BRIGHTER DAYS COUNSELING SERVICES, LLC
www.brighter-days.net

P.O. BOX 7974
LAKE CHARLES, LA 70606
748 E. BAYOU PINES, SUITE B
LAKE CHARLES, LA 70601
Phone: (337) 515-5654
Fax: (337) 214-1836
karensteenlpc@brighter-days.net

ADULT INTAKE FORM

CLIENT INFORMATION

Name: _____ Today's Date: ___/___/____ Sex: __M __F
Age: _____ Birth Date: ___/___/____ Social Security Number _____-_____-_____
Relationship Status: ___Single ____ Married ____ Long-term Relationship ____Divorced ____Separated ____Widowed
Occupation: _____ Employer: _____
Physical Address:
_____
Mailing Address:
_____
Home Phone: _____ Cell Phone: _____
Email Address: _____
Permission to confirm appointments via ____ Email _____ Text
Prefer billing and correspondence _____ Email _____ Physical Address _____ Mailing Address
Which number may we leave a message? ____ Home ____ Cell ____ Work ____ Other (_____)
In the event of an emergency, whom should we contact?
Name: _____Relationship: _____
Cell Phone: _____Email: _____

YOUR RELATIONSHIPS

Please list your marriage(s) or other important significant-other relationships:

Partner's Name	Year Begun	Year Ended	Married	Children & Ages

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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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ADULT INTAKE FORM

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
_____Family/Friend
_____School
_____Courts/Judicial System
_____Managed Care
_____Employee Assistance Pr ogram
_____Insurance Carrier
_____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?

_____
_____
_____

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ADULT INTAKE FORM

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**

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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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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: _____

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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.

____ ADD/ADHD	____ Bulimia	____ Mental retardation
____ Alcoholism	____ Arthritis	____ Diabetes
____ Asthma/Allergy	____ Drug Abuse	____ Respiratory Illness
____ Autism	____Anorexia	____ Speech Problems
____ Back Problems	____ Epilepsy	____ Sleeping Disorder
____ Headaches	____ Stomach Problems	____ Tuberculosis
____ Cancer	____ Heart Disease	____ Cardio-Vascular
____ Kidney Disease	____ Weight Problems	____ Mental Illness
____ Other Impairment	____ 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**

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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 (748 Bayou Pines East, Suite B, Lake Charles, LA 70601) 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

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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 Bayou Pines East, Suite B
Lake Charles, LA 70601
Phone: (337) 515-5654
Fax: (337) 214-1836
karensteenlpc@brighter-days.net

QUALIFICATIONS: I hold a Master of Arts in Clinical/Counseling Psychology from McNeese State University. I am licensed as a 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 Provisional Licensed Professional Counselors working towards their licensure in the State of Louisiana.

AREAS OF EXPERTISE: I have training and experience working with individuals, adults, adolescents, children, families, couples and groups on a variety of issues such as depression, anxiety, interpersonal relationships and other mental health concerns. I 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 in the five parish area. I have training in and work with clients using Eye Movement Desensitization Reprocessing (EMDR) therapy which is aimed at giving relief to individuals suffering symptoms related to trauma. I am currently working towards certification for this specialized therapy. I also have training in and practice Anthetics Therapy involving inner figure work with individuals to relieve their suffering from a variety of mental health issues.

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 EMDR, Anthetics Therapy or the 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 cash/self pay fee for an initial 45-50 minute individual or family session is $120.00. The cash/self pay fee for additional 45-50 minute sessions is $75.00. If insurance is being used, client is responsible for any copay or deductible required by their insurance company. Fees can either be paid at the end of the session with cash, check, debit or credit card, or client can choose to receive email invoices to be paid upon receipt. 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) _____ .

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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

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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

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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