Footsteps Christian Counseling, LLC
Mull Center
1025 Main St. Suite 507
Wheeling, WV 26003
(304) 242-8095

Adult Intake Form

Please do your best to complete this form. The information you provide will be used to start a discussion in our first session and will help me develop a treatment plan tailored to your needs.

Full legal name: _____ Date of birth: _____

Partner/Spouse name: _____ Date of birth: _____

Home address: _____

Phone: (home) _____ (cell) _____ (work) _____

Is it okay to leave a message at one of the above numbers? Yes ____ No ____ If yes, which one _____

Social Security Number: _____

Email address: _____

Is your email address confidential? Yes _____ No_____

Gender: _____

Ethnic/cultural background: _____ Native language: _____

Religious/Spiritual orientation: _____ Relationship status: _____

Educational background: _____

_____

Profession and employment status: _____

_____

Children (include biological, adopted, foster & step):

Name	Sex	DOB	Type (B/A/F/S)	Custody (Y/N)

_____

_____

_____

_____

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_____

Are you presently under a physician's care? Yes ____ No____

If yes, what for? _____

Name and address of physician: _____

_____

Person to contact in case of an emergency: _____

Name: _____

Phone: (home)_____ (cell) _____ (work) _____

Email address: _____

FAMILY HISTORY

Are your parents still living? Father _____ Mother _____

Do you have brother(s) and sister(s)? Yes ____ No ____

If yes, how many and what is the birth order? _____

_____

What is the relationship status of your parents? _____

_____

PERSONAL MEDICAL HISTORY

Do you have any allergies to food and/or medications? Yes ____ No ____

If yes, please describe:_____

Please list any prescription medications you currently use, include name, dosage, and frequency:

_____

Please list any over-the-counter medications you currently use such as vitamins, sleeping/diet pills, aspirin/pain relievers, etc., include name, dosage, and frequency: _____

_____

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Please list hospitalizations from past medical/surgical illnesses, include name of hospital, dates of admittance, illness and procedure(s): _____

_____

When was your last physical examination, include date and doctor's name: _____

_____

Were there any significant findings? Yes ____ No ____

When was your last blood test? _____

Are you currently being treated for any medical conditions? Yes ____ No ____

If yes, please list: _____

Do you experience any of the following, please circle which one(s) apply to you:

Double or poor vision **Fainting** **Blackouts** **Difficulty hearing**

Excessive thirst/dry mouth **Paralysis** **Stomach pain** **Thyroid problems**

Diarrhea or constipation **Chest pain** **Palpitations** **Sexual problems**

Vomiting/vomiting blood **Blood in stool** **Joint pain** **Trouble sleeping**

Cough or wheezing **Dizziness** **Headaches** **Shortness of breath**

Swelling of hands or feet **Convulsions** **Weakness or tiredness**

Problems with memory, thinking, concentration or attention

Indigestions, gas, heartburn **Change in appetite or eating habits**

Lumps anywhere on the body- please specify location: _____

Weight loss or gain: Gain _____Loss _____# of pounds _____ Time period _____

Have you ever used drugs or alcohol? _____

If yes, please describe: Substance _____ Amount _____

Frequency _____ Last Taken _____

Do you have a history of blackouts, seizures, or withdrawal symptoms? Yes ____No ____

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If yes, please describe: _____

Have you ever received mental health or substance abuse treatment? Yes ____ No ____

If yes, please describe (if applicable, please list the name of medication and dosage taken for condition):
Type of treatment (inpatient/outpatient)_____

Provider _____

First Seen _____ Last Seen _____

Are there any compulsive/repetitive behaviors or thoughts that are of concern to you and/or the people close to you? (i.e. gambling, spending, sexual behavior, use of food, exercise, television watching, hoarding, checking, counting, washing, illness-related, thought of harming someone, use or fear of use of obscene language, etc.)?: Yes _____No_____

If yes, please describe: _____

_____

Have you been arrested for a crime? Yes ____ No ____

If yes, please describe: _____

_____

LIFESTYLE

Please indicate which recreational behaviors may influence counseling:

	Currently usage	Most ever used	When/how long ago?
Gambling			
Caffeinated drinks			
Cigar/Cigarettes			
Alcohol			
Marijuana			
Prescription medication			

Please indicate and rate the severity (1-4) of the following issues or problems you would like to work on in treatment:

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	No Problem 1	Mild Problem 2	Moderate Problem 3	Severe Problem 4
Depression				
Anxiety				
Controlling stress				
Loss of a loved one				
Problems at school				
Problems at work				
Lack of Friends				
Loneliness				
Problems coping				
Abuse/victimization				
Financial Problems				
Legal Matters				
Marriage/ Relationship issues				
Sexuality				
Sexual issues				
Family conflict				
Behavior problems				
Eliminating drug/alcohol habit				
Eliminating another habit				

Other, please specify: _____

_____

Please describe your reason(s) for seeking treatment at this time, include date or month or year the problem started: _____

_____

Was there an event which made these issues or problems surface? Yes ____ No ____

If yes, please describe: _____

What results do you expect from treatment? _____

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Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas in your life:

	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	Not Applicable
Relationship						
Family						
Job/School performance						
Friendships						
Physical health						
Financial situation						
Anxiety level						
Mood						
Eating habits						
Sexual functioning						
Sleep habits						
Ability to concentrate						
Ability to control temper						
Spirituality						

How have you tried to solve the issue(s) Please be brief. _____

_____

Current exercise: Type(s) Frequency

_____

Current hobbies: _____

Hours/week spent at work: _____

FAMILY MEDICAL HISTORY

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Has anyone in your family had a serious illness? Yes ____ No ____

If yes, please explain: _____

Has anyone in your family had a psychiatric (nervous or mental) illness? Yes ____ No ____

If yes, please explain: _____

If yes, what type of treatment, if any, did they receive? _____

_____

May I contact and exchange information with your primary care physician to coordinate care? Yes ____ No ____

MORE ON YOU

What do you consider your most significant strengths? Please be brief. _____

_____

Who is involved and/or knows about you seeking counseling? Please be brief. _____

_____

What have I not asked you that might be important to know? _____

_____

Thank you for providing me information regarding your health and well-being. I will use this information to build a treatment designed specifically to meet your needs. Please feel free to discuss any aspect of your responses with me. Thanks for your time filling out this form -- Virginia Loew/Shelhammer, M.A.,LPC, BCPCC

_____

Signature Date

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COMMUNICATIONS CONSENT FORM

_____ _____

Patient Name ***Date of Birth***

I give permission to be contacted in the following manner (please fill in phone numbers and check all that apply)

Home Telephone #: _____□ Cell Phone #:_____

□ OK to leave message with information □ Leave message with call-back number only

□ OK to leave message at home or on the cell phone with the following family members: (list name(s) and relationship to patient)

_____

□ **Work Telephone #:_____**

□ OK to leave message with information □ Leave message with call-back number only

Appointment Reminders

Our office uses an automated appointment reminder system to contact you prior to your scheduled appointment. Please indicate your preference on how we contact you: □ Home Phone □ Cell Phone □ Text Message

Written Communication

□ OK to mail to my home address □ OK to mail to my work address

□ OK to fax to this number**:** _____ □ OK to send to this e-mail**:**_____

Communication with Other Healthcare Providers

Patient information or medical records may be communicated to other Healthcare Providers, hospitals or insurance companies if necessary.

Please list the name, address, and phone number of health care providers that you want to receive a copy of your office visit report.

Name: _____ **Name:** _____

Address: _____ **Address:** _____

_____ _____

Phone #: _____ **Phone #:** _____

_____

Patient or Legal Representative Signature **Date**

_____

(If legal representative's signature appears above, please describe relationship to the patient)

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Insurance Information

Client Name: _____ **Date of birth:** ___/___/___

Address: _____

_____

City/Zip: _____

Phone #: ( ) -

Gender: _____
Relationship to Policy Holder:
self child spouse/partner

Employment: full, part, student, un-employed

Primary Insurance:		**Secondary Insurance:**	
Address of Insurance:		**Address of Insurance:**	
Telephone number:		**Telephone number:**	
Policy Holder's name:		**Insured's name:**	
Policy Holder's date of birth:	/ /	**Insured's date of birth:**	/ /
Policy Holder's Address:			
Policy or ID #:		**Policy or ID #:**	
Group #:		**Group #:**	
Effective date of policy:	/ /	**Effective date of policy:**	/ /
Employer or School :			
Policy Holder's SS number:			

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Footsteps Christian Counseling, LLC to:

1) Furnish my insurance company with any/all information requested concerning my present claim(s), including records if requested.

2) Bill my insurance company, and to accept payment from that company on my behalf, for all services relating to my care.

I acknowledge:

1) I am responsible for all charges not covered by my insurance, including missed appointments.
2) Any money credited as overpayment due to me will be refunded after completion of treatment.
3) I will be charged for any appointment that I fail to keep or cancel within 24 hours prior to that appointment time.

_____ _____

Client's Signature Date Responsible Party Signature Date

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Fees and Insurance

The established fee for individual counseling is $100.00 per session.
A 30% discount is offered for payment at the time of service ($70.00)

Marital and relationship counseling is available at $55.00 per session. No discount available

Payment plans are available upon request when meeting the required income guidelines. Proof must be supplied.

Co-pays should be paid at the end of every session. Footsteps Christian Counseling, LLC accepts cash and checks only as payment.

When special considerations warrant, funding may be secured from a local church to cover your services. As a Christian counselor I do not want to neglect counseling because of an inability to pay. Please let me know if you are in need of this special funding so that it may be secured.

Clients are responsible for payment of any services not covered by insurance.

When an appointment is scheduled for you, 1 hour is set aside specifically for you.
Because of this commitment of time, if you cannot keep this appointment, you must cancel at least 24 hours in advance by calling the office, unless it is an **Emergency**! Insurance companies do not pay for missed sessions. Therefore, you will be billed for all appointments not properly canceled.

Signature: _____ Date: _____

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Footsteps Christian Counseling, LLC Payment Agreement

_____Please bill my insurance company. I understand that I am responsible for any balance not paid by my insurance company. *Individual counseling sessions $100.00 per session*

_____I understand that *marriage counseling* is rarely covered by health insurance. Insurance may cover marriage counseling if the counseling focus is helping a mentally ill spouse as it relates to the marriage. *Marriage counseling is available at $55 per session*

_____I will be paying for my sessions by cash, check, or credit card. (Discount available if paid in full on the date of service.)

_____Our office is not permitted to accept Medicare or Medicaid. Charity care may be available for those with this type of coverage.

_____I request that a payment plan be approved so that I may receive services. I am able to pay $_____per month until my bill is paid in full.

_____My counseling fees are being paid by an outside agency or grant. Please list source:

_____.

_____I am unable to contribute to my counseling costs because of the following circumstances: (verification may be requested) I request that local churches, donors, and outside sources be contacted on my behalf to cover the cost of services.

_____
_____
_____

_____I would like to make a donation for those unable to pay for services

_____Other

Name_____
Date_____

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☐ ***Client Request***

☐ Counselor Request

Authorization to Release Protected Health Information

I, _____, hereby authorize
Name of Client/Guardian

_____Virginia Loew/Shelhammer____ of Footsteps Christian Counseling, LLC, 1025 Main Street, Wheeling, WV (304) 242-8095, to disclose or receive, a copy of specific health/mental health information initialed below regarding
_____ consisting of:

__Therapy/case notes	__Psychological reports	__Progress reviews
__ Psychiatric reports	__Medical reports	__ Treatment Plans
__Medications used in treatment	__ Assessments	__School reports
__ Discharge Summary	__ Psycho-educational reports	

__ Results of court proceedings (other than expunged records)
__Other (specify): _____
to or from (name and address of recipient or sender):

_____
Name, Title, Business Name, Address, and Phone Number

I have been informed and fully understand that this protected health information may be in written, oral, or report form. I understand that the information used or disclosed related to this authorization may be subject to redisclosure and may no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/ AIDS information, mental health information, and drug/alcohol diagnosis, treatment, or referral information.

I understand that I have the right to refuse to sign this authorization and that my refusal will not condition treatment, payment, enrollment or eligibility for benefits. You may revoke this authorization in writing anytime, but such recovation may not be retroactive. If you revoke your authorization, the information described above may no longer be disclosed for the purposes described above. To revoke this authorization, please send a written statement that you are revoking this authorization to Footsteps Christian Counseling, LLC at the address listed above.
I have read this authorization and I understand it. Unless revoked, this authorization expires in 180 days from the date of the signature below.

Signature: _____Date:_____
Individual, Legal guardian, or Personal representative

Description of personal representative's authority: _____

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HIPAA Privacy Notice

Notice of Privacy Practices
Effective Date: September, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

What is this Notice and Why is it Important? As of April of 2003, a new federal law ("HIPAA") went into effect. This law requires that health care practitioners create a notice of privacy practices for you to read. This notice tells you how the practitioners at Footsteps Christian Counseling, LLC required to be HIPAA compliant will protect your medical information, how I may use or disclose this information, and describes your rights. If you have any questions about this notice, please contact me directly at (304) 242-8095.

Understanding Your Health Information During each appointment, I record clinical information and store it in your chart. Typically, this record includes a description of your symptoms, your recent stressors, your medical problems, a mental status exam, any relevant lab test results, diagnoses, treatment, and a plan for future care. This information, often referred to as your medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the health professionals who contribute to your care
- Legal document of the care you receive
- Means by which you or a third-party payer (e.g. health insurance company) can verify that services you received were appropriately billed
- A tool with which I can assess and work to improve the care I provide

Your Health Information Rights You have the following rights related to your medical record:

- *Obtain a copy of this notice*.
  You can read this notice in the waiting room, and you can also obtain your own copy if you would like.
- *Authorization to use your health information*.
  Before I use or disclose your health information, other than as described below, I will obtain your written authorization, which you may revoke at any time to stop future use or disclosure.
- *Access to your health information*.
  You may request a copy of your medical record from me at any time.
- *Change your health information*.
  If you believe the information in your record is inaccurate or incomplete, you may request that I correct or add information.
- *Request confidential communications*.
  You may request that when I communicate with you about your health information, I do so in a specific way (e.g. at a certain mail address or phone number). I will make every reasonable effort to agree to your request.
- *Accounting of disclosures*.
  You may request a list of disclosures of your health information that I have made for reasons other than treatment, payment or healthcare operations.

My Responsibilities

- I am required by law to protect the privacy of your health information, to provide this notice about my privacy practices, and to abide by the terms of this notice.

- I reserve the right to change my policies and procedures for protecting health information. When I make a significant change in how I use or disclose your health information, I will also change this notice.
- Except for the purposes related to your treatment, to collect payment for my services, to perform necessary business functions, or when otherwise permitted or required by law, I will not use or disclose your health information without your authorization. You have the right to revoke your authorization at any time.

When Can I Legally Disclose Your Health Information Without Your Specific Consent?

- *In order to facilitate your medical treatment.*
  For example: Your primary care physician or your psychotherapist might call me to discuss your treatment, and in that situation I would disclose information about your diagnosis, your medications, and so on.
- *In order to collect payment for health care services that I provide.*
  For example: In order to get paid for my services, I have my billing office send a bill to you or your insurance company. The information on the bill may include information that identifies you, as well as your diagnosis, and type of treatment. In other cases, I fill out authorization forms so your insurance company will pay for extra visits, and this includes some information about you, including your diagnosis.
- *In order to facilitate routine office operations.*
  For example: Occasionally, I dictate notes from visits, usually for letters to other clinicians. In that case, your health information will be disclosed to the transcriptionist.

Will I Disclose Your Health Information to Family and Friends? While the new law allows such disclosures without your specific consent (as long as it contributes to your treatment), my office policy is that I will *never* share your clinical information with your family without a signed authorization from you. The BIG EXCEPTION to this is if I believe you pose an immediate danger to yourself or someone else—in that case, I will do whatever is necessary, even if that means breaching confidentiality.

Less Common Situations in Which I Might Disclose Your Health Information

- Workers compensation: I may disclose your health information to comply with laws relating to worker's compensation or other similar programs.
- Law enforcement: I may disclose your health information for law enforcement purposes as required by law or in response to a valid subpoena, or court or administrative order. This includes any information requested by the Department of Social Services (DSS) related to cases of neglect or abuse of children.
- Food and Drug Administration (FDA): I may disclose to the FDA your health information relating to adverse events due to medications.
- Business associates: I hire a billing company to send out bills to insurance companies. Some of the employees of this company have access to a small portion of your health information in order to allow them to do their job.

For More Information or to Report a Problem. If you have questions, would like additional information, or want to request an updated copy of this notice, you may contact us any time at (304) 242-8095. If you feel your privacy rights have been violated in any way, please let me know and I will take appropriate action. You may also send a written complaint to:

Department of Health & Human Services, Office of Civil Rights,
Hubert H. Humphrey Building 200 Independence Avenue
S.W. Room 509 HHH Building
Washington, D.C. 20201

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We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

Name: _____ Date: _____/____/_____

Signature: _____

Witness: _____