CLIENT INTAKE FORM- EMPLOYEE THERAPY

Name: _____ **Nickname:** _____ **DOB:** _____

Gender Identity *(Please circle):* **Male** **Female** **Transgender** **Prefer not to Answer** **Other:** _____

Home Street Address: _____

Apt: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Phone #: Cell/ Work/ Home _____ **Alternate #:** _____

Please circle **YES** or **NO** if allowed to leave a voicemail.

Please circle **YES** or **NO** if allowed to send text communications.

General concern (please circle) ☐ **Anxiety** ☐ **Depression** ☐ **Work Stress** ☐ **Home Stress** ☐ **Family Stress**

More specifically, briefly describe your reason for seeking therapy services:

How are you feeling today?

What are contributing factors to feeling this way?

What have been your three dominant emotions this week?

What are some things that trigger negative emotions?

What do you expect from meeting with a therapist?

What outcome do you expect to achieve through counseling?

Rate your mental health this week:

Adverse Childhood Experience Questionnaire for Adults

California Surgeon General's Clinical Advisory Committee

aces aware
SCREEN. TREAT. HEAL.

Our relationships and experiences—even those in childhood—can affect our health and well-being. Difficult childhood experiences are very common. Please tell us whether you have had any of the experiences listed below, as they may be affecting your health today or may affect your health in the future. This information will help you and your provider better understand how to work together to support your health and well-being.

Instructions: Below is a list of 10 categories of Adverse Childhood Experiences (ACEs). From the list below, please place a checkmark next to each ACE category that you experienced prior to your 18th birthday. Then, please add up the number of categories of ACEs you experienced and put the *total number* at the bottom.

1. Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?	☐
2. Did you lose a parent through divorce, abandonment, death, or other reason?	☐
3. Did you live with anyone who was depressed, mentally ill, or attempted suicide?	☐
4. Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?	☐
5. Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?	☐
6. Did you live with anyone who went to jail or prison?	☐
7. Did a parent or adult in your home ever swear at you, insult you, or put you down?	☐
8. Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?	☐
9. Did you feel that no one in your family loved you or thought you were special?	☐
10. Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?	☐
Your ACE score is the total number of checked responses	

Do you believe that these experiences have affected your health? ◯ **Not Much** ◯ **Some** ◯ **A Lot**

Experiences in childhood are just one part of a person's life story.
There are many ways to heal throughout one's life.

Please let us know if you have questions about privacy or confidentiality.

5/5/20

CONSENT FOR SERVICES FORM- EMPLOYEE THERAPY

Your therapist, Susan Beeson, has asked you to read and sign this Consent before you start therapy. Please review the information. If you have any questions, contact your Provider.

THE THERAPY PROCESS

Therapy is a collaborative process where you and your Provider will work together on equal footing to achieve goals that you define. This means that you will follow a defined process supported by scientific evidence, where you and your Provider have specific rights and responsibilities. Therapy generally shows positive outcomes for individuals who follow the process. Better outcomes are often associated with a good relationship between a client and their Provider. To foster the best possible relationship, it is important you understand as much about the process before deciding to commit.

Therapy begins with the intake process. First, you will review your Provider's policies and procedures. Second, you will discuss what to expect during therapy, including the type of therapy, the length of treatment (short term – maximum of 5 consecutive sessions), and the risks and benefits. If your Provider is practicing under the supervision of another professional, your Provider will tell you about their supervision and the name of the supervising professional. Third, you will form a treatment plan, including the type of therapy, how often you will attend therapy, your goals, and the steps you will take to achieve them. If following this short-term service, you and your provider feel you need a longer term option, resources will be provided to you. After intake, you will attend regular therapy sessions at your Provider's office or through video, called telehealth. Participation in therapy is voluntary - you can stop at any time. At some point, you will achieve your goals. At this time, you will review your progress, identify supports that will help you maintain your progress, and discuss how to return to therapy if you need it in the future.

TELEHEALTH SERVICES

To use telehealth, you need an internet connection and a device with a camera for video. Your Provider can explain how to log in and use any features on the telehealth platform. If telehealth is not a good fit for you, your Provider will recommend a different option. There are some risks and benefits to using telehealth:

• Risks

• Privacy and Confidentiality. You may be asked to share personal information with the telehealth platform to create an account, such as your name, date of birth, location, and contact information. Your Provider carefully vets any telehealth platform to ensure your information is secured to the appropriate standards.

• Technology. At times, you could have problems with your internet, video, or sound. If you have issues during a session, your Provider will follow the backup plan that you agree to prior to sessions.

• Crisis Management. It may be difficult for your Provider to provide immediate support during an emergency or crisis. You and your Provider will develop a plan for emergencies or crises, such as choosing a local emergency contact, creating a communication plan, and making a list of local support, emergency, and crisis services.

• Benefits

• Flexibility. You can attend therapy wherever is convenient for you.

• Ease of Access. You can attend telehealth sessions without worrying about traveling, meaning you can schedule less time per session and can attend therapy during inclement weather or illness.

• Recommendations

• Make sure that other people cannot hear your conversation or see your screen during sessions.
• Do not use video or audio to record your session unless you ask your Provider for their permission in advance.
• Make sure to let your Provider know if you are not in your usual location before starting any telehealth session.

CONFIDENTIALITY

Your Provider will not disclose your personal information without your permission unless required by law. If your Provider must disclose your personal information without your permission, your Provider will only disclose the minimum necessary to satisfy the obligation. However, there are a few exceptions.
• Your Provider may speak to other healthcare providers involved in your care.
• Your Provider may speak to emergency personnel.
• • If your Provider believes there is a specific, credible threat of harm to someone else, they may be required by law or may make their own decision about whether to warn the other person and notify law enforcement. The term specific, credible threat is defined by state law. Your Provider can explain more if you have questions.
• If your Provider has reason to believe a minor or elderly individual is a victim of abuse or neglect, they are required by law to contact the appropriate authorities.
• If your Provider believes that you are at imminent risk of harming yourself, they may contact law enforcement or other crisis services. However, before contacting emergency or crisis services, your Provider will work with you to discuss other options to keep you safe.

RECORD KEEPING

Your Provider is required to keep records about your treatment. These records help ensure the quality and continuity of your care, as well as provide evidence that the services you receive meet the appropriate standards of care. Your records are maintained in an electronic health record provided by TherapyNotes. TherapyNotes has several safety features to protect your personal information, including advanced encryption techniques to make your personal information difficult to decode, firewalls to prevent unauthorized access, and a team of professionals monitoring the system for suspicious activity. TherapyNotes keeps records of all logins and actions within the system.

COMMUNICATION

You decide how to communicate with your Provider outside of your sessions. You have several options:
• Texting/Email
• Texting and email are not secure methods of communication and should not be used to communicate personal information. You should carefully consider who may have access to your text messages or emails before choosing to communicate via either method.
• Secure Communication
• Secure communications are the best way to communicate personal information, though no method is entirely without risk. Your Provider will discuss options available to you. If you decide to be contacted via non-secure methods, your Provider will document this in your record.
• Social media/review websites
• If you try to communicate with your Provider via these methods, they will not respond. This includes any form of friend or contact request, @mention, direct message, wall post, and so on. This is to protect your confidentiality and ensure appropriate boundaries in therapy.

COMPLAINTS

If you feel your Provider has engaged in improper or unethical behavior, you can talk to them, or you may

contact the licensing board that issued your Provider's license, your insurance company (if applicable), or the US Department of Health and Human Services.

ACKNOWLEDGEMENT

My signature on this document represents that I have received the Consent for Services form and that I understand and agree to the information therein.

Signature: _____ Date: _____

Printed Name: _____

LAKEMARY CENTER, INC.

100 Lakemary Drive, Paola, KS 6607
15145 S. Keeler, Olathe, KS 66062
5940A Dearborn, Mission, Ks 66202

Notice of Privacy Practices

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) and the HITECH Act of 2009 requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper or orally be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. We have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. Without your specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers so Lakemary Center, Inc. can treat you or assist others in your treatment. Examples would include doctors, nurses, pharmacists, social workers, therapists and affiliated health care personnel as well as hospitals, clinics, nursing homes, residential treatment facilities, laboratory and diagnostic facilities, etc. Treatment would also include sharing information with your designated personal representative if they will be involved in your care and treatment.

- **Payment** means such activities as confirming insurance coverage, obtaining reimbursement for services, billing /collection activities and utilization review. Payment may also require that we provide details regarding your pre-treatment condition and/or periodic updates concerning your progress to obtain payment for required services.

- **Health Care Operations** include the operating aspects of our business, such as conducting quality assessment and improvement activities internally and through accrediting and credentialing organizations, auditing and corporate compliance functions, cost-management analysis and customer service.

In addition, we are permitted by law to make certain uses and disclosures of your personal health information without your consent, subject to those conditions specified in the law. Your confidential information may be released to:

- comply with federal, state or local law, statute or regulations
- for public health activities, such as required reporting of disease, injury, death and for required public health investigations
- notify certain governmental agencies if we suspect child abuse or neglect; or if we believe that you may be a victim of abuse, neglect or domestic violence
- notify entities regulated by the Food and Drug Administration if necessary to report adverse events, product defects or to participate in product recalls
- comply with government oversight agencies that have legal authority to conduct audits, investigations, inspections and related functions
- prevent a serious and imminent threat to a person or to the public as would be encountered in an emergency situation
- comply with a bona fide court or administrative order, subpoena or discovery request; in most cases you will have notice of such release
- comply with requests from law enforcement officials to identify or locate suspects, fugitives or witnesses or victims of crime or for other allowable law enforcement purposes
- notify coroners, medical examiners and/or funeral directors
- provide notice to you or your designated medical representative with a reminder (i.e. telephonic, US Mail, etc.) of an upcoming appointment

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regard to your protected health information, which you may exercise by presenting a written ***request to our Privacy Officers at the location listed below***. Although under specific circumstances these rights may be limited, generally they include:

- The right to have your personal health information kept confidential.
- The right to know why we need to ask questions about your past medical history and current medical condition and the right to refuse to answer such questions.
- The right to request restrictions in our use or disclosure of your protected health information for treatment, payment or health care operations including that related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to such a restriction.
- If we do agree to a restriction and we later deem that the restriction to be inappropriate, we retain the right to terminate an agreed upon restriction and we will provide you notice of this change.

- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations. We will accommodate reasonable requests by you.
- The right to request an amendment to your protected health information if you believe that it is incorrect or incomplete.
- The right to access, inspect and copy your protected health information. Lakemary Center, Inc. may charge a cost based fee for copying and mailing such information.
- The right to receive an "accounting of disclosures" or list of certain protected health information disclosures our organization has made excluding those related to treatment, payment and health care operations. Under certain circumstances, there may be a cost based charge for compiling this list.
- The right to obtain a paper copy of this notice from us upon request.
- The right to file a complaint if you believe your privacy rights have been violated.
- The right to provide an authorization for other use and disclosure that is not identified in this notice or permitted by applicable law.

Confidentiality of Alcohol and Drug Abuse Records HIV- Related Information and Mental Health Records. The confidentiality of alcohol and drug abuse records, HIV information and mental health records maintained by us is specifically protected by state and/or Federal law and regulations. Generally, we may not disclose such information unless you consent in writing, the disclosure is allowed by a court order, or in other limited and regulated circumstances. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

Business Associates. Certain aspects and components of our services are performed through contracts with other healthcare professionals and / or organizations, such as auditing, accreditation, legal services etc. At times it may be necessary for us to provide certain of your personal health information to one or more of these persons or organizations who assist us with treatment, payment/ billing and healthcare operations. In such circumstances, we require these business associates to appropriately safeguard the privacy of such information.

Persons Involved In Your Care. Unless you specifically object, we may, in our professional judgment, disclose to a member of your family or personal representative, a close friend or any other person you identify, your personal health information to facilitate that person's involvement in caring for you or in payment for that care. We may use or disclose personal health information to assist in notifying a family member, a personal representative, or any other person that is responsible for your care and general condition. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts to locate a family member or other persons that may be involved in some aspect of caring for you.
Paper Copy As Notice. As a patient, you retain the right to obtain a paper copy of this Notice of Privacy Practices, even if you have requested such a copy by email or other electronic means. You may also download and print a copy of this Notice from our website located at www.lakemary.org.

Research. We may use and disclose your de-identified personal health information as permitted or required by law for research, subject to your explicit authorization.

This notice is effective as of January 2017 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services. Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our privacy practices, please contact:

Privacy Officers at our Toll Free Number 866-557-0700 OR directly at:

Jamee Engelby, Corporate Compliance Officer; 913-937-9288 OR jamee.engelby@lakemary.org
Lakemary Center, Inc., 100 Lakemary Drive. Paola, KS 66071 Fax: 913-557-4910

For more information about HIPAA or to file a complaint:

The U.S. Department of Health and Human Services
Office of Civil Rights Phone: 877-696-6775
200 Independence Avenue SW
Washington, D.C. 20201

By signing below, I attest that I have been provided with a copy of this brochure, my rights have been reviewed, and questions have been answered.

_____ _____
Name Date
Select one: ☐ Individual Served ☐ Parent ☐ Guardian ☐ Volunteer/Intern ☐ Staff ☐ Other:_____

Originated: April 2003
Reviewed: 04/04; 04/05; 04/06; 04/07; 04/08/; 04/09; 11/11;
07/14 Revised: 11/10; 09/13; 03/15; 03/17; 08/18; 02/23

CLIENT RIGHTS AND RESPONSIBILITES – EMPLOYEE THERAPY

AS A CLIENT, YOU HAVE CERTAIN RIGHTS:

1. **You have the right to non-discrimination.**
   You have a right to reasonable access to care, regardless of race, religion, color, national origin, ancestry, political affiliation, religion, sex, sexual orientation, ethnicity, age, or disability. If you have any physical problems that make it difficult for you to come to one of our offices, please let the receptionist know so we can try to make special arrangements. You have the right to adequate treatment and considerate care that respects your personal values, belief systems, and personal dignity.

2. **You have the right to know about your treatment.**
   You have a right to an explanation of any treatment prescribed; the reason for such treatment, and any known risks associated with such treatment.

3. **You also have the right to see and review your clinical record.**
   An exception to this right is if the disclosure might be injurious to your welfare in which case our executive director will give a written explanation of the reason for refusal to you.

4. **You have the right to be involved in decisions regarding your treatment; and to be involved in planning for both your treatment and discharge of services.**

5. **You have the right to know approximately how long you will be in treatment.**
   While the duration of treatment may vary for everyone, your mental health professionals can provide you with an estimate of the time required to address your particular needs.

6. **You have the right to refuse any form of treatment.**
   Our staff will advise you as to what types of treatment or services may be helpful to you. You can choose to decline any treatment or services offered, but your overall treatment plan may need to be reevaluated.

7. **You have the right to request alternative treatment information.**
   If you want to know about other treatment alternatives, please discuss this with your Lakemary Crisis Team.

8. **You have the right to confidentiality.**
   Protection of your confidentiality is particularly important to us. Lakemary Center staff may not disclose that you have previously or are currently receiving any type of mental health treatment or disclose any information you have provided during your treatment. If you want your confidential information released, you will need to sign a written authorization. You have the right to revoke that authorization at any time and prevent further disclosure.

   ***EXCEPTIONS*:**

   (a) If a medical emergency arises where failure to release would endanger your life.

(b) If a medical or psychological emergency occurs where there is an immediate danger of harm to you or others.

(c) If disclosure of information is required by law (e.g., court order, bench warrant). Crimes at the treatment program, service, delivery, against the facility or Personnel. Concerns of crime to the premises or against program personnel.

(d) If child abuse or neglect is suspected, mental health professionals are required to report this to the appropriate agency.

(e) Research or Audit: The proposed sharing of information is for the purpose of research or part of an audit or review of program activities.

(f) Internal Communication: The information to be shared is with other staff of Lakemary Center.

9. **You have the right to be accompanied or represented by a person of your choice during your contacts with Lakemary Center.**
   If you feel more comfortable bringing a friend, relative, or representative with you, you are welcome to do this unless it interferes with your treatment.

10. **You have the right to Lakemary Center services while seeing a mental health practitioner who is not affiliated with Lakemary Center.**
    It is acceptable for you to see a psychiatrist/physician or a mental health practitioner elsewhere while coming to Lakemary Center for other aspects of your treatment. We request that you allow us to communicate with your psychiatrist/physician or a mental health professional so that we can coordinate your treatment.

11. **You have the right to be informed of any experimental or research activities that are involved in your treatment.**
    You have the right to refuse to participate (or withdraw consent and discontinue participation) without this resulting in denial or alteration of the services needed.

12. **You have the right to always be treated with dignity and respect and not to be subjected to any verbal or physical abuse or exploitation.**

13. **You have the right not to be subjected to the use of any type of treatment, technique, or practice performed solely as a means of coercion, discipline, or retaliation for the convenience of staff, any volunteer or contractor.**

14. **You have the right to make a written complaint regarding violations of these rights and/or any other matter.**
    Our staff can provide you with a form for this purpose. You have the right to representation by legal counsel in filing a complaint.

AS A CLIENT, YOU HAVE CERTAIN RESPONSIBILIITIES:

1. **Provide accurate information needed for treatment.**
   This includes your history and reasons for seeking treatment to allow us to effectively collaborate with you. Mental health professionals need your honest communication as to how you feel and what your needs are. Open and honest expressions of your thoughts, feelings and needs are vital components of successful treatment.

2. **Be invested and participate in understanding your behavioral health care problems and develop mutually agreed upon treatment goals to the best of your ability.**

3. **Follow the plan for treatment.**
   The mental health professional will assist you in achieving the goals developed on the treatment plan. However, much of the effort needed for change will come from you.

4. **Keep your appointments or cancel in a timely manner.**
   We appreciate at least a twenty-four (24) hour notice of cancellation. This allows an opportunity for another individual to use the time.

5. **Let us know of any special arrangements and/or accommodations you might need due to a handicap, disability or special condition.**

6. **Let the mental health professional know if medications are discontinued, or problems with medications are occurring.**

7. **Let the agency know if a crisis or emergency situation exists.**

8. **Respect others' confidentiality.**
   Please keep any information from group sessions and/or information about others that might be seeking treatment confidential.

9. **Let us know if your name, address, or insurance information changes.**
   Your help in keeping our records updated will be appreciated.

10. **Let the agency know if you do not plan to return for services.**