CLIENT INTAKE FORM

Kristen H. Umholtz MA LMHC **Lake Howell Health Center**

Today's Date: _____

Full legal Name:

_____

Preferred name:_____

Birth date: _____/_____/_____ Age:_____ Gender: Male Female Transgender

Marital status: Never married Partnered Married Separated Divorced Widowed

Number of children: _____ Ages:_____

Current address: _____

(city) (state) (zip)

Home phone:_____ May we leave a message? Yes No

Cell/other: _____ May we leave a message? Yes No

Email: _____ May we email you? Yes No

Who may we contact in case of an emergency: _____ Telephone number_____

Referred by: Internet search Provider in office Psychology today Open Path Collective

Other:_____ Person who referred you: _____

Are you currently receiving psychological services, professional counseling, psychiatric services, or any other mental health services? Yes No

Reason for change:_____

Are you currently taking any psychiatric prescription medication? Yes No

If yes, please list:_____

Have you been prescribed psychiatric prescription medication in the past? Yes No

If yes, please list:_____

Have you been psychiatrically hospitalized in the past? Yes No

If yes, please list dates and locations:_____

Religious/Spiritual Information

Do you practice a religion? Yes No

If yes, what is your faith? _____

Would you like your belief system applied to the therapy process? Yes No

If yes, what are your expectations? _____

General Health Information

Please provide the name, address and telephone number for your primary care physician: _____

_____

_____

How is your physical health at the present time? Poor Unsatisfactory Satisfactory Good Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, thyroid dysfunction, etc.): _____

_____

_____

Are you on any medication for physical/medical issues? Yes No
If yes, please list:_____

Are you having any problems with your sleep habits? Yes No
If yes, circle those that apply:
Sleep too much Sleep too little Poor quality Disturbing dreams Other:_____

Are there any changes or difficulties with your eating habits? Yes No
If yes, circle those that apply:
Eating less Eating more Bingeing Restricting Other:_____

Have you experienced a weight change in the last two months? Yes No

Do you exercise regularly? Yes No
If yes, how many days per week do you exercise? _____ How many minutes/hours per session: _____

Do you consume alcohol regularly? Yes No
In one month, how many times do you have four or more drinks in a 24-hour period?_____

How often do you engage in recreational drug use? Daily Weekly Monthly Rarely Never
What kinds of recreational drugs do you use: _____

Are you currently in a romantic relationship? Yes No
If yes, how long have you been in this relationship?_____
On a scale from 1-10 (10 being great), how would you rate the quality of your relationship? _____

In the last year, have you had any major life changes (e.g. new job, moving, illness, relationship change, etc.)?

_____

_____

Quick Check

Check the issues below that apply to you.

Depressed mood	Panic Attacks	Memory Lapse	Relationship Problems
Mood Swings	Phobias	Trouble planning	Hallucinations
Rapid Speech	Repetitive Behaviors	Sleep Disturbance	Eating difficulties
Suicidal Thoughts	Anxiety	Time loss	Body Complaints
Homicidal thoughts	Excessive Worry	Alcohol/Drug abuse	Traumatic Event

Have you felt depressed recently? Yes No

If yes, for how long?_____

Have you had any suicidal thoughts recently? Yes No

If yes, how often? Frequently Sometimes Rarely

Have you ever had suicidal thoughts in your past? Yes No

If yes, how long ago?_____

How often did you have these thoughts? Frequently Sometimes Rarely

Family Mental Health History

The following is to provide information about your family history. Please mark each as yes or no. If yes, please indicate the family member affected.

Depression	Yes	No	_____
Suicide	Yes	No	_____
Anxiety Disorders	Yes	No	_____
Bipolar Disorder	Yes	No	_____
Panic Attacks	Yes	No	_____
Alcohol/Substance Abuse	Yes	No	_____
Eating Disorder	Yes	No	_____
Trauma History	Yes	No	_____
Domestic Violence	Yes	No	_____
Sexual Abuse	Yes	No	_____
Obesity	Yes	No	_____
Obsessive Compulsive Behavior	Yes	No	_____
Schizophrenia	Yes	No	_____

Any other family history I should be aware of?

_____

Occupational Information

Are you currently employed? Yes No

If yes, who is your employer?_____

What is your position?_____

Are you happy in your current position? Yes No

Does your work make you stressed? Yes No

If yes, what are your work-related stressors?_____

Other Information

List your strengths and what you like most about yourself:_____

_____

_____

List areas you feel you need to develop _____

_____

_____

What are some ways you cope with life obstacles and stress?_____

_____

_____

What are your goals for therapy/what would you like to accomplish?

_____

_____

_____

By signing below, I am acknowledging that I have chosen to receive mental health services in the form of evaluation and psychotherapy from Kristen H. Umholtz MA LMHC. My decision is voluntary and I understand that I may terminate these services at any time. I also understand that during the course of treatment I may need to discuss material of an upsetting nature in order to resolve my problems. Further, I understand it cannot be guaranteed that I will feel better after completion of treatment.

_____ _____

Signature Date

FINANCIAL POLICY

The doctors and staff at Lake Howell Health Center would like to welcome you to our practice. We strive to provide you with excellent medical care and our goal is to make your visits as convenient as possible.

By signing below you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any address or telephone number changes.
- Your account is to be kept current—Payment will be collected at the time of service. Payable by cash, check, Visa, MasterCard or Discover.
- If you do not have your payment(s), your appointment may be rescheduled.
- You may be asked to schedule another appointment for issues other than the reason for you original appointment.
- A returned check will result in a $40 service charge and all future payment being required in the form of cash or credit card.
- Cancellations within less than 24 hours and missed appointments will result in a full charge of session.
-

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. IF you have any questions about the above information please do not hesitate to ask us. We are here to help you.

I have read and understand the above Financial Policy and agree to meet all financial obligations.

_____	X_____	_____
Patient Name (please print)	Patient Signature	Date
_____	X_____	_____
Patient Name (please print) (if other than patient)	Responsible Signature	Date

Lake Howell Health Center
Consent/HIPPA Form

Financial Policy/Authorization to release inform to insurance company
I, Undersigned, certify that I (or my dependent) has insurance coverage as listed above and assign directly to LLHC understand that I am financially responsible for all charges whether or not paid by insurance. I remain responsible for payment of copayments, deductibles, non-covered services, and any other charges not paid by insurance within 30 days. I hereby authorize Lake Howell Health Center (LHHC) to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance claims.
Signature X_____Date:_____
Are you the Guarantor? Yes____No____ If not please see the receptionist.

Consent for Treatment & Release information to pharmacy/consulting physician/hospitals
Having voluntarily presented myself (or my dependent) LHHC I acknowledge recognition of the fact that the evaluation and treatment received, I also give LHHC permission to discuss RX history, advised or deemed necessary, to be the judgment of the physician.
Signature X_____Date:_____

Acknowledgement of receipt of privacy notice (HIPPA)
Health Insurance Portability and Accountability Act
By signing this form, you acknowledge that LHHC has offered or given to you a copy of its Privacy Notice, which explains how your health information will be handled in a various situations. We must attempt to have you sign this form on you first date of service with us after April 2003. This includes the situation where your first date of service occurred electronically. If our first date of service with us was an emergency, we must attempt to give you this notice and get your signature acknowledging receipt of this notice as soon as possible after the emergency.

- ☐ I have received a copy of the Privacy Notice of LHHC
- ☐ LHHC has offered me a copy of the Privacy Notice with I have declined and has given me the chance to discuss my concerns and questions about the privacy of my health information.

Signature X_____Date:_____

Additional Person(s) Authorized to make the use or disclosure of my PHI
We at LHHC value and do everything in our power to protect your privacy. Your medical information will not be given to any individual (including spouses, parents, children, or any significant other with our written consent). If you want anyone other than your referring physician to have access to your medical information please list their name(s), and relationship(s) below. (Note: Uses and disclosures may be permitted without prior consent in an emergency.)
Name_____Relationship_____
Name_____Relationship_____
Signature X_____Date:_____

Witness Signature
The Staff of LHHC complete this section of Acknowledgement Form is not signed by the Patient:

1. Does the Patient have a copy of the Privacy Notice? Y or N
2. Please explain why the patient was unable to sign an acknowledgment form and our efforts in trying to obtain the Patient signature:_____

Employee Signature:_____Date_____

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ **Patient DOB:** _____

Person/Organizations providing the information:

Person/Organizations receiving the information:

_____

_____

Please initial the category of information that you wish to be released:

____Record of attendance and participation in program activities

____Treatment recommendations

____Assessment results and history

____Medical Information

____Psychological examination

____Frequency and results of urinalysis tests

____Other specific information: _____

Method of releasing the information: (Please initial all that apply)

____Telephone ____Written ____Face to Face, in person ____Facsimile

I understand and agree that:

*my behavioral healthcare service/treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations;

*this authorization is voluntary;

*my health information may contain information created by other persons or entities including

health care providers and may contain medical, pharmacy, dental, vision, mental health,

substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;

* I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;

my health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations;

* this authorization will expire on __/__/__ (MM/DD/YY). I may revoke this authorization at any time by notifying in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

_____

Printed Name of Patient

_____ _____

Signature of Patient **Date**

You may refuse to sign this authorization.

This is not a consent to be treated or for payment of services.