHONE: _____

INSURANCE #1: _____ POLICY#: _____
GROUP#: _____ EMPLOYER: _____
POLICY HOLDER: _____ SS#: _____
PHONE: _____ INSURED D.O.B.: _____

INSURANCE #2: _____ POLICY#: _____
GROUP#: _____ EMPLOYER: _____
POLICY HOLDER: _____ SS#: _____
PHONE: _____ INSURED D.O.B.: _____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____
PHONE: _____ ALT PHONE: _____

AUTHORIZATION FOR TREATMENT AND BILLING SERVICES

I AGREE TO CONSENT TO RECEIVE COUNSELING FOR MENTAL HEALTH AND/OR SUBSTANCE ABUSE AT LAKE HOUSE COUNSELING. I ALSO GIVE PERMISSION FOR LAKE HOUSE COUNSELING TO LEAVE VOICEMAIL, EMAIL, AND/OR TEXT MESSAGES REGARDING MY APPOINTMENTS.

IN ORDER TO SUBMIT A CLAIM FOR PAYMENT TO LAKE HOUSE COUNSELING FOR SERVICES COVERED UNDER YOUR POLICY, WE MUST OBTAIN YOUR AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO YOUR INSURANCE COMPANY AND OUR BILLING COMPANY FOR PAPER AND ELECTRONIC BILLING TO GET REIMBURSED. I AUTHORIZE THE RELEASE OF ONLY NECESSARY MENTAL HEALTH RECORD INFORMATION TO PROCESS MY MEDICAL SERVICE CLAIMS. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. I HEREBY AUTHORIZE THE THERAPIST'S BILLING COMPANY TO FILE FOR BENEFITS ON MY BEHALF FOR THE MEDICAL SERVICES RENDERED. INSURANCE PAYMENTS SHALL BE MADE DIRECTLY TO LAKE HOUSE COUNSELING. IF I HAVE MEDICARE INSURANCE, I AUTHORIZE THE THERAPIST TO RELEASE TO THE SOCIAL SECURITY AND CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I CERTIFY THAT I AM FINACIALLY RESPONSIBLE FOR ALL SERVICES NOT PAID BY INSURANCE OR AS OWED FOR SERVICES RENDERED. THIS AUTHORIZATION IS INVALID IDENFINETLY UNTIL REVOKED BY MYSELF IN WRITTEN REQUEST.

SIGNATURE: _____ DATE: _____

Welcome to **Lake House Counseling, PLLC**. Please take a few moments to complete this assessment. The information you provide is confidential and will assist your therapist at your initial intake appointment. Please let your therapist know if you have any questions.

Name: _____ Today's Date: _____
Age: _____ Date of Birth: _____
Education/Highest Grade Completed: _____
Occupation: _____ Employer: _____
Religious Preference: _____
Importance of Religion/spirituality in therapy: _____
Cultural/ethnic/sexual orientation
FOR ADULT CLIENTS: PLEASE LIST SPOUSE/PARTNER AND OR CHILDREN'S NAMES/AGES:
_____
_____

FOR CLIENTS UNDER 18 YEARS OF AGE:
Parent Marital Status: Single Married Separated Divorced
Custody Arrangement: _____
Sibling (names/ages): _____
_____

FAMILY HISTORY
Where were you born and raised? _____
How would you describe your childhood? Good Fair Poor
Comments:_____
_____
Mother age: _____ Mother Occupation: _____ Living Deceased
Relationship with mother: Good Fair Poor Marital Status: Single Divorced Widowed Remarried
Father age: _____ Father Occupation: _____ Living Deceased
Relationship with father: Good Fair Poor Marital Status: Single Divorced Widowed Remarried
Please list names and ages of any siblings:
_____
_____
Describe any family history of mental health or substance abuse: _____
_____

MEDICAL INFORMATION
Primary Care Physician: _____ Phone Number: _____
Psychiatrist: _____ Phone Number: _____
Other Helper(s): _____ Phone Number: _____
Current medications/supplements: _____
_____

Relevant health history (hospitalizations, surgeries, brain injuries, major illnesses or conditions): _____
_____
_____

Do you smoke? **Y N** If so, how much? _____
Do you drink alcohol? **Y N** If so, how much? _____
Do you exercise? **Y N** If so, how much? _____
Caffeine consumption? **Y N** If so, how much? _____
Other chemical substances? **Y N** If so, what/how much? _____
Height: _____ Weight: _____

LEGAL INFORMATION

Do you have a history or any current legal involvement (DUIs, MIPs, incarceration, arrest)? **Y N**
If yes, briefly describe: _____
_____

MILITARY

Military Service? **Y N** If yes, Branch: _____ Dates: _____
Military Status: _____
_____

COUNSELING INFORMATION

Who referred you or how did you find out about Lake House Counseling? _____
Have you ever sought counseling before: **Y N** If yes, when and where? _____
Reason for prior counseling and outcome: _____
Have you ever been hospitalized for self-harm or suicidal thoughts or actions? **Y N**
If yes, when/where? _____
Briefly describe what brings you here today?
_____
_____
_____
_____

What are you your two most important goals for therapy?
1. _____
2. _____

Common Problems/Symptom Checklist

Please identify the problems you have currently or in the past. Then rate the problems/symptoms if you are currently experiencing them, using the scale: **0 = none, 1 = mild, 2 = moderate, 3 = severe**

☐ Trauma	☐ Co-dependency	☐ Self-esteem
☐ Depression	☐ Parents/aging	☐ Loneliness
☐ Anxiety/Panic	☐ Life Transitions	☐ Chronic illness/self
☐ Mood swings	☐ Academic stress	☐ Chronic illness/others
☐ Abuse	☐ Family stress	☐ Terminal illness/self
☐ Marriage/relationship	☐ Children/parenting	☐ Terminal illness/others
☐ Divorce/Separation	☐ Anger	☐ Eating Disorder
☐ Sexual/intimacy	☐ Communication	☐ Alcohol/drugs

- ☐ Addiction(s)
- ☐ Grief/Loss
- ☐ Life meaning
- ☐ Caregiver fatigue
- ☐ Unresolved issues
- ☐ Employment
- ☐ Confidence
- ☐ Disability
- ☐ Stress management
- ☐ End of Life
- ☐ Financial stress
- ☐ Other/list: _____ _____
- ☐ Other/list: _____ _____
- ☐ Other/list: _____ _____

Crisis Information

Are you having any current thoughts, feelings, or actions of self-harm or suicide? **Y N**
If yes, please explain: _____

Are you having any current homicidal or violent thoughts, feelings or anger-control problems? **Y N**
If yes, please explain: _____

Any issues, hospitalizations for suicidal or assault behavior? **Y N**
If yes, please explain: _____

Any current fear or risk of significant loss or harm (illness, divorce, custody, job loss, illness, etc.)? **Y N**
If yes, please explain: _____

Personal

How do you spend your free time? _____
Who do you count on for social support? _____
Any other information you want us to know? _____
_____
_____
_____
_____

_____

Signature: _____ Date: _____
Person filling out form/relationship to client: _____

BENEFITS AND RISKS OF COUNSELING

Research has shown that therapy is beneficial for a wide variety of problems. The majority of people who receive counseling make significant improvements. However, it should be understood that some people do not report themselves as significantly improved at the end of treatment and a small percent report that they feel worse after receiving treatment. In counseling we discuss both negative and positive experiences, but negative experiences may bring up negative feelings, thoughts, or behaviors. These may play out in your life outside of therapy, such as in their relationships and behaviors towards other people. Therefore, as with any treatment, whether it is psychological or medical, therapy is should only be entered with proper consideration. A client always has the right to inquire and choose treatment modalities as well as terminate counseling at any time.

CONFIDENTIALITY

As a client or parent/guardian of a client of Lake House Counseling, PLLC, you have certain rights regarding the confidentiality of the information you share and the information that is kept in you and/or child's record. Federal and state laws, along with professional ethical standards, prohibit the disclosure of any information you provide, unless I have your written consent. There are a few exceptions to theses confidentiality laws and standards, which include:

- If I believe that you, your child, or someone else is in clear and imminent danger of harm, I am legally obligated to inform proper authorities and others in order to help prevent harm from occurring.
- I you provide information indicating that someone under the age of 18 years old is being abused or neglected of information that any disabled adults or elderly person is being abused, neglected, or exploited, I am legally required to notify the proper authorities.
- In very rare cases, a court order may compel me to disclose information and you or your child via a properly issued subpoena.
- Additionally, you are protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). Under HIPAA, client and record information can be released under certain other circumstances, which are outlined in the HIPAA Notice of Privacy Practice document. You are allowed to revoke any written consent for release of information at any time, but this revocation must be done in writing.

When working with minors, I generally will not share the content of sessions with parents/guardians though I reserve the right to disclose information due to my clinical judgement, such as safety purposes or if therapeutic judgement warrants sharing content for the welfare and health of the minor.

FEE, CREDIT CARD, AND CANCELLATION POLICY

All intakes are up to 75 minutes. All other sessions are 50-60 minutes. Other services such as court appearances, significant telephone consultations, or detailed documentation requests are subject to an additional fee. These are not covered by your insurance and will be the responsibility of the client or responsibility party. Lake House Counseling accepts cash, checks, and credit cards as form of payment. There is a $20.00 fee for returned checks. Client will be charged $50.00 for appointments not cancelled 24 hours prior to their appointment. This payment will need to be paid prior to rescheduling a new appointment. Insurances do not cover late cancellations, and this will be the responsibility of the client or responsibility party.

Lake House Counseling keeps a credit card on file for each client in order to ensure on-time payment and payments for late cancels or missed sessions, co-payments or deductibles.

INSURANCE

I participate in most insurance plans. To find out about your insurance coverage, please call the toll-free number on the back of yourcard. Ask for "Outpatient Mental Health Benefits" or "Behavioral Health Benefits". When asked for the provider's name, tell the person: **Kristi A. Garcia.** You may be asked for the NPI (National Provider Identification) Number(s). Provide them the following NPI(s):

- **Group: 1053880146**
- **Provider Individual: 1235142811**

Ask if the provider is in network, if there are any applicable deductibles or copayments and if authorization is required.

PROFESSIONAL SERVICES

I am available for counseling appointments at scheduled times throughout the week. If a client believes they are in crisis and having thoughts of suicide, overwhelmed, or issues related to safety outside, they are asked to call 911 or go to the nearest emergency room, or the Community Mental Health Crisis Help Line at 517-337-1717.

CLIENT RIGHTS

- To end counseling whenever you choose. Participation is voluntary.
- Receive respectful services.
- Receive treatment in a safe and confidential environment.
- Refuse to answer any questions I don't feel comfortable answering.
- Report complaints about my therapist without fear of retaliation.
- See my therapist's credentials and training at my request.
- Have your privacy and confidentiality maintained.
- Refuse any treatment offered.

SECURE AND NON-SECURE COMMUNICATION POLICY/CONFIDENTIALITY

Lake House Counseling utilizes a HIPAA-compliant secured email: kristi@lakehousecounselingpllc.com. It is important to remember that confidentiality is limited. Client's must consider and understand the limitation of confidentiality and agree that the client is responsible for keeping their email account private to the extent that they desire for it to be private.

Text messages are only to be used for scheduling reminders and questions. Any therapeutic processing should be reserved for sessions and/or phone consultation. The client is agreeing that they have considered and understand the limits of confidentiality and agree that the client is responsible for keeping their text messages private to the extent that they desire them to be private.

For the purposes of professionalism and relational clarity, it is the policy of Lake House Counseling to not accept gifts of any kind from the client (with notes/greeting cards being the only exceptions). As a matter of policy, if a therapist and client see each other in a public setting, the therapist will not acknowledge the client unless the client first does so. Client is solely responsible for all public interactions with the therapist and others in the public setting. I do not interact or engage with clients on any form of social media.

_____ _____

Signature Date

Authorization for Recurring Credit Card Payments

Lake House Counseling, PLLC keeps a credit card on file for each client in order to ensure on-time payment for private pay sessions, insurance deductible or co-payments, and payments for late cancels or missed sessions.

Cancellation Policy
Clients will be charged **$50.00** for appointments not cancelled **24 hours prior** to their appointment time.

- If you are choosing to turn in receipts for insurance reimbursement, the missed/cancelled sessions will not be counted as a treatment session, so you will not be reimbursed for the session
- All clients are required to keep a credit card on file to pay for those cancelled/missed sessions.
- These sessions will be charged the day of the session using the credit card number provided below.

Credit Card Policy

In addition to payment in cash or check, clients may choose to keep a credit card on file to pay for sessions.

Account Type: Visa MasterCard Discover

Name (as it appears on card): _____

Account Number: _____

Expiration Date: _____ CVC: _____ Billing Zip Code: _____

Email Address (for receipts): _____ Would you like to use this credit card to pay for all sessions? **Y N**

I authorize Lake House Counseling, PLLC to make charges to my credit card for payment of counseling services when I do not provide cash or check for those sessions. I understand the cancellation policy and give Lake House Counseling, PLLC permission to charge any missed or cancelled session on the credit card listed above.

_____ _____

Signature Date

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

As a patient of Lake House Counseling, PLLC, your signature on this form indicates that you have received privacy practices information about our counseling practice. Please read the statement below and sign and date it. If you do not understand any of the information, we will try to explain it to you in a form that you are able to understand. Your signature below indicates that you have an understanding of what you have read.

I have acknowledged that I have received a copy of the Notice of Privacy for Lake House Counseling, PLLC and have been given the opportunity to ask questions about these practices.

_____ _____

SIGNATURE DATE

_____ _____

SIGNATURE OF PARENT OR GUARDIAN DATE