Lighthouse Counseling Intake

521 State Street
St Joseph Michigan 49085
(269) 408-6031
www.lightousecounseling.org

Client Information: **Today's Date_____**

Name: Last_ First_____ Middle_____

Address_____ City_____ State_____ Zip Code_____

Phone (Home)_____ Work_____ Cell_____

Which number do you prefer we use? _____ Can we leave a message?_____

E-mail Address_____ may we contact you by email?_____

Marital Status_____ [S-Single, M-Married, W-Widowed, D-Divorced, P- Separated]

Sex_____ Date of Birth_____ Age_____ Social Security # _____/_____/_____

Emergency Contact_____Phone_____ Relationship_____

Employment Information:

Employer_____ Occupation_____

Employer Address_____

Phone Number_____ Address_____

Who is Financially Responsible for this Account?

Name:_____ Relationship_____

Date of Birth_____ Social Security# _____

Address_____ City_____

State_____ Zip_____

Insurance Company Name_____

Group Number_____ Insured's ID#_____

Do you have Employee Assistance? _____ If so what is your authorization number_____

_____ _____
Signature of client Date

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Adult Checklist of Concerns

Name: _____ Date: _____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

- ❑ I have no problem or concern bringing me here
- ❑ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- ❑ Aggression, violence
- ❑ Alcohol use
- ❑ Anger, hostility, arguing, irritability
- ❑ Anxiety, nervousness
- ❑ Attention, concentration, distractibility
- ❑ Career concerns, goals, and choices
- ❑ Childhood issues (your own childhood)
- ❑ Codependence
- ❑ Confusion
- ❑ Compulsions
- ❑ Custody of children
- ❑ Decision making, indecision, mixed feelings, putting off decisions
- ❑ Delusions (false ideas)
- ❑ Dependence
- ❑ Depression, low mood, sadness, crying
- ❑ Divorce, separation
- ❑ Drug use—prescription medications, over-the-counter medications, street drugs
- ❑ Eating problems—overeating, under eating, appetite, vomiting, weight and diet issues
- ❑ Emptiness
- ❑ Failure
- ❑ Fatigue, tiredness, low energy
- ❑ Fears, phobias
- ❑ Financial or money troubles, debt, impulsive spending, low income
- ❑ Friendships
- ❑ Gambling
- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Guilt
- ❑ Headaches, other kinds of pains
- ❑ Health, illness, medical concerns, physical problems
- ❑ Housework/chores—quality, schedules, sharing duties
- ❑ Inferiority feelings
- ❑ Interpersonal conflicts
- ❑ Impulsiveness, loss of control, outbursts

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- ❑ Irresponsibility
- ❑ Judgment problems, risk taking
- ❑ Legal matters, charges, suits
- ❑ Loneliness
- ❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- ❑ Memory problems
- ❑ Menstrual problems, PMS, menopause
- ❑ Mood swings
- ❑ Motivation, laziness
- ❑ Nervousness, tension
- ❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ❑ Oversensitivity to rejection
- ❑ Pain, chronic
- ❑ Panic or anxiety attacks
- ❑ Parenting, child management, single parenthood
- ❑ Perfectionism
- ❑ Pessimism
- ❑ Procrastination, work inhibitions, laziness
- ❑ Relationship problems (with friends, with relatives, or at work)
- ❑ School problems (see also “Career concerns ...”)
- ❑ Self-centeredness
- ❑ Self-esteem
- ❑ Self-neglect, poor self-care
- ❑ Sexual issues, dysfunctions, conflicts, desire differences, other (see also “Abuse”)
- ❑ Shyness, oversensitivity to criticism
- ❑ Sleep problems—too much, too little, insomnia, nightmares
- ❑ Smoking and tobacco use
- ❑ Spiritual, religious, moral, ethical issues
- ❑ Stress, relaxation, stress management, stress disorders, tension
- ❑ Suspiciousness, distrust
- ❑ Suicidal thoughts
- ❑ Temper problems, self-control, low frustration tolerance
- ❑ Thought disorganization and confusion
- ❑ Threats, violence
- ❑ Weight and diet issues
- ❑ Withdrawal, isolating
- ❑ Work problems, employment, workaholism/overworking, can’t keep a job, dissatisfaction, ambition
- ❑ Other concerns or issues: _____

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:

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Substance Use History

	No	Yes/Past or Yes/Now	Route	How Much	How Often	Date/Time of Last Use	Quantity Last Used
Alcohol							
Caffeine							
Cocaine							
Crystal-Meth Amphetamines							
Heroin							
Inhalants							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers							
PCP							
Stimulants							
Tranquilizers (sleeping pills)							
Ecstasy							
Other							

Substance abuse Treatment History

Have you ever had any substance abuse treatment? ☐N/A ☐N ☐Y ☐Not Sure
Have you ever detoxed? ☐N ☐Y How many times_____
Have you ever been prescribed Suboxone or Methadone? ☐N ☐Y
If so was it helpful? ☐N ☐Y
Why or why not?_____

Clean Time History

How many attempts have you made to get clean?_____
What is the longest period that you have gone without using the above drugs since you started using them: _____ days/weeks/months.
When was this?_____

Overdose

Have you ever overdosed? ☐N ☐Y
What substance did you overdose on?_____

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Number of lifetime overdoses_____
Have you ever been hospitalized due to an overdose? ☐N ☐Y

Criminal History

Have you ever been incarcerated? ☐N ☐Y If so how many times?_____
Was your arrest related to your substance use?_____
Are there any current legal issues we should be aware of (probation, parole)? ☐N ☐Y

Mental Health

Have you ever been diagnosed with a mental illness? ☐N ☐Y
If so, what was the diagnosis?_____
Have you ever been hospitalized for mental health issues? ☐N ☐Y
If so, when?_____
Have you ever received counseling? ☐N ☐Y
If so, was it helpful? Why or why not?_____
Have you ever attempted to end your life or to hurt yourself? ☐N ☐Y
If yes, when was this?_____
Have you or a family member ever been diagnosed with a psychiatric or mental illness? ☐N ☐Y
(Please describe) _____
_____
Have you ever taken or been prescribed antidepressants? If so, for what reason
_____
_____
Medication(s) and dates of use _____

Abuse

Have you ever been abused? ☐N ☐Y
☐Physically ☐Sexually (including rape or attempted rape) ☐Verbally ☐Emotionally

Health Status

Do you have any chronic medical conditions?
If yes, please explain?_____ _____
Date of last physical _____ Are you pregnant? ☐N/A ☐N ☐Y ☐Not Sure
Current or past medical conditions (check all that apply) family history please put an "F" next to that illness
☐Asthma/respiratory disease ☐Cardiovascular (heart attack, high cholesterol, angina)
☐Hypertension ☐Epilepsy or seizure disorder ☐GI disease ☐Head trauma ☐HIV/AIDS ☐Diabetes ☐Liver problems ☐Pancreatic problems
☐Thyroid disease ☐STDs ☐Abnormal Pap smear ☐Nutritional deficiency ☐Head Trauma
☐Other (Please describe) _____
_____
Is there a family history of anything NOT listed here? (Please explain)
_____
Have you ever had surgery or been hospitalized? (Please describe)
_____
Please list all current prescription medications and how often you take. DO NOT include medications you may be currently misusing (that information is needed later)
_____
Please list any allergies you have (penicillin, bees, peanuts)

_____

Childhood Illnesses
☐Measles ☐Mumps ☐Chicken Pox

Education and Employment:

☐High School Grade ☐Professional or Vocational School ☐College ☐Graduate school
Are you currently employed? ☐N ☐Y How many hours/week (avg.)? _____
What type of work do/did you do? _____

If I were to ask you for 3 goals in reference to your recovery and incarceration what would they be?
1.
2.
3.

_____ _____
Signature of therapist Date
❑ Copy accepted by client ❑ Copy kept by therapist

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law

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AUTHORIZATION TO OBTAIN, DISCLOSE AND EXCHANGE PROTECTED HEALTH INFORMATION

The undersigned hereby authorizes the name/agency listed to Obtain From, Disclose To, and Exchange with, protected health information either orally or in writing to _____ at
NAME/AGENCY_____
ADDRESS_____

A. Any and all information, EXCEPT substance abuse (drugs and alcohol), mental health, and AIDS-related information, must be specifically authorized in Section E to be disclosed: OR ONLY the following information (check only if applicable):

B. Check one(s) that applies:

___ Summaries and notes of participation in treatment
___Evaluations and Recommendations
___Psychological and psychiatric testing & evaluation results
___Treatment Plan, Progress & Discharge reports
___Information relating to medical history
___Information relating to social history
___Other information_____

C. PURPOSE. The purpose for this disclosure is to facilitate effective treatment service coordination. A photocopy or exact reproduction of this Authorization shall have the same effect as the original.

D. SPECIFIC AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION PROTECTED BY STATE AND FEDERAL LAW

___ Assessment
___ Diagnosis
___ Psychological Evaluation
___ Treatment Plan or Summary
___ Progress in Treatment
___ Billing Information
___ Coordinate Treatment Services_____
___ Other_____
____ Testing Information
____ Education Information
____ Presence/Participation in Treatment
____ Continuing Care Plan
____ Medication List
____ Verbal Consultation

I acknowledge that information to be disclosed may include material that is protected by Federal and/or State law applicable to substance abuse, mental health and AIDS.
___Substance abuse (drug or alcohol) information
___Mental Health information
___AIDS-related information

E. Furthermore, I SPECIFICALLY AUTHORIZE disclosure of protected health information to all persons referred to in the authorization. The undersigned has a right to inspect the disclosed information and information being obtained from, disclosed to, and/or exchanged with at any time. This authorization shall be in effect for 12 months

_____ _____
Signature of client Date

LIGHTHOUSE COUNSELING
guiding families to a better life

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CLIENT RIGHTS AND RESPONSIBILITIES/EXPLANATION OF SERVICES

Counseling is a collaborative process with your therapist/counselor that involves…….

- **Exploring** the issues that brought you to therapy.
- **Building** a trusting relationship with your therapists.
- **Deciding** upon specific goals and objectives.
- **Working** toward these goals and objectives
- **Evaluating** your progress on a regular basis.

I understand…..

· That I have chosen to receive treatment services and I may terminate my therapy/counseling at any time, unless ordered by the court.
· That there is no assurance that I will feel better.
· That during the course of my treatment, material may be discussed that is upsetting in nature. This is a part of the therapy/counseling process and may be necessary to resolve my concerns.
· That I may be contacted by my health plan to ensure continuity and quality of therapy/counseling or after the completion of treatment to assess the outcome of treatment.
· That records and information collected during my treatment will be held or released in accordance with Federal and State laws regarding confidentiality of such records and information.
· That State and Local laws require that my therapist report all cases where there exists a danger to self or others.
· That there may be other circumstances in which the law requires my therapist/counselor to disclose confidential information.

I have the right…….

· To be treated with dignity, consideration, and respect at all times.
· To expect quality service provided by concerned, trained, professional and competent employees.
· To expect complete confidentiality within the limits of the law and to be informed about the legal exceptions to confidentiality and to expect that no information will be released without the client's knowledge and written consent.
· To appropriate information regarding employee education, training, skills, license, and practice limitations and to request and receive referrals to other clinicians when appropriate.
· To be a collaborative partner with my therapist/counselor in the development of treatment plans and goals.
· To obtain information about case records and to have this information explained clearly and directly.
· To request information and/or consultation regarding the conduct and progress of services.
· To refuse any recommended services and to be advised of the consequences of this action.
· To a safe environment free of emotional, physical, and sexual abuse.
· To a client grievance procedure, including requests for consultation and/or mediation and to file a complaint with a supervisor and/or the appropriate credentialing body.
· To make an informed decision about whether to accept or refuse treatment.
· To contact and consult with counsel at my expense.
· To a clearly defined ending process and to discontinue services at any time.

I am responsible for…….

· Being on time for my appointments.
· To cancel appointments that I am unable to keep, within a timely manner.
· Informing my therapist of any change in residence or work telephone numbers and/or address.
· Contacting my therapist to confirm my appointment on days when the weather is inclement.

_____ _____

Signature of client Date

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Clinician-Patient Agreement and Financial Responsibility

Please read and *sign. If you would like a copy for your records please feel free to request a copy.*

Appointments:

- All office visits are by appointment and may be scheduled through the office manager or your counselor directly.
- Please arrive on time, as you use up your own time when you arrive late for an appointment. The usual length of an appointment is 50 minutes.
- Late cancellation (less than 24 hours before) *and/or* no-show appointments are billed to the client for the full amount. In the case of illness, please notify us no later than 9:00 a.m. the day of the appointment. Please leave a message if you get voice mail. If your appointment is cancelled or missed, contact the office for a new appointment time. Insurance companies will not pay for no-show charges or late cancellation charges or for telephone consultations.

Fees:

- **The client portion (co-pay) of fees is expected at the time of service.**
- Your health insurance may help you recover some of your counseling costs. Most group policies, but few individual policies cover outpatient psychotherapy. Please verify with your company the amounts of coverage for outpatient psychotherapy by licensed professionals. If your policy requires preauthorization to receive services, it is your responsibility and needs to be handled prior to your first visit.
- Insured clients are expected to take care of their fees as services are rendered. Our office will bill your insurance company for services provided. You will receive a statement each month reflecting any balance due on your account. This office cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim. You are responsible for payment (and insurance claims) on your account. ***Failure to pay your part may jeopardize your benefits. Co-pays are not negotiable***.
- Clients paying on a cash basis, and not billing any insurance company are expected to pay in full at time of service unless a payment plan has been previously arranged.
- Except in the case of minors or when other arrangements are made, the person receiving the counseling service is financially liable.
- Accounts become delinquent after thirty (30) days. ***Accounts 90 days in arrears will be terminated***.
- Any change in my financial situation I will discuss with my therapist. In the event you find it necessary to change mental health providers and require records to be sent from Lighthouse Counseling your account will need to be paid in full.

I have read, understand and agree to the above policies. I have been offered a copy of these policies to take with me if desired. I hereby authorize **Lighthouse Counseling** and my therapist to release any information acquired in the course of my therapy to my insurance company for billing purposes (if client is a minor, parent or guardian sign). I understand my insurance coverage is a relationship between me and my insurance company, and I agree to accept financial responsibility for payment of charges incurred. I understand that a re-billing fee/financial charge complying with Michigan State Law will be applied to any overdue balance, and in the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. I have read and/or received a copy of The Lighthouse Counseling's Privacy Policy

Initial Interview $200.00_____.

Session Fee (50min) ____150.00

Non or Late Cancellation $25.00 _____

We do make exceptions to rates and can calculate rates on a sliding scale. Adjusted Fee _____

Client(s) Signature(s): _____ Date:_____
Therapist Signature: _____ Date:_____
Emergencies:

The **best phone number** for all offices is 269-408-6031. If you receive the voice mail, please leave a message. Your counselor may be on the phone, in therapy with someone else, or out of the office. In a crisis situation, and your therapist cannot be reached you may **call your therapists cell number *or* go immediately to your local hospital emergency room.**

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