Blair Counseling Services

90 North Main • P.O. Box 650158 • Sterling, UT 84665 • 435-703-0756 • 888-528-3070
www.BlairCounselingAndLifestar.com

Client Information

Full Name: _____ Date: _____

Address: _____

City, State, ZIP: _____ Gender: ○ Male ○ Female

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Pager: _____

E-mail Address: _____

How do you prefer to be contacted, and may we leave messages?: _____

Date of Birth: _____ Age: _____ SSN:_____

Marital Status: ○ Never Married ○ Married ____ Years ○ Separated ○ Divorced ○ Widowed

Employer or School: _____ Employment Status: _____

Spouse/Parent's Name: _____ Phone: _____

Emergency Contact: _____ Phone:_____

Responsible Party: _____

Referred by: _____

Additional Information (if any)

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Primary Insurance Information

Full Name of Insured: _____

Relationship to Client: ○ Self ○ Spouse ○ Father ○ Mother ○ Guardian ○ _____

Birth date of Insured: _____ SSN: _____

Insurance Company: _____

Insurance Company Address: _____

City, State, ZIP: _____

Phone: _____ Fax: _____

Plan Name: _____ Subscriber ID #: _____

Group #: _____ Employer: _____

Co-pay: _____ Deductible: _____ Sessions Available: _____

Secondary Insurance Information

Full Name of Insured: _____

Relationship to Client: ○ Self ○ Spouse ○ Father ○ Mother ○ Guardian ○ _____

Birth date of Insured: _____ SSN: _____

Insurance Company: _____

Insurance Company Address: _____

City, State, ZIP: _____

Phone: _____ Fax: _____

Plan Name: _____ Subscriber ID #: _____

Group #: _____ Employer: _____

Co-pay: _____ Deductible: _____ Sessions Available: _____

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Self-Pay and/or Co-pay Information

□ I agree to pay $ _____ per session at the time of each session. This amount represents (check one) ○ my co-pay, ○ my payment until I reach my deductible or ○ my balance due each session.

Signature _____ Date: _____

□ Please charge my credit card for the above agreed amount. My signature below authorizes Blair Counseling Services charge my credit card for each session.

Credit Card number ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Expiration ___ ___ / ___ ___ Security code ___ ___ ___ ___ Zip Code ___ ___ ___ ___ ___

Authorization Signature _____ Date: _____

□ Other financial arrangements:

Signature _____ Date: _____

Authorization and Release

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to Blair Counseling Services. I understand that I am financially responsible or all charges whether or not paid by insurance, for all services rendered on my behalf or my dependents.

_____ _____

Signature of Responsible Party Date

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Health Intake Form

Please note: The information you provide here is protected as confidential information.

Full Name: _____ Date: _____

Parent/Guardian (if under 18): _____

Date of Birth: _____ Age: _____ Gender: ○ Male ○ Female

Marital Status: ○ Never Married ○ Married ____ Years ○ Separated ○ Divorced ○ Widowed

List Children and their ages: _____

_____

Address: _____

City, State, ZIP: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Pager: _____

E-mail Address: _____

How do you prefer to be contacted, and may we leave messages?: _____

Referred by: _____

1. Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)

□ No

□ Yes, previous therapist/practitioner: _____

2. Are you currently taking any prescription medication?

□ No

□ Yes, please list: _____

_____

3. Have you ever been prescribed psychiatric medication?

□ No

□ Yes, please list and provide dates: _____

_____

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Health Intake Form—Continued

4. How would you rate your current physical health?

□ Poor

□ Unsatisfactory

□ Satisfactory

□ Good

□ Very Good

5. How would you rate your current sleeping habits?

□ Poor

□ Unsatisfactory

□ Satisfactory

□ Good

□ Very Good

Please list any specific sleep problems you are currently experiencing: _____

_____

6. How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

7. Please list any difficulties you experience with your appetite or eating patterns: _____

_____

8. Are you currently experiencing overwhelming sadness, grief, or depression?

□ No

□ Yes. This has been going on since _____

9. Are you currently experiencing anxiety, panic attacks or have any phobias?

□ No

□ Yes. This began _____

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Health Intake Form—Continued

10. Are you currently experiencing any chronic pain?

□ No

□ Yes. Please describe: _____

11. Do you drink alcohol more than once a week?

□ No

□ Yes

12. How often do you engage in recreational drug use?

□ Daily

□ Weekly

□ Monthly

□ Infrequently

□ Never

13. Are you currently in a romantic relationship?

□ No

□ Yes. For how long?

How would you rate your relationship with 10 being wonderful to 1 being not good. _____

14. What significant life changes or stressful events have you experienced recently: _____

_____

_____

_____

_____

_____

_____

_____

_____

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Health Intake Form—Continued

15. FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If "Yes," please indicate the family member's relationship to you in the space provided (i.e. Father, Grandmother, Uncle, etc.)

	Circle One		If Yes, List Family Member
Alcohol/Substance Abuse	Yes	No	
Anxiety	Yes	No	
Depression	Yes	No	
Domestic Violence	Yes	No	
Eating Disorders	Yes	No	
Obesity	Yes	No	
Obsessive Compulsive Behavior	Yes	No	
Schizophrenia	Yes	No	
Suicide Attempts	Yes	No	

ADDITIONAL INFORMATION

16. Are you currently employed?

□ No

□ Yes. If yes, what is your current employment situation? _____

_____

Do you enjoy your work? Is there anything stressful about your current work? _____

_____

_____

17. Do you consider yourself to be spiritual or religious?

□ No

□ Yes. If yes, describe your faith or belief _____

_____

_____

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Health Intake Form—Continued

18. What do you consider to be some of your strengths? _____

_____

_____

_____

_____

19. What do you consider to be some of your weaknesses? _____

_____

_____

_____

_____

20. What would you like to accomplish out of your time in therapy? _____

_____

_____

_____

_____

21. Any additional information you would like to share? _____

_____

_____

_____

_____

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Authorization for Use or Disclosure of Protected Health Information

Client's Full Name: _____

Date of Birth: _____ Date Authorization Initiated: _____

Name of Person Initiating Authorization: _____

Information to be released:

□ Authorization for Psychotherapy Notes ONLY. (If this authorization is for Psychotherapy Notes, it must not be used as an authorization for any other type of protected health information.)

□ Authorization for (describe information in detail) _____

_____

Purpose of Disclosure: The reason I am authorizing release is:

□ My request.

□ Other. Please describe: _____

Person(s) Authorized to Make the Disclosure: _____

_____

Person(s) Authorized to Receive the Disclosure: _____

_____

This Authorization will expire on _____ (date) or upon the happening of the following event:

_____

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

_____ _____

Patient's Signature Date

_____ _____

Patient's Representative's Signature (and relationship) Date

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Patient Rights and HIPAA Authorizations

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time. ("HIPAA")

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.
5. If this office initiated this authorization, you must receive a copy of the signed authorization.
6. **Special instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.** HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e. paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as noted recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

   In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of the Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.

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Cancellation Policy

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full-session fee is charged for missed appointments or cancellations with less-than-a-24-hour notice unless it is due to illness or emergency. A bill may be mailed directly to clients who do not show up for an appointment or cancel an appointment without 24 hours notice.

Thank you for your consideration regarding this important matter.

_____ _____

Client's Signature (Parent/Guardian if client under 18) Date

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Limits of Confidentiality

Contents of all therapy sessions are considered to be confidential. 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. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warm the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children or Vulnerable Adults
If a client sates or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, he mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____ _____
Client's Signature (Parent/Guardian if client under 18) Date

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Client Rights in Psychotherapy

Initials

_____ 1. I consent to therapy.

_____ 2. I have the right to decide not to receive psychotherapy from Blair Counseling Services. If I desire, Blair Counseling Services will provide me with the names of other qualified psychotherapists.

_____ 3. I have the right to end therapy at any time without any moral or legal obligation, or without incurring any further financial obligations.

_____ 4. I have a right to confidentiality. I have the confidential privilege to all the information presented during therapy. My personal information is held in strict confidence and will not be revealed to any other professionals, clergy or agency without my written permission, within limits. I realize there are certain situations in which Blair Counseling Services is required by law to reveal information obtained in psychotherapy to other professionals or agencies without my written permission. Additionally, Blair Counseling Services is not required by law to inform me of any actions in this regard. These situations are as follows:

a. If I threaten bodily harm or death to another person, Blair Counseling Services is required by law to inform the intended victim and the appropriate law enforcement agencies;
b. If a court of law issues a legitimate subpoena;
c. If I am in therapy or being evaluated by a court of law, the results of the treatment or evaluation performed must be revealed to the court.
d. If there is sufficient evidence presented in therapy to suspect that a child is being abused or neglected. Blair Counseling Services is required by law to report "reasonable suspicion of such abuse or neglect." Blair Counseling Services has no authority or responsibility to investigate.
e. In the case of a potential suicide, Blair Counseling Services is allowed by law to inform necessary individuals and/or agencies to prevent self-harm.

_____ 5. At my request, any part of the records in my file can be released to any professionals, agencies or clergy that I designate.

I have read, understand and initialed the above information. All of my questions have been answered to my satisfaction. My signature signifies my understanding and acceptance of the terms specified in this agreement with Blair Counseling Services.

_____ _____
Signature Date

_____ _____
Signature Date

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Life Star Registration

☐ Phase 1 ☐ Phase 2 ☐ Phase 3

Full Name: _____ Date: _____

Address: _____

City, State, ZIP: _____ Gender: ○ Male ○ Female

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Pager: _____

E-mail Address: _____

How do you prefer to be contacted, and may we leave messages?: _____

Date of Birth: _____ Age: _____ SSN:_____

Marital Status: ○ Never Married ○ Married ____ Years ○ Separated ○ Divorced ○ Widowed

Employer or School: _____ Employment Status: _____

Spouse/Parent's Name: _____ Phone: _____

Emergency Contact: _____ Phone:_____

Responsible Party: _____

Referred by: _____

□ Down Payment $ _____ .

□ I agree to pay $ _____ per session at the time of each session. This amount represents (check one) ○ my co-pay, ○ my payment until I reach my deductible or ○ my balance due each session.

Signature _____ Date: _____

□ Please charge my credit card for the above agreed amount. My signature below authorizes Blair Counseling Services charge my credit card for each session.

Credit Card number ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Expiration ___ ___ / ___ ___ Security code ___ ___ ___ ___ Zip Code ___ ___ ___ ___ ___

Authorization Signature _____ Date: _____

□ Other financial arrangements:

Signature _____ Date: _____