SAFE HARBOR COUNSELING
PARTNERS IN HOPE. SOLUTIONS FOR LIFE.

Main Office: 2213 N. Sunrise Drive Round Lake Beach, IL 60073
Phone: 847-223-2561 Email:robertbennett4180@att.net
Robert J. Bennett, Director

CONFIDENTIAL CLIENT INTAKE FORM

Name: ___________________________________ Today's Date: __________________

Sex: ◻ Male ◻ Female Date of Birth: ________________ Age: ________

Home phone: _______________________ Work phone: _________________________

Cell phone: _________________________ Pager number: ________________________

Any number you do not want to be contacted at: ________________________________

Check here if you want Christian counseling ☐

Do you regularly attend a church, synagogue, or other religious institution? ◻ Yes ◻ No

If yes, which one? ____

RELATIONAL INFORMATION

Current marital status: ◻ Single ◻ Engaged ◻ Married ◻ Separated ◻ Divorced ◻ Widowed
If engaged, married, separated, divorced, or widowed, for how long? _______
Number of previous marriages for you. _________ For your spouse. _______
If married, spouse's name: _________________________ Age: ____________
Is your spouse supportive of you seeking counseling? ◻ Yes ◻ No ◻ Unsure ◻ Spouse doesn't know

Please provide a brief description of your spouse (e.g., angry and controlling; outgoing and supportive):
____

What is your current occupation? ____

What is your level of satisfaction with your occupation?
____

Please list your children (including step, adopted, foster) below:

Name	Sex	Age or yr. of death	Relationship to you	Living with whom?

Who else lives with you? ____

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Please list your father, mother, sisters, brothers, stepfamily relations, or other family members who had a significant effect on your life (either positive or negative). (Use the back of this sheet if necessary.)

Name	Sex	Age or yr. Of death	Relationship to you	Describe him/her (e.g. angry, outgoing, supportive, controlling)

COUNSELING HISTORY

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the names of the therapists or programs. (Use the back if necessary.)

Therapist's Name or Program	Major Issue	Dates

Has anyone in your family ever been treated or hospitalized for substance abuse, mental health issues, or psychiatric conditions?
□ Yes □ No
If yes, please describe: ____

Have any of your family members or friends ever attempted or committed suicide?
□ Yes □ No
If yes, who and when: ____

MEDICAL HISTORY

Please list any conditions, illnesses, treatments, or surgeries that might be relevant to your reason for seeking counseling:
____

Are you currently receiving any medical treatment? □ Yes □ No If yes, please describe: ________________________

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Please list all current medications you are taking and the reasons for taking them. (List even if you seldom use, or take only as needed.)		
Name of medications	Dose	Reason for taking

Are you taking these medications according to the doctor's recommendations?
□ Yes □ No

If no, please explain: ____

Date and outcome of last physical exam: ____________________________________

PRESENT ISSUES AND GOALS
Please describe why you are coming to counseling. (i.e. what are your issues, problems, symptoms, how long, etc. Use the back if necessary.):

____
____
____

Check any of the following symptoms or problems that you currently are or recently have experienced:

List 1	List 2	List 3
□ Stress	□ Marital Problems	□ Compulsive Behaviors
□ Anxiety	□ Other Relational Problems	□ Seeing Things Others Don't
□ Panic	□ Physical Abuse	□ Hearing Voices
□ Depression	□ Emotional Abuse	□ Racing Thoughts
□ Apathy	□ Verbal Abuse	□ Eating Problems
□ Fatigue/Lack of Energy	□ Sexual Abuse	□ Drug Use
□ Loss of Appetite/Overeating	□ Sexual Problems	□ Alcohol Use
□ Trouble Sleeping	□ Gender Identity Issues	□ Pregnancy
□ Poor Concentration	□ Anger	□ Abortion
□ Feeling Worthless	□ Aggressive Behavior	□ Legal Matters
□ Recent Death	□ Bad Dreams	□ Work Stress
□ Grief	□ Unwanted Memories	□ Career Choices
□ Chronic Pain	□ Loss of Control	□ Indecisiveness

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□ Loneliness	□ Impulsive Behavior	□ Parenting Problems
□ Fears	□ Controlling	□ Financial Problems
□ Shyness	□ Controlled by Others	□ Spiritual Problems
□ Low Self-Esteem	□ Obsessive Thoughts	□ Other ______________________

Please use an "X" on the scale below to indicate how distressing your problem(s) are to you.

[--]

Very Minimally Distressed	Moderately Distresed	Very Extremely Distressed

Are you currently experiencing any suicidal thoughts? □ Yes □ No
Have you experienced suicidal thoughts in the past? □ Yes □ No
Have you attempted suicide in the past?
□ Yes □ No
Are you currently experiencing any violent or homicidal thoughts? □ Yes □ No

What do you hope to gain from this counseling experience?

____

____

____ _______________
Client's Signature Date

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POLICIES AND PROCEDURES
(Client Copy)

Welcome to Safe Harbor Counseling. Please read all documents thoroughly and complete them where necessary, so that you are prepared to discuss any questions with your therapist during your first session.

1. RELEASE OF INFORMATION FORM

All information obtained/derived by the course of treatment is fully confidential; disclosures you share with your therapist are confidential unless you have SIGNED a consent form to release part or all of the information.

Therefore, to either release or obtain information from a specific individual or agency, a Release of Information must be obtained. Exceptions to this guideline include instances when 1) the patient is a clear danger to (a) themselves or (b) others and, 2) instances when the patient is a minor (under the age of 18) and reports that he or she is or has been a victim of physical or sexual abuse, and 3) there is any suspected abuse to a child or adult. Please sign and date all Release of Information documents.

In addition, cases are occasionally discussed by the clinic's professional staff to obtain feedback and provide alternative treatment plans and continuity of care (e.g. your therapist, if unlicensed, will discuss your case with his or her Clinical Supervisor). Your signature on this form will allow this process to proceed smoothly.

2. TELEPHONE CALLS

Occasionally the need to talk to your therapist may arise between normally scheduled sessions. It is difficult to conduct psychotherapy over the phone but your therapist will respond to your call during his or her normal business hours. A charge will be incurred by the patient for any telephone consultation time between schedules sessions with his or her therapist or any on-call therapist. If there is an emergency and a therapist or anyone at Safe Harbor Counseling is unable to be reached, call 911 or go immediately to your local Emergency room.

3. LENGTH OF SESSION

The psychotherapy session is about 45-50 minutes in length beginning at our appointed time and concluding 45-50 minutes after (75 minutes sessions may be prearranged with your therapist). Therefore, it is to your benefit to arrive a few minutes in advance of the appointment time. Since your therapist has sessions scheduled after yours, the sessions must end 45-50 minutes after the appointment time regardless of your arrival time (full fee for the session will be charged).

4. FEES AND PAYMENT

All copays are due at the time of service. We accept cash or check made payable to Safe Harbor Counseling. A $25.00 service charge will be levied on all checks returned by a bank for insufficient funds. Our current fee per session is $90- $120 depending on your therapist. If any or all outstanding balances are not paid, Safe Harbor reserves the right to release a client's name and address to a collection agency. Also, a monthly interest fee of 2% will be charged for these balances until they are paid in full.

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5. INSURANCE

We will bill your insurance company for all sessions unless otherwise agreed upon. Please not that you are responsible for payment in cases when your insurance company does not pay for our services.

6. CANCELLATIONS AND MISSED APPOINTMENTS

When an appointment is scheduled, that time is reserved for you. If the appointment is missed or cancelled without sufficient notice, the therapist is unable to make use of that time. Please note that the reason for missing an appointment is not relevant to the cancellation fee being assessed. This fee is assessed regardless of whether or not it is the client's "fault" that they missed. The reason for this is that our counselors have reserved this time for the client. Therefore, sessions must be cancelled 24 hours in advance or a cancellation fee of $60 will be charged.

We trust that your involvement within our Clinical System will be helpful and profitable to you. If you have any questions regarding these arrangements or other aspects of your relationship with us, please discuss them with your therapist or his or her Clinical Supervisor.

This is to certify that I have read, understand, and have been given a copy of this document.

Patient's Signature ____ Date _______________

Additional Policies and Procedures

If your insurance changes or is terminated: Please notify the Safe Harbor office at 847-223-2561 and let the office staff know all of your new information and have them check out the benefits as the coverage is probably different than your old policy. Please note that you are responsible for the entire fee if the insurance changes and you fail to notify us as this will result in the claim being denied from the insurance company.

Cash-paying clients: Occasionally there are clients who pay out of pocket with a reduced fee due to the fact that it is not expected that insurance will pay. Sometimes the insurance does unexpectedly pay. When this happens, note that these insurance payments will be applied to your balance due to having a reduced fee. Any money still left after Safe Harbor's fee has been totally paid, will be refunded to the client.

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Patient's Signature ____ Date _______________

Additional Policies and Procedures

If your insurance changes or is terminated: Please notify the Safe Harbor office at 410-893-4600 and let the office staff know all of your new information and have them check out the benefits as the coverage is probably different than your old policy. Please note that you are responsible for the entire fee if the insurance changes and you fail to notify us as this will result in the claim being denied from the insurance company.

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PRIVACY NOTICE OF SAFE HARBOR COUNSELING (SHCC)

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

THIS NOTICE GIVES YOU INFORMATION REQUIRED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) that prescribes legal duties and privacy practices to protect the privacy of your individual identifiable health information; this is, *Protected Health Information (PHI)*, as that term is defined in the HIPAA under *AInformation*.

THE EFFECTIVE DATE OF THIS NOTICE IS APRIL 14, 2003. SHCC is required to follow the terms of this Notice until it is replaced. SHCC may make changes to the terms of this Notice at any time. **Upon your request**, we will provide you with a copy of the current Notice. SHCC reserves the right to make the changes apply to your *Information* maintained in my files before and after the effective date of the new Notice. The following is a general description of how Federal and State law permits me to use and disclose your *Information*.

Purposes for which SHCC May Use or Disclose Your Mental Health Information with your Consent
SHCC may request your consent for the use and/or disclosure of your *Information* for *treatment*, *payment* or *health care operations* as described below:

- *Treatment*. SHCC with use and disclose your *Information* to provide, coordinate, or manage your mental health care and any related services. SHCC may disclose your *Information* to physicians, therapists, other mental health providers, or other health care providers who are treating you or assisting in your diagnosis, treatment, or recovery.

- *Payment*. Your *Information* will be used and disclosed, as needed, to obtain payment for your mental health care services. This may include certain activities that your health insurance plan undertakes before it approves or pays for the mental health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and utilization review activities. If more than one, third party payer is responsible for payment for your health care, SHCC may disclose your *Information* to more than one health plan and those health plans may share your *Information* with each other. Your *Information* may also be used and disclosed as needed to obtain payment for mental health care services rendered to you by other providers.

- *Mental Health Care Operations*. SHCC may use or disclose, as needed, your *Information* in order to support my delivery of mental health care services. SHCC may call you by name in the waiting room area. SHCC may use or disclose your *Information*, as necessary, to contact you to schedule an appointment or remind you of your appointment.

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- SHCC may share your *Information* with third party ABusiness Associates@ who perform various administrative services. For example, those within SHCC, or with whom SHCC contracts, who perform billing services, transcription services, record retention, or other professional consultants. Whenever an arrangement between a Business Associate and me involves the use or disclosure of your *Information*, we will have a written contract that contains terms that will protect the privacy of your *Information*.

- *Health Care Services*. Your *Information* may be used and disclosed to contact you and to give you information about treatment alternatives or other health benefits and services that may be of interest to you.

Uses and Disclosures With Your Verbal Consent

Your *Information* may be disclosed to a family member, friend, or other person designated by you or as designated by the law, if you verbally agree.

Uses and Disclosures with Your Written Authorization

Except as provided below, your *Information* will not be used for any non-routine purposes unless you give your written authorization to do so. If you give written authorization to use or disclose your *Information* for a purpose that is not described in this Notice, then, with certain exception, you may revoke it in writing at any time. Your revocation will be effective for the *Information* SHCC maintains, unless SHCC has taken action in reliance on your authorization.

Uses and Disclosures Without Your Consent

As required by law;

- To comply with legal proceedings, such as a court or administrative order or subpoena;
- To law enforcement officials for limited law enforcement purposes;
- To a coroner, medical examiner, or funeral director about a deceased person;
- To avert a serious threat to your health or safety or the health or safety of others;
- To a governmental agency authorized to oversee the mental health care system or government programs;
- To federal officials for lawful intelligence, counterintelligence, and other national security purposes; and
- To public mental health authorities for public health purposes.

Your Rights

You may make a written request to me to do one or more of the following concerning your *Information*:

- Put additional restrictions on use and disclosure of your *Information*.
- Communicate with you in confidence about your *Information* by a different means than SHCC is currently doing.
- See and get copies of your *Information*.
- Receive a list of disclosures of your *Information* that SHCC has made for certain purposes for six (6) years prior to your request (after April 14, 2003), with certain exceptions permitted by law, which includes exceptions for disclosure made directly to you or made pursuant to your authorization.

If you want to exercise any of these rights or require further information about privacy practices, please contact me at the address below. In certain instances, SHCC is not required to agree to your request. SHCC will give you the necessary information and forms for you to complete and return to request your *Information*. SHCC is

permitted, by law, to charge you a fee for copying any documents requested in accordance with Ayour rights@ as listed above. (Fee $1.00 per page.)

Complaints

If you believe that SHCC violated your privacy rights, you have the right to complain to me or to the Secretary of the U.S. Department of Health and Human Services (DHHS). You may file a written complaint with me at the address below. An individual must file a complaint within 180 days of when he/she knew or should have known that the act or omission occurred, unless the time limit is waived by the Secretary of DHHS. SHCC will not retaliate against you if you choose to file a complaint.

Contact Address

Safe Harbor Christian Counseling
2213 N. Sunrise Drive
Round Lake Beach, IL 60073
Phone: 847-223-2561

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PRIVACY NOTICE ACKNOWLEDGEMENT

As a client of Safe Harbor Counseling, I acknowledge that I have been given the Privacy Notice required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that prescribes legal duties and privacy practices to protect the privacy of my individually identifiable health information, by Safe Harbor Counseling.

Client Name or Guardian ____

Client Signature ________________________________ Date __________________

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Safe Harbor Counseling
Financial and Scheduling Policy/Agreement

(Client Copy)

Financial:

- Payment is expected at the time service is rendered. If you choose to pay by check for counseling services, please be prepared to supply a form of ID, such as a driver's license.

For insurance payments:

- I/we understand that even though Safe Harbor Counseling is billing my/our insurance that I/we are responsible for any balance that insurance does not cover.
- All balances on accounts will be collected from clients 90 days after insurance has been billed. This means that Safe Harbor Counseling is giving your insurance company 90 days to pay the claim. The law states that it must be processed within 30 days of receipt.
- After 90 days, you are responsible to pay Safe Harbor Counseling directly. We will give you a receipt, which you can use to try to get your insurance company to reimburse you.
- I/we understand that by signing this form, I/we agree to pay Safe Harbor Counseling any unpaid balance on my/our account in a prompt manner.

Scheduling:

Normally our counselors schedule clients into a particular time slot, which is either a weekly or every other week time slot.

It is our policy to allow one cancellation for every six months that you occupy a particular spot.

The second time that you cancel an appointment you have an option: you can either risk losing your spot or by another client. This would mean that in order to reschedule, you would need to take another spot.

If you opt not to pay the cancellation fee, we will consider your spot to be an open spot that could be filled by another client. This would mean that in order to reschedule, you would need to take another spot.

If you choose to pay the cancellation fee, your spot would automatically be reserved for you.

- Note: Everything on this form pertains to keeping your normal spot. If you cancel with less than 24 hours notice, the cancellation fee always applies.

I, ____________________________, have read the Safe Harbor Financial/Scheduling Policy in its entirety and agree to it.

Date: _______________________

Signature: ___________________________________

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CREDIT/DEBIT CARD AUTHORIZATION FORM

Client Name: ____

Name on Card: ____

Cardholder's Phone Number: _________________________________

Type of Card: Credit Card ______________________
(only MC or VISA) Debit Card ______________________
Flex Spending/HSA Card ________

Credit Card Number: _______________________________________

Expiration Date: ____

Counselor: ____

Date of Service:

Charge Amount:

I, ______________________________, authorize Safe Harbor Counseling to bill my credit card for the amount indicated above and/or for any ongoing balances on my account.

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Consent For Treatment of a Minor

I, _________________, give Safe Harbor Counseling and ___________________
Therapist
Permission to provide treatment for _____________________________________.

Confidentiality Statement

I, ________________, and _________________ understand limits to confidentiality and have
parent child
been provided with a copy of this statement.

For the Parent/Guardian: The right to confidentiality is maintained with two exceptions:

1. The professional has reason to believe that you will harm yourself.
2. The professional has reason to believe that you will harm others, including your child.

For the Child: The right to confidentiality is maintained with three exceptions:

1. The professional has reason to believe that you will harm yourself.
2. The professional has reason to believe that you will harm others.
3. The professional has reason to believe that someone or something is harming you including your parents.

Additional Disclosures at the Parent's Request:

____
____
____
____
____

_________________________ _____________________________ ________
Therapist Parent/Guardian Date

____
Child