

ADULT INTAKE FORM

HOME INFORMATION

List all persons living in the home

Name	Age	Relationship	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any immediate family members not living with you due to some type of separation:

YOUR FAMILY

Relative	Name(s)	Living?	Age or age at death	Occupation	Describe Relationship
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

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HISTORY

Have you ever sought counseling before? ___Y ___N

If yes, name of professional: _____

Duration of counseling: _____

Who referred you to Karen L. Steen, MA, LPC-S?

___ Self/Former Client

___ Managed Care

___ Family/Friend

___ Employee Assistance Program

___ School

___ Insurance Carrier

___ Courts/Judicial System

___ Other _____

EDUCATION

Where did you attend public school? _____

Did you attend college/professional school? ___Y ___N If yes, when, where & what degree earned? _____

Any plans to further your education? ___Y ___N

If yes, when and what? _____

COMPLAINT DESCRIPTION

Please list the main reason for seeking counseling at this time:

What would you like to get out of counseling at this time?

Is there anything else you would like me to know?

ADULT INTAKE FORM

COMPLAINT CHECKLIST

Please check any of the following symptoms you are currently experiencing.

Abuse – emotional	Abuse – neglect	Abuse – physical	Abuse – sexual
Aggression	Anger	Anxiety	Arguing
Attention problems	Career concerns	Childhood issues	Children – care of
Children/Parenting	Choices I have made	Codependence	Compulsive spending
Concentration problems	Confusion	Crying	Crying – unable to
Deaths	Debt	Decision making	Delusions – false ideas
Dependence	Depression	Distractibility	Divorce
Drug abuse – over the counter	Drug abuse – prescription	Drug abuse – street drugs	Drug abuse – alcohol
Eating – poor appetite	Eating – making myself vomit	Eating – overeating	Eating – undereating
Emptiness	Failure	Fatigue	Fears
Financial troubles	Friendship problems	Gambling	Goals not being met
Grieving	Guilt	Headaches/pain	Health/Medical concerns
Hearing Things or Seeing Things	Hostility	Impulsive spending	Impulsiveness
Indecision	Inferiority feelings	Inhibitions	Interpersonal conflicts
Irresponsibility	Irritability	Judgment problems	Laziness
Legal matters	Loneliness	Loss of control	Low energy
Marital coldness	Marital conflict	Marital distance	Marital infidelity/affairs
Memory problems	Menopause	Menstrual problems	Mood swings
Motivation	Obsessions	Oversensitivity	Panic or anxiety attacks
Perfectionism	Pessimism/Negativism	Phobias	Poor self care

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SYMPTOM CHECKLIST

Please check any of the following symptoms you are currently experiencing.

Procrastination	Relationship problems	Relaxation	Remarriage
Risk taking	Sadness	School problems	Self abuse – burning
Self abuse – cutting	Self abuse – other	Self abuse – scratching	Self centeredness
Self control	Self esteem	Self neglect	Separation
Sexual conflicts	Sexual desire differences	Sexual dysfunctions	Sexual – other issues
Shyness	Sleep – insomnia	Sleep – nightmares	Sleep – too little
Sleep – too much	Stepparenting	Stress	Stress management
Suicidal thoughts	Suspiciousness	Temper problems	Thought disorganization
Threats of violence	Tobacco use	Violence	Violence – victim of crime
Work problems	Weight and diet issues	Withdrawal – isolating	Employment problems
Employment – lack of	Employment – overdoing	Employment – termination	Other concerns or issues

ADULT INTAKE FORM

INSURANCE INFORMATION

Please provide a copy of both sides of your insurance card and driver's license for verification of benefits and identity. You can bring these with you on the day of your appointment if you would like it to be verified at that time. For your convenience, you can also scan these and email to karensteenlpc@brighter-days.net or take a picture and text it to 337-515-5654 if you would like it to be verified prior to your appointment.

RESPONSIBLE PARTY

Name: _____ Birth Date: _____
Address: _____
Drivers License #: _____ SS# _____ Phone: _____

INSURANCE INFORMATION

Who is the insured? _____ SS # _____
Birth Date: _____ Relationship to Client: _____
Cell Phone: _____ Work Phone: _____
Employer of Insured: _____
Insurance Company Name: _____
Insurance Phone # for Mental Health _____ Member ID#: _____
Group ID#: _____

I authorize the release of any medical or other information necessary to process an insurance claim. I understand that Brighter Days Counseling Services, LLC will diligently attempt to get accurate information regarding my mental health insurance benefits. I will not hold Brighter Days Counseling Services, LLC liable for insurance nonpayment due to misquoted benefits. I will not hold Brighter Days Counseling Services, LLC responsible to know and understand my benefits plan. Brighter Days Counseling Services, LLC will file my insurance claims for me as a courtesy. I am ultimately responsible for all charges my insurance company does not pay, except for contracted network provider discounts that may apply. I also request benefits be paid to Brighter Days Counseling Services, LLC.

Signature of Client and/or Responsible Party: _____
Date: _____

Court/Report Policy

This policy needs to be signed by each client receiving services in order to provide for any potential future needs from this office involving the described services below

I, _____, understand that fees for Karen Steen, MA, LPC-S, to appear in court are as follows:

Appearance fees are billed at the court rate of **\$250.00** an hour with a 2 hour minimum with a deposit of **\$750.00** required before the scheduled court date. If the counselor does not appear in court and all matters have been completely settled the deposit will be refunded, minus a **\$100.00** court preparation fee and any outstanding balance for appointments and requested reports. Depositions are billed at **\$150.00** per hour due upon completion of interview.

As a general rule, progress notes are not released without a judge's order. In lieu of progress notes, a written report and case summary can be provided with signed releases. Report fees are billed at a rate of **\$150.00** per hour. If you, the Client, chooses to not release your file or records to the court, you will be responsible for all attorney fees, court fees, and filing fees associated with your decision to not release your information. Brighter Days Counseling Services, LLC or Karen Steen, MA, LPC-S will not be responsible for any legal fees accrued by the client.

Services involving mental health assessments of any kind require a **\$500.00** deposit prior to making any appointments and are billed as follows: **\$150.00** per 1 hour session, **\$150.00** per hour for reports, and **\$150.00** per hour for phone consultations between assessed parties and/or their attorneys which will be prorated accordingly. Any balance that remains beyond the deposit must be paid in full prior to the release of the reports. An extensive assessment report involving your individual therapy that does not require the assessment of other parties is also billed at the rate of **\$150.00** per hour paid in full prior to the release of the report.

All of the above services cannot be billed through your insurance carrier, therefore are your full responsibility.

If you do not understand any of the information contained in this policy or have any questions concerning this policy, please do not hesitate to bring your concerns to your counselor.

CLIENT

DATE

COUNSELOR

DATE

DECLARATION OF PRACTICE AND PROCEDURES

KAREN L. STEEN, MA, LPC-S
748 E. Bayou Pines, Suite B
Lake Charles, LA 70601
P.O. Box 7974
Lake Charles, LA 70606
Phone (337) 515-5654
Fax: (337) 214-1836
karensteenlpc@brighter-days.net
www.brighter-days.net

QUALIFICATIONS: I hold a Master of Arts in Clinical/Counseling Psychology from McNeese State University. I am licensed as an Licensed Professional Counselor (#3088) with the LPC Board of Examiners, which is located at 8631 Summa Avenue, Baton Rouge, LA 70809, (225) 765-2515. I am an LPC-S, certified to supervise Counselor Interns in the State of Louisiana.

AREAS OF EXPERTISE: I have training and experience working with individuals, adults, adolescents, children, families and groups on a variety of issues such as depression, anxiety, interpersonal relationships and other mental health concerns. I also have training in the field of Infant Mental Health and have done dyadic work with mothers and infants and have provided mental health consultation to childcare centers.

THERAPEUTIC RELATIONSHIP: I view the counseling relationship as one built on trust, where teamwork is a must. We will work to develop and implement goals to improve your quality of life. While it is not possible or realistic to guarantee certain results, together you and I can work to achieve positive results for you.

I see a variety of people and use a variety of formats including individual, dyadic, couples, families and group settings. I choose techniques that fit each client's beliefs and needs individually and techniques that will be the most beneficial to them. While I typically prefer to use either a client-centered or cognitive-behavioral approach, I often integrate other theoretical approaches into the sessions.

CODE OF CONDUCT: It is important for you to realize that we are entering a professional relationship and that you are experiencing me in my professional role. I am best able to serve you if our relationship stays strictly professional and if our sessions focus only on your concerns. Additionally, while I can assist in understanding the consequences of making certain decisions, my professional code of conduct prohibits me to advise you how to make decisions. I am required by state law to adhere to the Code of Conduct for practice that has been adopted by the Louisiana Licensed Professional Counselors' Board of Examiners. A copy of the code of Conduct is available upon request.

PRIVILEGED COMMUNICATION: I am required to abide by the professional practice standards for Licensed Professional Counselors and Louisiana law. Information shared during sessions will be kept confidential, with certain exceptions, such as a client's written consent authorizing the sharing of information or when I am mandated or permitted by law to disclose information.

State law mandates that I report to the appropriate authorities suspected cases of child abuse/neglect, elder abuse/neglect (60 or older), or abuse/neglect of a disabled person, and instances in which you are believed to be a danger to yourself or someone else. Certain types of litigation may result in a court-order to release information without your consent.

In family counseling situations, information obtained from an individual adult client may be shared with the client's family members only with the written consent of the client, with the exception of marriage counseling situations. Material which is discussed with a minor client may be shared with the client's parent or legal guardian.

In marriage counseling situations, I do not withhold information from one spouse/partner which is provided to me by another spouse/partner. This includes any and all information provided to me through individual counseling sessions with a spouse/partner or through any type of electronic communication such as email, phone calls, texts, etc. Should you desire such confidentiality, I can assist you with a referral to a therapist who can provide marriage counseling where such information is shared only with your written consent or I can assist you with a referral to a therapist who can provide you with individual counseling that can occur in conjunction with the marriage counseling I provide to you and your spouse/partner.

FEE SCALES: The fee for an initial 45-50 minute individual or family session is \$150.00. The fee for additional 45-50 minute individual or family sessions is \$110.00. All fees will be collected before each session. In the case of insurance clients, copays will be collected before each session and, as a courtesy, I will submit claims to insurance companies for you. Any portion not paid by your insurance company will be your responsibility. Except in the event of an emergency, any cancellation or rescheduling of appointments made with less than 24 hours notice will result in your being charged the full session fee. Arriving late does not extend the counseling hour. All sessions will end at the scheduled time regardless of the time at which you arrive for the appointment. This is a courtesy to other clients who may be scheduled after your appointment.

CLIENT RESPONSIBILITIES: As a client, your honesty and participation are necessary if progress and success are the desired results. During this process, should questions or concerns arise regarding the services received, I would hope that you would share those with me so that we can address those issues. If you should feel you would be better served by another mental health provider, I will assist you with a referral. If you are currently seeing another mental health professional, I ask that you inform me of this and grant me permission to share information with them so that we may coordinate our efforts to better serve you.

In the counseling relationship, clients are primarily responsible for following appointment scheduling procedures, making a committed effort in the counseling process, and terminating one counseling relationship before beginning another.

POTENTIAL COUNSELING RISK: The client should be aware of the possibility that counseling could result in having underlying issues brought to the surface which you may not have been aware of prior to the onset of the counseling relationship.

PHYSICAL HEALTH: Physical health can be an important factor in an individual's emotional well being. If you have not had a physical examination within the past year, it is recommended that you do so and that you provide me with a list of any medications which you are currently taking, in an effort to help me better serve you.

AFTER HOURS AND EMERGENCY SITUATIONS: If a crisis or emergency should arise, you may seek assistance through hospital emergency room facilities or by calling 911.

Client Signature

Date

Karen L. Steen, MA, LPC-S

Date

I, (parent or guardian) _____, give permission

for Karen L. Steen, MA, LPC-S to conduct counseling with my (relationship)

_____ (name of minor) _____ .

MEDICAL INFORMATION

In order to provide you with quality care, your counselor needs to know as much about you as possible. This includes obtaining information regarding your health.

SECTION I: Medical Checklist

Please review and check any of the following you are experiencing or have experienced in the past.

- | | | |
|---|---|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Bulimia | <input type="checkbox"/> Mental retardation |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Asthma/Allergy | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Respiratory Illness |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Anorexia | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sleeping Disorder |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cardio-Vascular |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Weight Problems | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Other Impairment | <input type="checkbox"/> Sexually Transmitted Disease | |

If other has been indicated, please describe: _____

SECTION II: Medications

List the medications you are currently taking:

Medication	Dosage	Start Date

Date of your last physical examination: _____ **Doctor:** _____

Client Name: _____

Signature of Client/Caregiver

Date

Request/Authorization for Releasing/Obtaining Information

Client Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Parent/Guardian Name (if minor) _____

I, _____, hereby authorize Brighter Days Counseling Services, LLC and Karen L. Steen, MA, LPC-S (118 State St, Lake Charles, LA 70605) to exchange information with _____ (name of individual or organization). This information will be shared for the following purpose(s):

- Assist with treatment planning for the continuity of care
- Document a need for services
- Other: _____

Individual or Organization Information

Name: _____ Contact Person: _____

Address: _____ Phone: _____

_____ Fax: _____

I understand that I may revoke this consent at any time. I further understand that this consent may not be renewed without my written consent. This consent will expire in one year from the signature date.

Client Signature or Parent/Guardian/
Representative

Printed Name

Date

Notice of HIPAA Practices

Please take a moment to review the following notice carefully as it describes my duty to protect your Personal Health Information. Protecting the privacy and security of my client's Personal Health Information is important to me. This notice describes how I may use your information or disclose it, what your privacy rights are and how you may gain access to your own Personal Health Information.

PRIVACY PRACTICES

Designated Security and Privacy Officer for Brighter Days Counseling Services, LLC

Karen L. Steen, MA, LPC-S is the designated Security Officer and Privacy Officer and all privacy and security questions, concerns or requests should be directed to me as I will be responsible for handling them.

How Karen Steen Uses and/or Discloses Your Personal Health Information

Abuse, Neglect or Domestic Violence – As a mandated reporter in the State of Louisiana, if I believe you or your child/children may be victims of abuse, neglect or domestic violence I may disclose health information about you or your child/children to the appropriate agency which requires me to disclose this information.

Serious Threat to Safety or Health – I may use or disclose information about you or your child/children if I believe that there is a serious and immediate threat and that it is needed in order to protect the safety of you, your child/children, a person, or the public.

Judicial Proceedings – I may use or disclose you or your child/children's health information in any judicial proceeding if I receive a court ordered subpoena that requires me to disclose it.

Privacy and Security Policies

All reasonable measures have been taken to ensure confidentiality of any and all electronic information sent and received (i.e. emails, texts). It is important for you to be aware of the risks taken when information is shared in this format. Some possible risks of sharing personal or confidential information in this way:

- Accidental delivery of an email or text to an incorrectly typed address or phone number
- Email accounts may be "hacked" giving a 3rd party access to sensitive

Notice of HIPAA Practices

Information such as the content of the message, email addresses, etc.

- Email providers (Gmail, Yahoo, etc) keep a copy of each email on their servers, where it might be accessible to their employees or other company individuals

Karen Steen takes precautions to help minimize the chance of a compromise in your Personal Health Information

- Cell phones and lap top contains password protection
- When electronic devices such as cell phone or laptop is retired, it is first "wiped" of all information before it is either recycled or destroyed
- If there is a breach of your Personal Health Information, I will personally contact you to inform you of the extent of the breach and the plan to contain the situation
- I will not sell any of your Personal Health Information for marketing purposes
- I follow all Ethical Codes which help in securing your information. You may obtain a copy of the Codes on the Louisiana LPC Board's Official Website.
- All HIPAA documentation will be kept on file for a minimum of 6 years

Storage of Client Files

Your client file containing your Personal Health Information as well as any and all information concerning treatment are stored in a locked file cabinet for 5 years after the date of the last session. If something should happen to me, the LPC Board has a designated counselor on record who is responsible for taking possession of my files. They will store them under the same guidelines to protect your confidentiality. When a file is ready to be destroyed, it is shredded.

CLIENT PRIVACY

Private Health Information may be used and/or disclosed in the following situations:

- Information that is necessary in order to file insurance claims and complete billing and collection procedures
- When required for workman's compensation
- When required by any state or federal law, such as in cases of abuse or neglect
- When required by any specialized government or military functions
- When required in cases of an individual who is confined to a correctional

Notice of HIPAA Practices

institution or under any type of law enforcement supervision

- When used for any clerical purposes and necessary file audits by managed care companies

As a client, you have the following rights with regard to your Personal Health Information:

- The right to review or receive a copy of your records by signing and providing a written request. Under rare circumstances, a request may be denied. In such cases, you may choose to receive a summary of progress instead which will include information about symptoms and treatment plans. Requests for records will receive a response or will be completed within 15 days
- The right to request information on any party that has requested information pertaining to your Private Health Information from me
- The right to receive confidential information about your Private Health Information
- The right to revoke this consent in writing. However, please be aware that it will not affect any information already disclosed
- The right to request a copy of this notice at any time

As a mental health professional, I have the responsibility to:

- Make each client aware of the Privacy Notice and any changes made to it
- Make necessary changes to the Privacy Notice as required by law

The protection and security of your Personal Health Information is very important to me. If you have questions or comments about this Privacy Notice, please let me know. If you as the client feel your privacy has been violated, you have the right to contact the U.S. Department of Health & Human Services Office of Civil Rights at www.hhs.gov/ocr/hipaa/ . Any and all complaints filed against me will be recorded on this company's Complaints Form and provided to any and all of Karen's clients with the intake paperwork.

By signing below, I acknowledge that I have read and understand this document.

Client Signature

Date

Karen L. Steen, MA, LPC-S

Date