Safe Harbor Client Intake Packet:

Welcome to Safe Harbor Christian Counseling (SHCC). We hope your counseling experience with us will be positive and that our assistance will be beneficial to your mental health. 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.

Name: _____ Today's Date: _____

Gender: □ Male □ Female □ Other Date of Birth: _____ Age: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Any number you *do not* want to be contacted at: _____

Check here if you want Christian counseling: □ Yes □ No

Do you regularly attend church, synagogue or other religious institutions? □ 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: _____

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,):

_____

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? _____

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):

Name	Sex	Age or yr. of death	Relationship to you	Describe him/ her

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, which one? _____

Have any of your family member or friends ever attempted or committed suicide?
□ Yes □ No
If yes, which one? _____

Medical History

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: _____

When did you last have bloodwork completed, and for what reason?_____

_____

_____

Present Issues and Goals

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

_____

_____

_____

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

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?

_____

_____

_____

I certify that all the preceding information (personal, relational, counseling history, medical, present issues and goals) is honest and truthful to the best of my knowledge.

_____ _____

Client Signature Date

Safe Harbor Christian Counseling Policies and Procedures

The purpose of Safe Harbor Christian Counseling (SHCC) mental health treatment is to help you achieve your goals and overcome aby obstacles that led to seek counseling with SHCC. Treatment will include various mental health modalities. You are encouraged to work with your counselor in the development of your treatment plan and informed of any new modes used within your treatment process. The associated risks of mental health counseling are limited. You may experience some emotional difficulty, which your counselor will do their best to help you work through. The benefits to be gained from counseling are vast. Some potential benefits of counseling are an improved outlook on life, more effective coping skills, greater understanding of yourself, and better communication tools that will not only have positive effects on your relationships, but through many spheres of your life.

1. **Participation in Counseling**
    a. As a client of SHCC, you are not required to accept treatment from SHCC at any time and you have the right to decline part or all of your treatment, including withdrawal from our services should you not be willing to participate.

2. **Informed Consent for One Medical Record**
    a. I understand and consent to SHCC having one medical record for me. I understand that every counselor that provides treatment for me at SHCC will have access to all clinical notes in my clinical record.

3. **Informed Consent for Research**
    a. There may be opportunity in the course of your treatment to participate in research or outcome based metrics. You are not required to participate and there will be no direct or implied deprivation or penalty for refusal to participate.

4. **Release of Information Form**

    a. All information obtained/derived during 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.

        If you desire SHCC to either release or obtain information from a specific individual or agency, a ***Release of Information*** form must be obtained. A fee may be associated with providing information to a specific individual or agency.
        Exceptions to this guideline include instances when 1) the client is a clear danger to (a) themselves or (b) others and, 2) instances when the client 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.

    b. In addition, cases are occasionally discussed by the Safe Harbor Christian Counseling 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).

5. **Telephone Calls**
    a. Occasions may arise when you need to talk to your counselor in between normally scheduled sessions. If you leave a message with your counselor, they will make every effort to respond in a timely manner. Any consultation by telephone made between scheduled sessions will incur a charge to the client. If there is a life-threatening emergency, call 911 or go immediately to your local Emergency Room.

6. **Length of Session**
    a. Depending on what your insurance allows and authorizes, the psychotherapy sessions are varied in length between 38 and 53 minutes in length. It is to your benefit to arrive a few minutes in advance of the appointment time. Since your counselor has additional sessions scheduled after yours, the session must end at the appointed time regardless of your arrival time.

7. **Fees and Payment**
    a. Our current fee per session is $100-$150 depending on the Current Procedural Terminology (CPT) code.
    b. All payment is due at the time services are rendered. Payment may be made in the form of cash, check, or credit. If you choose to pay by check, please be prepared to supply a form of ID (e.g. driver's license) and make checks payable to Safe Harbor Christian Counseling. A $25.00 service charge will be levied on all checks returned by a bank for insufficient funds. If you choose to pay by credit card, please us the 'Credit Card Authorization' form contained in this packet. *(Does not apply to Medicaid clients)*
    c. If any or all outstanding balances are not paid in a timely manner, SHCC reserves the right to release a client's name and address to a collection agency. Also, a montly fee of 2% will be charged for these balances until they are paid in full. *(Does not apply to Medicaid clients)*
    d. There are additional fees for requests for additional medical records.

8. **Insurance**
    a. Safe Harbor Christian Counseling will bill your insurance company for all sessions unless otherwise agreed upon. You are responsible for any balance that insurance does not cover and agree to pay any unpaid balance on your account in a prompt manner.
    b. All balances on accounts will be collected from clients 90 days after insurance has been billed. This means that SHCC 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 SHCC directly. We will give you a receipt to submit to your insurance to pursue reimbursement.
    c. If your insurance changes or terminates, please call the SHCC Administrative Office as soon as possible to provide updated information. If the insurance changes or terminates and you fail to notify us, this will result in the claim being denied from the insurance company and you will be held responsible for the entire fee.

9. **Cancellations and Missed Appointments**
    a. 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. ***It is your responsibility to give at least 24 hours' notice if you must miss or cancel an appointment.*** Therefore, a cancellation fee of $60 will be assigned every time an appointment is missed or cancelled with less than 24 hours' notice. This fee is assessed regardless of the reason for missing or cancelling the originally scheduled appointment. Repeated missed appointmens or cancellations may affect the retention of your allotted time slot.

10. **Inclement Weather Policy**
    a. The counselor is responsible for determining if the weather is too hazardous to commute to your practice location. If your counselor decides to hold the session as originally scheduled, you are expected to attend and will be charged a cancellation fee for missed appointments. If your counselor decides to cancel your session, they will contact you to inform you of the change.

We trust that your involvement within Safe Harbor Christian Counseling will be helpful 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/ her Clinical Supervisor.

My signature certifies that I have thoroughly read, understand and agree to all of the Policies and Procedures of Safe Harbor Christian Counseling listed above. I have been given a copy of the Policies and Procedures.

Client's Signature _____ Date _____

HIPAA Privacy Notice of Safe Harbor Christian Counseling

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 *Information*.

THE EFFECTIVE DATE OF THIS NOTICE IS April 14, 2003. Safe Harbor Christian Counseling (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 us to use and disclose your *Information*.

Purposes for which Safe Harbor Christian Counseling May Use or Disclose Your Mental Health Information with your Consent

Safe Harbor Christian Counseling 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 will 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 with SHCC 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 on 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 delivery of mental health care services. SHCC may call you by name in the waiting area. SHCC may use or disclose your *Information*, as necessary, to contact you to schedule an appointment or remind you of your appointment.

- *Business Associates:* SHCC may share your *Information* with third party Business Associates who perform various administrative services. Whenever an arrangement between a Business Associate and SHCC 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 SHCC 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 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 your rights as listed above. (Fee $1.00 per page.)

Complaints
If you believe that Safe Harbor Christian Counseling violated your privacy rights, you have the right to complain to us or to the Secretary of the U.S. Department of Health and Human Services (DHHS). You may file a written complaint with SHCC 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. Safe Harbor Christian Counseling will not retaliate against you if you choose to file a complaint.

Contact Address:
Safe Harbor Christian Counseling

1208 E Churchville Road
Suite 300
Bel Air, MD 21014

As a client of Safe Harbor Christian 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 SHCC.

Client Name or Guardian (Print)_____

Client Signature _____ Date _____

CREDIT CARD AUTHORIZATION

Client Name: _____

Counselor: _____

Date of Service: ____/____/_____

Charge Amount: $ _____

Specify Type of Credit Card:

☐ Credit Card
☐ Debit Card
☐ Flex Spending/HSA Card

Name on Card: _____

Cardholder's Phone Number: _____

Credit Card #: _____

Expiration Date: ____/____

Security Code: _____

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

Note: There will be a time delay in the processing of charges to your credit card due to the nature of our billing system.

Safe Harbor
CHRISTIAN COUNSELING

Administrative Office:
1208 E. Churchville Road, Suite 300
Bel Air, Maryland 21014
TOLL FREE: 800-305-2089 / FAX: 443-640-4358

Erik L. Sundquist, LCSW-C
National Director
Phone: 410-893-4600 x 227
Email: erik@safeharbor1.com
www.safeharbor1.com

AUTHORIZATION TO RELEASE INFORMATION

I authorize SAFE HARBOR COUNSELING to release to, and receive from (Select one, fill out additional forms if necessary)

☐ MHPG
☐ Pediatrician
☐ Family Member/Support person
☐ Hospital
☐ Court System
☐ Primary Care Physician [ ]
☐ School System
☐ Other _____

(Release To Name)_____
(Release To Address)_____
(Release To Phone Number)_____

_____ _____
(Patient name) (DOB)

_____ Medical Records
Clinical Records
_____ Neurological Evaluation
_____ Results of Drug and Alcohol treatment/testing
_____ Academic Records/Educational Evaluation
_____ Treatment Plan/Patient Progress
_____ Special Education File
_____ Immunization Records
_____ Other (Specify) _____

For the purpose of: _____

This Release Expires On (one year from current Date): _____

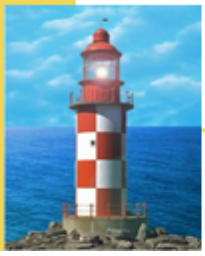
I have been informed of the type of information being released, the benefits and disadvantages (if any), and understand that treatment services are not contingent upon my decision concerning the signing of this release. I have also been informed that my photocopied signature is as valid as the original.

Signature of Patient: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____
(If patient is a minor)
Signature of Witness: _____ Date: _____

Note: Remember to ask for permission to release information to any key person who has worked with the patient and family (i.e. probation officer, hospital clinician, private practice clinician, teacher, guidance counselor, attorney, etc.)

As required by Section 2.32(a) PROHIBITION ON DISCLOSURE –rule: "This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose."



Safe Harbor
CHRISTIAN COUNSELING
Administrative Office:
1208 E. Churchville Road, Suite 300
Bel Air, Maryland 21014
TOLL FREE: 800-305-2089 / FAX: 443-640-4358

Erik L. Sundquist, LCSW-C
National Director
Phone: 410-893-4600 x 227
Email: erik@safeharbor1.com
www.safeharbor1.com

Primary Care Physician (PCP) Coordination of Care Release (Optional)

I authorize SAFE HARBOR CHRISTIAN COUNSELING to release to, and receive from my primary care physician:

Doctor's Name: _____

_____ _____

Doctor's Office Phone Doctor Office Fax

For the purpose of Mental Health Collaboration

This Release of Information is active for the duration of treatment unless otherwise noted

Client Name:_____

Insurance/Policy Number:_____

Client DOB:_____

Client Signature:_____ Date:_____

Clinician Signature:_____ Date: _____

To Be Filled Out By Clinician

Clinician:_____ Date of first counseling session: _____

ICD-10 Diagnosis Code:_____ Diagnosis:_____

Presenting Problem: _____

_____

_____

_____

This client has begun outpatient mental health counseling services with Safe Harbor Christian Counseling, LLC. If you would like to discuss this client at any time, please contact my direct line at: _____. I can also be reached by email at: _____.

Please complete this form and fax to:
Rachel Alger
Email: Ralger@safeharbor1.com
Fax: 443-640-4358