GATEWAY COUNSELING CENTER, INC.

(417) 869-8400

CONFIDENTIAL: Client Intake Information Form

Date:_____ Referred By:_____

Individual Information:

Name:_____
Last First M.I.

Address:_____
Street City State Zip

Date of Birth: _____Age:____S.S.#:_____E-mail_____

Home Phone:(____)_____Work Phone:(____)_____Cell Phone:(_____)_____

May we contact you at these numbers (check one)? ___Yes ___ No

May we leave a brief message at any of these numbers (check one)?___All or ___Home __Work ___Cell

Place of employment:_____

Additional Person Information (spouse, fiancé', parent, guardian, other):

Name:_____
Last First M.I.

Address:_____
Street City State Zip

Date of Birth: _____Age:____S.S.#:_____E-mail_____

Home Phone:(____)_____Work Phone:(____)_____Cell Phone:(_____)_____

May we contact you at these numbers if necessary (check one)? ___Yes ___ No

May we leave a brief message at any of these numbers (check one)?___All or ___Home __Work ___Cell

1864 S. Kentwood Avenue • Springfield, MO 65804
Phone: 417-869-8400 Fax: 417-869-8401

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Client Payment Information

Note: All records are confidential. No outsider is permitted to view your records without your written consent.

Please Check one:

□ Insurance Information:

Do you have Health Insurance (check one)? ___Yes ___ No

Do you want us to file your insurance (check one)? ___Yes ___ No

Insurance Provider:_____

Name of Policy Holder:_____

Relationship to client: _____

Policy Holder's Place of Employment:_____

Policy Holder's S.S.#:_____Date of Birth:_____

Member policy #:_____Group #:_____

□ Secondary insurance policy:

Insurance Provider:_____

Name of Policy Holder:_____

Relationship to client: _____

Policy Holder's Place of Employment:_____

Policy Holder's S.S.#:_____Date of Birth:_____

Member policy #:_____Group #:_____

□ Personal Payment:

Payment Method (check one)? ___Check ___Cash _____ Credit Card (REQUIRED)

Card Holders Name: _____
Card#:_____CVV Code:_____ Expires:_____

*If Client is self-pay (insurance is not billed) - Terms agreed to by Counselor & Client (write below):

_____

(Optional)Autopay for appointment with credit card: _____
Client's Signature Date

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Guarantee of Payments

I, _____by my signature below agree to make payment in full for any services or other fees that are due Gateway Counseling Center, Inc. and am responsible for such payments independent from any efforts to obtain such payments from insurance or other financial providers. I hereby release Gateway Counseling Center, Inc. and their agents or other persons acting in their behalf from all harm and I hereby waive all rights to confidentiality in matters concerning collection of payments due. I accept full responsibility for any fees or other costs that may be incurred in the collection of payments due Gateway Counseling Center, Inc. If there are couples or family counseling we are prohibited to be witnesses for custody cases or determined parental rights.

NOTICE OF CANCELLATION OR FAILURE TO SHOW FOR APPOINTMENT

I understand that it is my responsibility to give at least 24 hours notice to cancel a session. By my signature below I understand that I may be required to pay the session fee for each occurrence of a missed session or late cancellation.

Note: Your credit card will be charged for missed sessions

_____

Client's Signature Date

_____

Client's Signature Date

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Description of Symptoms

This information is between you and your counselor only. Please fill it out as specifically as possible. If more room is needed please use the back of the sheet.

Describe briefly what main problems/issues prompted you to seek counseling at this time.

_____
_____
_____
_____

Describe the ways your problem interferes with your personal and work performance.

_____
_____
_____
_____

What have you already tried to do about this situation and what was the result?

_____
_____
_____
_____

When did the problem start?_____

How long have you been concerned about this issue (i.e. week, month, etc)?_____

Have you seen another counselor, psychologist, or psychiatrist about this issue? If so, when?:

_____
_____

What did you receive treatment for?_____

Do you attend church? _____Denomination: _____

Please list any other health issues you are presently dealing with (heart surgery, thyroid, fibromyalgia, and/or other):

_____
_____
_____
_____

Who is your physician? _____Physician's Telephone Number_____

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Please check all that apply to you even if it seems unrelated to your current counseling issue. Circle those of greatest concern to you currently.

RECENT CHANGES IN:
- □ Appetite
  - □ Increase
  - □Decrease
- □ Weight
  ___lbs. lost/gained
- □ Physical energy
  - □ Increase
  - □Decrease
- □ Health

CONFLICT WITH:
- □ Family Member
- □ Friend
- □ Colleague
- □ Boss
- □ Co-worker
- □ Other

_____

THOUGHTS OF:
- □ Harming self
- □ Harming others

SLEEP DIFFICULTIES:
- □ Increase
- □ Decrease
- □ Difficulty falling asleep
- □ Early morning awaken

How many hours do you sleep each night? _____

VICTIM OF:
- □ Accident
- □ Abuse
  - □ Physical
  - □ Emotional
  - □ Sexual
- □ Violent crime

ACCUSED OF:
- □ Abuse
- □ Violent crime

EXPERIENCE OF:
- □ Vivid dreams
- □ Nightmares
- □ Hearing voices
- □ Being out of body
- □ Visions

RELATIONSHIP STATUS:
- □ Single never married
- □ Single dating
- □ Single cohabitating
- □ Married
- □ Separated
- □ Divorced
- □ Re-married

How many times ____

DECREASE CONTROL OF:
- □ Drinking
- □ Fighting
- □ Spending
- □ Sexual behaviors
- □ Stealing
- □ Gambling
- □ Eating
- □ Temper
- □ Relationships
- □ other _____

FEAR OF:
- □ Loss of control
- □ Death
- □ Being alone
- □ Objects or animals
- □ Places/situations
- □ Cancer
- □ AIDS
- □ Being possessed
- □ Being insane
- □ other

_____

_____

LIFE CHANGE (last 2 yrs.):
- □ Death in family
- □ Divorce/Separation
- □ Loss of Significant other
- □ Loss of a friend
- □ Fired from job
- □ Pregnancy
- □ Surgical/medical procedure
- □ Other _____

_____

PRESENT USE OF:
- □ Alcohol
- □ Illegal drugs
- □ Cigarette smoking
- □ Prescription drugs
- □ Laxatives
- □ Diet pills
- □ Sleeping pills
- □ Other

_____

_____

Please list all medications, vitamins, and/or diet pills presently taking.

_____

_____

_____

_____

_____

_____

_____

_____

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Religious-Spiritual Intake

1. Are religious or spiritual issues important in your life?
   ___Yes ____No ____Somewhat
2. Do you wish to discuss them in counseling?
   ___Yes ____No
   If not, you do not need to answer the remaining questions about religion and spirituality.
3. Do you believe in God or a Supreme Being? ___Yes ___No
   Please elaborate if you wish:

   _____

   _____

   _____
4. Do you believe you can experience spiritual guidance?
   _____Yes ____No
   If so, how often have you had such experiences?
   ____Often _____Occasionally _____Rarely ____Never
5. What is your current religious affiliation (if any)?
6. Are you committed to it and actively involved?
   ____Yes ____Somewhat ____No
7. What was your childhood religious affiliation (if any)?
8. How important was religion or spiritual beliefs to you as a child and adolescent?
   ___Important ___Somewhat important ___Unimportant
   Please elaborate if you wish:

   _____

   _____

   _____
9. Are you aware of any religious or spiritual resources in your life that could be used to help you overcome your problems? _____Yes _____No
10. Do you believe that religious or spiritual influences have hurt you or contributed to some of your problems? ____Yes ____No
    If yes, can you briefly explain how? _____
    _____
    _____
11. Would you like your counselor to consult with your religious leader if it appears this could be helpful to you? _____Yes _____No _____Maybe
    If yes, a permission and confidentiality form will be provided for you to sign.
12. Are you willing to consider trying religious or spiritual suggestions from your counselor if it appears that they could be helpful to you? ____Yes ____No

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NOTICE OF PRIVACY PRACTICES

Gateway Counseling Center, Inc.

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The information we collect about you and place in your healthcare record will likely include information about your past, present, or future health or conditions, tests, treatment, or payment for healthcare. The law refers to this as Protected Health Information (PHI). We are required by law to maintain the privacy of your PHI and to provide you with this notice of my legal duties and privacy practices. In order to provide care to you we need to collect, use and, in some cases, share health information you provide to me. We must also have your consent to do so. Therefore, you must sign the Consent form before we may begin to treat you. If you do not provide your consent, we cannot treat you.

How Your PHI May be Used or Disclosed - We may use or disclose your PHI for three purposes: treatment, obtaining payment, and healthcare operations (TPO). Below are some examples.

Treatment is when we use your medical information to provide you with psychological treatments or services. For example, we may share or disclose your PHI to others who also provide treatment to you, such as your family physician, psychiatrist, or another mental health professional. If you are being treated by a team of professionals, we may share some of your PHI with them to coordinate services.

Payment is when we use your information to bill you, your insurance, or others. An example of disclosure would be when we communicate with your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

Healthcare Operations are activities that related to the performance and operation of my practice. Some examples are quality assessment and improvement activities and audits and administrative services. Other uses of your PHI may be involved in such activities as contacting you for appointment reminders/re-scheduling. If you do not want us to call you at a specific phone number or leave messages, you may indicate that to us and we will honor your request as long as we have an alternate means of contacting you.

Uses / Disclosures that require Authorization

If we want to use your PHI for any purpose besides TPO, or those we described above, we must have your written permission to do so. This written permission permits only specific disclosures in specific situations. If you do provide us with written permission to use your PHI, you may revoke that permission, in writing, at any time. After your revocation, we will not use or disclose your PHI for those specific purposes. Of course, we cannot take back any information we may have already disclosed with your permission. In the case where written permission is necessary as a condition of obtaining insurance coverage, you may not revoke it.

Uses / Disclosures that require NEITHER Consent nor Authorization

In the following circumstances we are required by law to use or disclose your PHI whether or not I have your Consent or Authorization:

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Child Abuse/Neglect - If we have reasonable cause to suspect that a child in your care has been or may be subjected to abuse or neglect, we must report to the Missouri Division of Children's Services. We may also report this information to a law enforcement agency or juvenile office.

Adult/Domestic Abuse- If we have reasonable cause to suspect that an "eligible adult" presents a likelihood of suffering physical harm or is in need of protective services, we must report to the Missouri Department of Social Services. An "eligible adult" refers to any person 60 years of age or older or an adult between the ages of 18 and 59 who has a handicap that substantially limits mental or physical capacity who is unable to protect his/her own interests or adequately perform or obtain services necessary to meet his/her essential human needs.

Serious Threat to Health or Safety- If we judge that there is a clear and substantial risk of imminent serious harm being inflicted by you on yourself or another person, we must disclose your relevant PHI to the appropriate professional workers, public authorities, the potential victim, his/her family, or your family.

Judicial / Administrative Proceedings- If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and we will not release it without a written authorization from you or your personal or legally-appointed representative, or a court order. The privilege may be overridden by a court-order to release the information. Therapists cannot be subpoenaed as expert witnesses in court proceedings.

Worker's Compensation- If you file a worker's compensation claim, we must permit your record to be copied by the Missouri Labor and Industrial Commission or the Division of Worker's Compensation of the Missouri Department of Labor and Industrial Relations, your employer, you, and any other party to the proceedings.

Complaint/Lawsuit Filed against a Therapist- If you, the client, file a complaint or lawsuit against us, we may disclose relevant information for the purpose of defending ourselves. Government Health Oversight Activities- If a government agency is requesting information for health oversight activities, we may be required to provide general information to them.

Collection of Fees- If a bill for fees incurred becomes neglected, the law allows for use of a collection agency if necessary. Your Rights Right to Request Restrictions- You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.

Right to Receive Confidential Communications- You have the right to request and receive confidential communications of PHI in a particular way or at a certain place which is more private for you. For example, you can ask us to call you at home and not at work to schedule or cancel an appointment. We will try our best to do as you ask if you provide an alternate means of contact.

Right to Inspect and Copy- You have the right to view and obtain a copy of the PHI we have about you, such as your medical and billing records and routine progress notes.

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You may be denied access to your PHI under certain circumstances, such as situations in which disclosure of or viewing of PHI is reasonably likely to cause you undue harm or endanger others. This is called therapeutic privilege, and is protected under Missouri law. If you are granted the right to view your PHI records, we are allowed to charge a handling fee for copying records and a fee per page for copying the pages. If your request for access to your PHI is refused, you have a right of review, which will be discussed with you upon request.

Right to Amend- If you believe the information in your records is incorrect or missing important details, you can request an amendment in writing. You must tell me the reasons you want the make the changes. We may deny your request.

Right to an Accounting of Disclosures- We are required to keep a record of some of the disclosures of your PHI. You may request an accounting of these disclosures. Right to File a Complaint- If you believe your privacy rights have been violated, you can file a complaint with us directly in writing as well as with the Secretary of the Department of Health and Human Services. If you file a complaint, we will not retaliate against you in any way.

As Licensed Professional Counselors, we are required to follow the terms of the Notice of Privacy Practices (NPP) currently in effect. In accordance with federal regulations, we reserve the right to change the terms of the NPP and apply the changes to all the PHI that we maintain. A copy of any updated versions of this NPP will be provided to you at your request.

Changes to Privacy Practices- Privacy practices may be updated from time to time to comply with federal law and state laws. An updated Notice may be requested at any time by contacting us at the phone number listed below. If you need more information or have questions about the privacy practices described in this Notice, you may discuss them with us further by contacting Gateway Counseling Center, Inc. at (417)-869-8400.

I have read the above "Notice of Privacy Practices" and consent to these practices.

_____ _____ _____

Name Signature Date

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