New Client Packet

Kett Counseling & Educational Services, LLC

Biographical Information – Intake Form

Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Office Policy form and the HIPAA Notice of Privacy Practices. If you do not desire to answer any question, merely write, "Do not care to answer." Please print or write clearly and bring it with you to the first session.

NAME: ________________________________ MALE/FEMALE: ______ DATE: ___________

DATE OF BIRTH and PLACE OF BIRTH: __________________________ AGE: _________

ADDRESS: ____

TELEPHONES: H: ______ Cell: _________ Work/Off: ________ Fax: ____________________

FOR ROUTINE MESSAGES: Phone #______________ Email: _________________________

FOR CONFIDENTIAL/PRIVATE MESSAGES: Phone #______ Email: ______ Text: _______

HIGHEST GRADE/DEGREE: ___________ TYPE OF DEGREE: ________________________

PERSON & PHONE NO. TO CONTACT IN EMERGENCY: ____________________________

REFERRAL SOURCE: ____

OCCUPATION (former, if retired): ____

PRESENTING PROBLEM (be as specific as you can: when did it start, how does it affect you.):

____

____

Estimate the severity of above problem: Mild ____ Moderate ____ Severe ___Very severe ____

CURRENT: Marital status: ____ Live with someone: ____ Name: _______________Years: ____

PAST & PRESENT MARRIAGE/S (names, years together, and statement about the nature of the relationship(s), i.e., friendly, distant, physically/emotionally abusive, loving, hostile.):

____

____

____

PRESENT SPOUSE/PARTNER: Education: ____

Occupation: ____

CHILDREN/STEP/GRAND (names/ages & brief statement on your relationship with the person.)

1. ____
2. ____
3. ____

PARENTS/STEPPARENTS (Name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship.):

Father:____

____

____

Mother: ____

____

____

Stepparents:____

____

____

SIBLINGS (name/age, if deceased: age and cause of death and brief statement about the relationship.):

1. ____
2. ____
3. ____

MEDICAL DOCTOR (S) (name/phone): ____

____

____

PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness, etc.):

____

____

____

SPECIFY <u>MEDICATION</u> you are presently taking and for what. <u>PRINT</u> clearly:

____

____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments):

____

____

SUICIDE ATTEMPT/S or VIOLENT BEHAVIOR (describe: ages, reasons, circumstances, how, etc.)

____

____

FAMILY MEDICAL HISTORY (Describe any <u>illness</u> that runs in the family: e.g., cancer, epilepsy, etc):

____

____

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY:

____

____

PAST/PRESENT PSYCHOTHERAPY (specify: month year(s) (beginning—end), estimated no. of sessions, name, degree, phone & address, initial reason for therapy, Individual/Couple/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended):

1. ____

____

2. ____

____

3. *USE OTHER SIDE OF PAGE TO ADD MORE INFORMATION ABOUT PSYCHOTHERAPISTS, IF NEEDED.*

DESCRIBE YOUR CHILDHOOD, IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

____

____

IF PARENTS DIVORCED: Your age at the time: ______.

Describe how it affected you at the time

____

____

ESTIMATE HOW MANY HOURS/DAY YOU SPEND ONLINE (Facebook, YouTube, internet gaming, texting, browsing, etc.):

Facebook: ______ YouTube: ______ Gaming: ______ Texting: ______ Browsing: ______

Work/School: ______ Other: ______

DO YOU FEEL YOUR TECHNOLOGY USE IS BALANCED AND HEALTHY OR COULD IT USE IMPROVEMENT? Please explain:

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, OR VIOLENCE (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

____

____

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTE/S? (if you answer Yes, please explain):

____

____

What gives you the most joy or pleasure in your life?

____What are your main worries and fears?

____

What are your most important hopes or dreams?

____

Please add, on the other side of the page or on a separate page, any other information you would like me to know about you and your situation.

INFORMED CONSENT - Adult

Thank you for choosing Kett Counseling & Educational Services, LLC. The first appointment will take approximately 50 minutes. I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need. Jeanne Kett, LCPC, has earned a Master's Degree in Counseling Psychology from the Benedictine University. She is licensed by the State of IL as a Licensed Clinical Professional Counselor. She has clinical experience in treating adolescents, adults and families using individual and family therapy. Jeanne Kett practices standard, family-systems, client-centered and/or cognitive-behavioral therapy for most conditions. Although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy and plan limitations and risks will be discussed with you today.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: *Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims, b) information you and/or you child or children report about physical, sexual abuse or elder abuse; then, by Illinois State Law, I am obligated to report this to the Department of Children and Family Services, c) where you sign a release of information to have specific information shared and d) if you are determined to be a clear and present danger to yourself or others, developmentally or intellectually disabled then I am mandated to report you to the Department of Human Services e) information necessary for case supervision or consultation and f) or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary, please contact the emergency services in the community (911) for those services. Jeanne Kett will follow those emergency services with standard counseling and support to the client or the client's family.*

Signature(s) ____Date:________

FINANCIAL/INSURANCE ISSUES: *Clients are expected to pay* ***the standard fee of $90 for a 50 minute, individual session and $125 for a 75 minute, family/couple session.*** *Cash, check and credit cards are accepted and fee is due at the time of service. Kett Counseling will provide paperwork to submit to your insurance company as an out-of-network provider. Alternately, if eligible for coverage through Blue Cross Blue Shield, we will bill your insurance company directly. We ask that at each session you pay your co-pay or 50% of the fee. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you*

pay the balance due at that time. We ask that every client authorize payment of medical benefits directly to Kett Counseling & Educational Services.

I have received a copy of my fee schedule **_______________**

Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be charged a ***$50 late-cancellation fee.*** *We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask.* ***You may have a copy of this form if requested.***

***Signature(s)*____*Date*________**

COORDINATION OF TREAMENT: *It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. If you prefer to decline consent no information will be shared.*

____You may inform my physician(s) ____I decline to inform my physician

PHYSICIAN NAME: ____

CLINIC: ____
ADDRESS: ____

PHONE: _______________________________________

***Signature(s)* ____*Date*________**

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: *I/We have read and received a copy of the, Notice of Privacy Practices and Client Rights document.*

Signature(s) ____Date_______________

May we contact you at home (circle one) ***yes no****? May we contact you at work* ***yes no?*** *May we contact you by cell phone* ***yes no?*** *Where may we contact you ____?*

CLIENT RIGHTS

Right to request how we contact you

It is our normal practice to communicate with you at your home address and daytime phone number you gave us when you scheduled your appointment, about health matters, such as appointment reminders etc. Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way. May we contact you at home (circle one) **yes no**? May we contact you at work **yes no?**. May we contact you by cell phone **yes no?** Where may we contact you____?

Right to release your medical records

You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization

Right to inspect and copy your medical and billing records.

You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, contact the office manager. Under limited circumstance we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and supplies.

Right to add information or amend your medical records.

If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request with 60 days, or some cases within 90 days. Under certain circumstance, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the office manager. We will

require you to submit your request in writing and to provide an explanation concerning the reason for your request.

Right to an accounting of disclosures.

You may request an accounting of any disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment, or health care operational purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after April 14, 2003, please submit your request in writing to the Privacy Officer. We will notify you of the cost involved in preparing this list.

Right to request restrictions on uses and disclosures of your health information.

You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our office manager. However, we are not required to agree to such a request.

Right to complain.

If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

Right to receive changes in policy.

You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from the office manager.

Insurance Information: Please complete only for direct billing to insurance company

Intake information:

Last Name ***First Name***

____

Home Address

____

City ***State*** ***Zip***

____

Home phone number ***cell number*** ***work number***

____

DOB ***Social Security number***

_______________ ____

E-mail

Insurance information:

Name of insured

Last Name ***First Name*** ***Relationship***

____

DOB ***Social Security number***

______________ ____

Insurance ID number ***Group number***

_____________________ ____

Insured place of employment

____

Name and phone of insurance

____

Insurance Address

____

City ***State*** ***Zip***

Comments:____

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