The Porch Therapy Group – Couple Intake

Confidential Information

Please have both individuals in the relationship complete the form. Please bring them with you during your first appointment. Please note that you will be asked to talk about your answers in sessions but your partner will not be shown this form.

Patient Information

Name _____ First Appointment Date _____

Date of Birth _____ Age _____ Sex _____

SS# _____ Race _____

Children (Number and Ages) _____

Address _____ City _____ State _____ Zip _____

Who are you currently living with? _____

Home Phone # _____ Work # _____

Employer (school, if student) _____

Email Address _____ Driver's License # _____

Relationship Status: (Check all that apply)

□ Married
□ Separated
□ Divorced
□ Dating
□ Cohabitating
□ Living together
□ Living apart

Length of time in current relationship: _____

As you think about the primary reason that brings you here, how would you rate its frequency and your overall level of concern at this point in time?

Concern

□ No concern
□ Little concern
□ Moderate concern
□ Serious concern
□ Very serious concern

Frequency

□ No occurrence
□ Occurs rarely
□ Occurs sometimes
□ Occurs frequently
□ Occurs nearly always

What do you hope to accomplish through counseling?

_____

_____

_____

What have you already done to deal with the difficulties?

_____

_____

_____

What are your biggest strengths as a couple?

_____

_____

Please rate your current level of relationship happiness by circling the number that corresponds with your current feelings about the relationship.

1 2 3 4 5 6 7 8 9 10

(extremely unhappy) (extremely happy)

Please make at least one suggestion as to something you could personally do to improve the relationship regardless of what your partner does.

_____

_____

_____

Have you received prior couples counseling related to any of the above problems? □ Yes □ No

If yes, when: _____ Where: _____

By whom: _____ Length of treatment: _____

Problems treated: _____

_____

What was the outcome (check one)?

□ Very successful □ Somewhat successful □ Stayed the same □ Somewhat worse □ Much worse

Have either you or your partner been in *individual* counseling before? □ Yes □ No
If so, give a brief summary of concerns that you addressed.

_____

_____

_____

Do either you or your partner drink alcohol to intoxication or take drugs to intoxication? Yes □ No □
If yes for either, who, how often and what drugs or alcohol?

_____

_____

_____

Have either you or your partner struck, physically restrained, used violence against or injured the other person?

Yes □ No □ If yes for either, who, how often and what happened.

_____

_____

_____

Has either of you threatened to separate or divorce (if married) as a result of the current relationship problems?

Yes □ No □ If yes, who? ___Me ___Partner ___Both of us

If married, have either you or your partner consulted with a lawyer about divorce?

Yes □ No □ If yes, who? ___Me ___Partner ___Both of us

Do you perceive that either you or your partner has withdrawn from the relationship? Yes □ No □

If yes, which of you has withdrawn? ___Me ___Partner ___Both of us

How frequently have you had sexual relations during the last month? _____times

How enjoyable is your sexual relationship? (Circle one)

1 2 3 4 5 6 7 8 9 10
(extremely unpleasant) (extremely pleasant)

How satisfied are you with the frequency of your sexual relations? (Circle one)

1 2 3 4 5 6 7 8 9 10
(extremely unsatisfied) (extremely satisfied)

What is your current level of stress (overall)? (Circle one)

1 2 3 4 5 6 7 8 9 10
(no stress) (high stress)

What is your current level of stress (in the relationship)? (Circle one)

1 2 3 4 5 6 7 8 9 10
(no stress) (high stress)

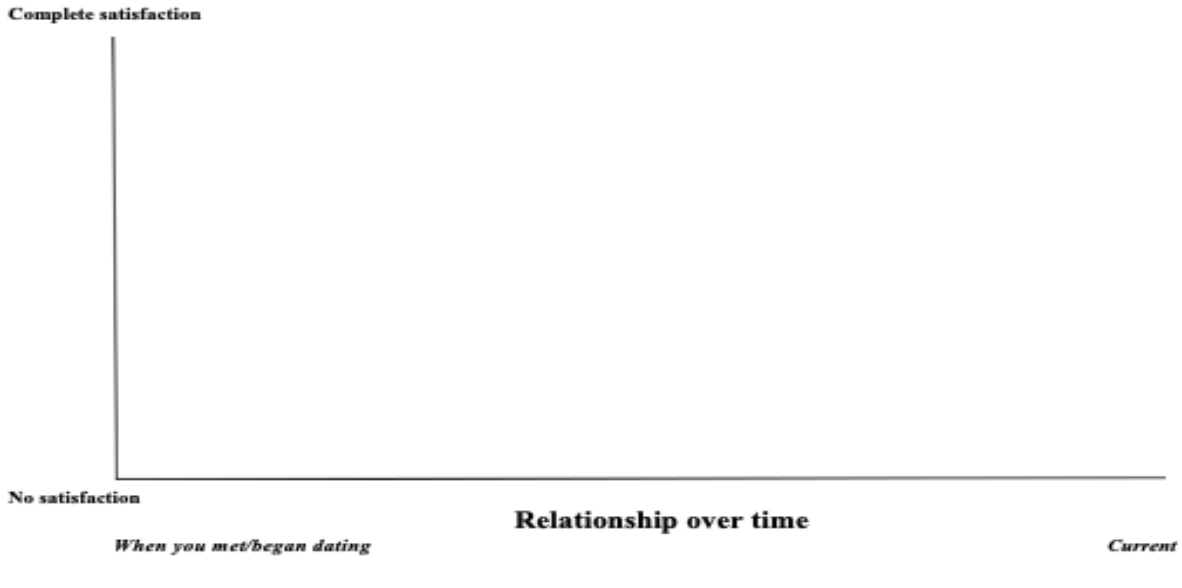
Rank order the top three concerns that you have in your relationship with your partner (1 being the most problematic):

1. _____

2. _____

3. _____

Lastly, please draw a graph indicating your level of relationship satisfaction beginning with when you met your partner. Note *pivotal/significant events* in your relationship (e.g., one of you moved out, one of you cheated)



Why Did You Seek The Evaluation At This Time? (What are your goals in being here?)

_____
_____
_____
_____
_____

Medical History

Current medical problems/medications (include dosage)_____
_____
_____
_____

Current supplements/vitamins/ herbs _____
_____
_____
_____

Past Medical problems/medications _____
_____
_____
_____

Other doctors/clinics seen regularly _____
_____

Any history of head trauma, concussion or significant accidents? (describe) _____
_____
_____

Ever any seizures of seizure like activity? _____

Prior hospitalizations (place, cause, date, outcome) _____
_____
_____

Prior Abnormal lab tests (x-rays, EEG, etc.) _____
_____

Allergies / Drug intolerances (describe) _____
_____

Current Height _____ Current Weight_____

Other medical history we may need to know _____
_____
_____
_____
_____

Please bring pertinent medical records: lab results, MRI reports, psychological testing, etc.

Prior Psychiatric Medications/Supplements (Please list all medications/supplements taken alone and all medications taken in combination; including dosages, effectiveness, and any side-effects [including self-medication also]) If you need more room please attach another sheet.

Date Taken	**Medication Individuals or Combinations Dosage(s) / Time(s) taken per day**	**Effectiveness**	**Side-Effects/Problems**
Example: 3/2015 – 12/2019	**Example:** - Ritalin 5 mg Once a day AM - Prozac 10mg QAM	**Example:** Improved concentration in morning, still moody	**Example:** Felt very unfocused in evening; hyperactive in evenings; dry mouth

Family History

Family Structure (who lives in your current household, please give relationship to each)

_____

_____

_____

_____

Current Marital or Relationship _____How satisfied?_____

Significant Developmental Events (include marriage, separations, divorces, deaths, traumatic events, losses, abuse, etc.) _____

_____

_____

_____

Natural Mother's History

Age/Age at Death _____Occupation _____

Highest Grade Completed _____Learning Problems _____

Behavior Problems _____Marriages _____

Medical Problems _____

_____

Childhood atmosphere (family position, abuse, illness, etc.) _____

_____

Has mother ever sought psychiatric treatment? Describe_____

_____

Mother's alcohol/drug use history _____

_____

Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations, etc. (Describe) _____

_____

Natural Father's History

Age/Age at Death _____Occupation _____

Highest Grade Completed _____Learning Problems _____

Behavior Problems _____Marriages _____

Medical Problems _____

_____

Childhood atmosphere (family position, abuse, illness, etc.) _____

_____

Has father ever sought psychiatric treatment? Describe_____

_____

Father's alcohol/drug use history _____

_____

Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations, etc. (Describe) _____

_____

Siblings (name, ages, problems [behavior, medical, psychiatric], strengths, relationship to patient)

_____

_____

_____

_____

_____

Children (name, ages, problems [behavior, medical, psychiatric], strengths, relationship to patient) _____

_____

_____

_____

_____

Cultural/Ethnic and Religious Background _____

_____

Describe Your Relationship with Friends _____

_____

_____

_____

Describe Yourself _____

_____

_____

_____

Describe your strengths _____

_____

_____

_____

STATEMENT OF UNDERSTANDING AND CONSENT TO EVALUATION/TREATMENT

Insurance plans are highly variable, and you are responsible for understanding your benefits. Calling the toll-free number on your insurance card and asking for a thorough explanation of your out-patient mental health benefits is advisable. Make sure you ask about services covered, deductibles, co-insurance payments, whether or not you are limited to a certain group of providers and the kinds of credentials your provider needs to have. Full payment is expected for all services delivered regardless of insurance coverage.

You will receive regular statements only if your account has a balance. A fee of $35 will be charged on all returned checks.

CANCELLATION POLICY: If you plan to miss your appointment, we request that you **notify the office 24 hours in advance to avoid a charge. A no-show appointment will result in a $50.00 charge**, as this time could have been scheduled for another individual. This charge is your financial responsibility and will not be filed with your insurance company.

I/We have read and understand the above Cancellation Policy: Initial _____ Date _____

CONFIDENTIALITY:

Physician Referrals: Information relevant to your case may be discussed with your referring physician in order to plan an effective coordination of treatment, unless the patient has specifically advised therapist not to consult with referring physician.

Self Referrals: Information concerning a patient will not be discussed or disclosed to anyone, except as required by law, without the express, prior written consent of the individual.

Dangerous Situations: If it is believed that the patient, another person, or property is at substantial risk of harm, or it appears that an illegal act or threat thereof has been committed, it is the therapist's obligation to disclose, as required by law, what information is necessary to prevent harm or protect against criminal acts.

LEGAL PROCEEDINGS: If you become involved in legal proceeding that require participation of a therapist at The PORCH Therapy Group, you will be expected to pay for the therapist's time, even if called to testify by another party. Because of the complicated nature of legal involvement, you will be charged $150 per hour for preparation time (minimum of 3 hours) and attendance at any legal proceeding.

CONSENT TO EVALUATION/TREATMENT:

The undersigned is/are applying for and consenting to treatment by:_____. (therapist)

I/We understand that any release of information from clinical record can only be made with written prior consent by all the undersigned.

All adults (non-minors) or guardians who are receiving services at this office must sign this document prior to receiving treatment.

Therapist's at The PORCH are independent practitioners. All checks are to be made out to _____.

I/We understand the above and hereby consent to evaluation/treatment.

Patient: _____ Date: _____

Legal Guardian Signature (if applicable): _____ Date: _____

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records or a summary/narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: _____ Date of Birth: _____

The information you may release subject to this signed release form is as follows:

- ☐ Complete Records
- ☐ Treatment Plan
- ☐ Progress Notes
- ☐ Demographic Information
- ☐ Billing Records
- ☐ Treatment Summary/Narrative
- ☐ Consultations
- ☐ Verbal Reports

Release my protected health information to the following physician/person/facility/entity and/or those directly associated with my medical care:

Name	Affiliation	Address	Phone#	Email

Signatures:

_____ _____

Patient Name Signature of Patient or Personal Rep.

_____ _____

Patient Date of Birth or Social Security Printed Name of Patient or Personal Rep.

_____ _____

Date Description of Personal Rep. Authority

Appointment Reminder Preference

Name: _____

The PORCH Therapy Group may notify you of your next appointment 24-48 hours in advance as a courtesy reminder. Please choose one reminder option.

☐ Yes, I would appreciate a phone reminder. Please call me prior to my appointment at _____. I understand that if others have access to this number, confidentiality cannot be ensured.

☐ Yes, I would appreciate a text reminder. Please text me prior to my appointment at _____. I understand that if others have access to this number, confidentiality cannot be ensured.

☐ No, I would prefer not to be reminded of appointments and will keep up with them myself.

Client _____ Date_____

Staff_____ Date_____

The PORCH Therapy Group
504 W Main, West Plains, MO 65775
417-815-6313

Health Insurance Portability Accountability Act (HIPAA) Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, explains HIPAA and its application to your PHI in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.

 **Updated 11.30.17, 4.16.18, 9.14.18*

5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Missouri Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- ***For Treatment –*** I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of our practice for your treatment by another health care provider, I will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- ***For Payment*** – I may use and disclose your health information to obtain payment for services provided to you as delineated in the Therapy Agreement.
- ***For Operations*** – I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

Patient's Rights:

- ***Right to Treatment*** – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.

- ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advanced and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- ***Right to Amend*** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days.
- ***Right to a Copy of This Notice*** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- ***Right to Choose Someone to Act for You*** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
- ***Right to Choose*** – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- ***Right to Terminate*** – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
- ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes,

however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

Complaints
If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of Missouri Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____ _____
Client/Legal Guardian Signature Date

_____
Printed Name

_____ _____
Client/Legal Guardian Signature Date

_____
Printed Name

_____ _____
Therapist Signature Date

