



Therapist: _____ Dx: _____ For office use only

CLIENT INTAKE FORM

PLEASE FILL OUT THE FOLLOWING INFORMATION AS COMPLETELY AS POSSIBLE.

Client's Full Legal Name: _____ Date: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (H) _____ (C) _____ If child, second parent phone: _____

Date of Birth: ____/____/____ Will Stenzel Clinical be billing your PPO insurance for you? _____

Subscriber Relationship to Client: Self Spouse Parent (Please complete below if other than self)

Subscriber Name: _____ Subscriber's Date of Birth: ____/____/____

Address of Subscriber: _____
(If different than above)

City: _____ State: _____ Zip: _____

Place of Employment: _____

Job Title: _____ Number of years at current job: _____

Highest education completed: High school/GED Some college College Graduate/other

Marital Status: Single Engaged Married Separated Divorced Widowed

If married, spouse's name: _____ Date of Birth ____/____/____

Spouse's occupation and place of employment: _____

Number of years married: _____

If you have children, please list their names and ages:

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

How were you referred to Stenzel Clinical Services, Inc.? Insurance Co. Physician School Church
 Friend Advertising Google Other search engine: _____

Is there a racial or ethnic group you identify with (or your parents) that you'd like me to be aware of? _____

Do you consider your spiritual life a resource? Yes No

What is your religious affiliation (optional) _____

Attendance: Regularly Sometimes Never

THE FOLLOWING QUESTIONS ARE DESIGNED TO HELP ME UNDERSTAND YOUR BACKGROUND. PLEASE COMPLETE THEM AS THEY APPLY TO YOU. THANK YOU.

Parent's names: (F) _____ Age _____ Deceased _____

(M) _____ Age _____ Deceased _____

Married Separated Divorced Widowed

Number of brothers _____ sisters _____

Has anyone in your family of origin had counseling? Yes No

If so, for what? _____

Is there any history of drug or alcohol abuse in either of your parent's families? Yes No

If yes, please describe _____

Was there any physical, sexual, or emotional abuse done to you or your siblings? Yes No

If yes, please describe _____

Are you in any way fearful of your current partner? Yes No

Does your partner have angry outburst or temper tantrums? Yes No

Has your partner ever pushed, grabbed, slapped, or hit you? Yes No

Please list any specific medical conditions that you have _____

Are you taking any prescription medications at this time? Yes No

If yes, what are they? _____

How long have you been taking this? _____ Who prescribed it for you? _____

What is your daily or weekly alcohol intake? _____

Do you have a past or current history of other drug abuse? Yes, current Yes, past No

If yes, please list _____

Have you been in therapy in the past? Yes No

If yes, when, for what, how long, and with whom? _____

Was the therapy helpful? _____

What is your reason for contacting Stenzel Clinical Services, Inc and seeking therapy? What are your goals for therapy?

Is there anything else that you feel is important to this therapy process?

Please fill out the checklist and return this form to your therapist.
If you will be utilizing your PPO insurance benefits please bring in your insurance card for your therapist to copy.

We look forward to working with you.

INFORMED CONSENT

Welcome to Stenzel Clinical Services, Ltd! We would like you to have a clear understanding of the services we provide and our expectations of you, our client. If you have questions or need clarification, please ask your therapist for assistance before you sign.

SERVICES OFFERED

Stenzel Clinical Services, Ltd, provides outpatient counseling services. We work with all age groups. Licensed practitioners provide individual, group, couples and family counseling, as well as case coordination. Psychiatric services can be arranged through a referral by the therapist. Sessions are typically 50 minutes in length.

We strive to return all messages as quickly as possible Monday through Friday. Routine messages left on the weekend may be returned Monday. We do not guarantee 24 hour crisis coverage and if your therapist is not available when you feel you are in crisis, please call the DuPage Crisis line at 630-627-1700, proceed to your local hospital emergency room, or call 911.

INITIAL ASSESSMENT, DIAGNOSIS, AND COUNSELING PROCESS

Initial assessments take place at the first appointment. These appointments are used to gather data, complete intake information, and to determine the best course of care. A diagnosis will be given for each client being seen, just as with a visit to a medical doctor. Employers, insurance companies, and schools can ask if someone has ever been diagnosed with certain conditions. The result of a positive response will vary; our obligation is to act in accordance with ethical standardized diagnostic coding procedures.

If ongoing counseling is recommended, we will diligently work to provide the best therapeutic methods and tools available. For counseling to be successful, your commitment to the process is absolutely essential. This includes regular attendance and active participation, homework between sessions to enhance or speed your growth, and completion of the process through planned termination of counseling services. You may begin to find some relief of symptoms initially, and it may be tempting to terminate. However, this initial relief is often temporary if counseling is stopped abruptly. Because all therapists want to see you have the greatest growth possible during the time you are here, we will work with you to plan a successful wrap-up. This is an important part of the counseling process, and we highly encourage you to honor your own effort by not neglecting this phase.

FEES

Initial assessments are \$140. Individual sessions are \$115, and family or couples sessions are \$125 per 50 minute session. Group therapy is \$65 per session. Telephone consultation less than 1-10 minutes is billed at \$25. Insurance companies will not cover these consultation fees. A phone session is billed at \$100. Likewise, insurance will not cover phone sessions.

If a check is returned for insufficient funds, the client is responsible for any bank fees assessed within one week, and an alternate method of payment is required.

If fees are not paid within 90 days, the account may be turned over to a collection agency.

INSURANCE

We bill most insurance companies as a courtesy to you. If we are not able to work with your insurance company, we will request payment in full and provide you the necessary information to submit your claim. **The first session must be paid in full until benefits, deductibles, and co-pays are verified by your insurance company.** If benefits have already been verified, you will find this information on the attached Benefits Inquiry sheet. **All expected out-of-pocket patient expenses (deductibles, copays, or coinsurance) are due at the time of service.**

CANCELLED OR MISSED APPOINTMENTS

Due to the nature of counseling services, we never overbook our schedules; therefore we request 24-hour notification of cancellation so that others may utilize that time. We also realize financial accountability enhances your commitment to your counseling work. As a result, we charge an **\$80 cancellation fee** when we do not receive this notice. *Insurance companies will not cover missed appointments.* Full payment for the missed session is due within one week. Please note that 2 or more instances of missed appointments without notifying your therapist may result in termination of services. In the event of inclement weather prohibiting travel to the office, a phone session will be offered (a parent consult for young children) if clinically appropriate.

CONFIDENTIALITY

Legal and ethical standards require us to maintain confidentiality. Information cannot be divulged to any outside parties without your written consent with the following exceptions: if you are or become a danger to yourself or others, we become aware of any real or alleged abuse to children, elderly, or incapacitated people (in which case we are mandated reporters to the State of Illinois), and if we receive a properly issued subpoena accompanied by a court order to produce records. If your therapist receives clinical supervision, s/he will inform you of that process. If you are here with family members, your therapist will discuss expectations and limitations of confidentiality.

TRANSFER PLAN

In the event of the incapacitation, death, or termination of a therapist’s practice at Stenzel Clinical during the course of your care, your records will remain in our possession and a new therapist will be made available to you. If you desire to transfer care outside of our practice, you may sign a release of records and we will release a standard extract from your file of the initial intake and the most recent progress notes. It is our standard policy to release records directly to another provider. Any variance will be arranged with the Director/designee.

AGREEMENT

I have read and understand the above statement on services, policies, and procedures. My signature below indicates that I give my full consent to receive services at Stenzel Clinical Services, Ltd.

Client (age 17 and over) _____ Date: _____

Client (spouse) _____ Date: _____

Client (age 12-16) _____ Date: _____

Client guardian (for minors) _____ Date: _____

Name: _____ Date: _____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU AT PRESENT:

- | | | |
|----------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------|
| <input type="radio"/> Suicidal thoughts | <input type="radio"/> Excessive spending of money | <input type="radio"/> Always worried |
| <input type="radio"/> Always tired | <input type="radio"/> Pornography use | <input type="radio"/> Nightmares |
| <input type="radio"/> Poor appetite | <input type="radio"/> Problems with children | <input type="radio"/> Feeling panicky |
| <input type="radio"/> Trouble sleeping | <input type="radio"/> Problems with parents | <input type="radio"/> Can't make decisions |
| <input type="radio"/> Loss of weight | <input type="radio"/> Fighting and quarreling often | <input type="radio"/> Can't make friends |
| <input type="radio"/> Weight gain | <input type="radio"/> Overly ambitious | <input type="radio"/> Unable to relax |
| <input type="radio"/> Fast heartbeat | <input type="radio"/> Difficulties at school | <input type="radio"/> Feeling fearful |
| <input type="radio"/> Frequent sweating | <input type="radio"/> Confused about personal
religious practice | <input type="radio"/> Overly sensitive |
| <input type="radio"/> Dizziness | <input type="radio"/> Recent loss of someone close
to me | <input type="radio"/> Anxious inside |
| <input type="radio"/> Shaky hands | <input type="radio"/> Crying spells | <input type="radio"/> Panic/Anxiety attacks |
| <input type="radio"/> Stomach trouble | <input type="radio"/> Unable to have fun | <input type="radio"/> Sexual problems |
| <input type="radio"/> Feeling tense | <input type="radio"/> Feeling easily hurt | <input type="radio"/> Easily excited |
| <input type="radio"/> Cold feet and/or hands | <input type="radio"/> Lacking confidence | <input type="radio"/> Quick tempered / lose temper |
| <input type="radio"/> Diarrhea | <input type="radio"/> Feeling grouchy | <input type="radio"/> Impatient with people |
| <input type="radio"/> Constipation | <input type="radio"/> Depressed | <input type="radio"/> Very restless |
| <input type="radio"/> Muscles twitching or jumping | <input type="radio"/> Feeling lonely | <input type="radio"/> Feel like hurting someone |
| <input type="radio"/> Nausea or Vomiting | <input type="radio"/> Not enjoying usual activities | <input type="radio"/> Feel like smashing things |
| <input type="radio"/> Headaches | <input type="radio"/> Feeling inferior | <input type="radio"/> Shy with people |
| <input type="radio"/> Fainting spells | <input type="radio"/> No one understands me | <input type="radio"/> Loss of meaning of life |
| <input type="radio"/> Chronic illness | <input type="radio"/> Worried about health | <input type="radio"/> Feelings of guilt |
| <input type="radio"/> Full of energy | <input type="radio"/> Can't concentrate | <input type="radio"/> Unable to pray |
| <input type="radio"/> Financial problems | <input type="radio"/> Can't get going | <input type="radio"/> Unable to forgive |
| <input type="radio"/> Marital problems | <input type="radio"/> Feeling angry | <input type="radio"/> Unable to feel forgiven |
| <input type="radio"/> Difficulties at work | <input type="radio"/> Don't like being alone | <input type="radio"/> Loss / disappointment |
| <input type="radio"/> Excessive drinking | | |
| <input type="radio"/> Excessive use of drugs | | |



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Stenzel Clinical Services, Ltd. established 12-1-03

Stenzel Clinical Services, Ltd. only releases information in accordance with state and federal laws and the ethics of the counseling profession. This notice describes our policies related to the use and disclosure of our client's healthcare information.

"Use and disclosure of protected health information for the purpose of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes."

TREATMENT

We use and disclose health information to:

- Provide, manage or coordinate care
- Consultants
- Referral sources

HEALTHCARE OPERATIONS

We use and disclose health information to:

- Review of treatment procedures
- Review of business activities
- Certification
- Staff training
- Compliance and licensing activities

PAYMENT

We use and disclose health information to:

- Verify insurance and coverage
- Process claims and collect fees

OTHER USES AND DISCLOSURES WITHOUT YOUR CONSENT

- Mandated reporting
- Emergencies
- Criminal damage
- Appointment scheduling
- Treatment alternatives
- As required by law

CLIENT RIGHTS

In the Notice of Privacy Practices counselors are required to inform clients as to their rights under state and federal law.

Right to request where we contact you

- Home yes no
- Work yes no
- Cell Phone yes no
- If not, how may we contact you _____

Right to release your medical records

- Written authorization to release records to others
- Right to revoke release in writing
- Revocation is not valid to the extent that you have acted in reliance on such previous authorization

CLIENT RIGHTS (continued)

Right to inspect and copy your medical billing records

- Right to inspect and copy records
- Counselor may deny this request
- Charges for copying, mailing, etc.

Right to add information or amend your medical records

- May request to amend records
- Number of days to decide
- May deny the request
- If denied, right to file disagreement statement
- Disagreement state and your response will be filled in the record
- Amendment request must be in writing

Right to Accounting of disclosures

- For a six year period beginning with date the counselor came in to compliance
- Exceptions:
 - Disclosure for treatment, payment or healthcare operations
 - Disclosure pursuant to a signed release
 - Disclosure made to client
 - Disclosures for national security or law enforcement

Right to request restrictions on uses and disclosures of your healthcare information

- Must be in writing
- You are not obligated to agree

Right to complain

- Please contact us first
- If not satisfied, right to complain to the U.S. Dept. of Health and Human Services
- No retaliation

Right to receive changes in policy

- May request any future changes
- Request to privacy officer

I have read and received a copy of this document outlining notice of privacy practices

Signature: _____ Date: _____

Signature: _____ Date: _____
(any other family member included in therapy)