

Client Information

Except in cases of child/elder abuse or immediate danger to yourself/others, all information provided will be kept strictly confidential and released only in accordance with professional ethics and applicable law.

Date _____ Referred by _____

Name _____ M F Birth Date ____/____/____

Spouse/partner's name _____ M F Birth Date ____/____/____

Relational Status: Married/cohabitating, separated, divorced, widowed, single, engaged

Children's names/DOB _____

Others living in your home _____

Address _____
Street Apt. # City Zip

Phone _____ Okay to leave message? Yes No Email _____

Occupation _____ Employer _____

Current Concerns

Check the areas which apply

- | | | |
|---|--|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Career/School | <input type="checkbox"/> Spiritual issues |
| <input type="checkbox"/> Anxiety/Stress | <input type="checkbox"/> Sexuality | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Relationships | <input type="checkbox"/> Grief | <input type="checkbox"/> Finances |
| <input type="checkbox"/> Eating issues | <input type="checkbox"/> Anger | <input type="checkbox"/> Health |
| <input type="checkbox"/> Life Transitions | <input type="checkbox"/> Abuse | <input type="checkbox"/> Insecurity |
| <input type="checkbox"/> Substance abuse | <input type="checkbox"/> Family | <input type="checkbox"/> Homicidal thoughts |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Parenting | <input type="checkbox"/> Suicidal thoughts |

What are the major concerns for which you've seeking counseling?

On a scale of 1 (mild) to 5 (severe), how would you rate your issues? 1 2 3 4 5

How long have these issues been a concern? _____

What are your goals for counseling? _____

Describe your personal strengths _____

Describe your support system (family, friends, church, etc) _____

Would including spirituality/religious views in your counseling be helpful? Yes No

If yes, what is your religious background and/or preference? _____

Have you received counseling in the past? Yes No

If yes, what were the issues and was it helpful? _____

Medical Information

Physicians name _____ Phone _____

Current medical conditions _____

Hospitalizations/major illnesses in the past 5 years (physical or mental) _____

List medications and vitamin/herbal remedies taken regularly. Indicate dosage and purpose

Emergency Contact _____

Name

Relationship

Phone

Use back of page for additional information that you believe would be helpful.

More on back

*Chris J Graham at the
Meridian Counseling Center
849 E. Fairview Ave.
Meridian, Idaho 83642
208-860-9868 cell
208-939-9009 fax*

Informed Consent

Therapy is a relationship that works because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have rights that are important for you to know. There are also certain limitations to those rights of which you should be aware. As a therapist, I have responsibilities to you too.

My Responsibilities to You as Your Therapist

Confidentiality

With the exception of certain specific exceptions described below, you have the absolute right to the confidentiality of your therapy. I cannot and will not tell anyone else what you have told me, or even that you are in therapy with me without your prior written permission. Under the provisions of the Health Care Information Act of 1992, I may legally speak to another health care provider or a member of your family about you without your prior consent, but I will not do so unless the situation is an emergency. I will always act to protect your privacy even if you do release me in writing to share information about you. You may direct me to share information with whomever you chose, and you can change your mind and revoke that permission at any time. You may request anyone to attend a therapy session with you. You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). The following are legal exceptions to your right to confidentiality. I would inform you of any time when I think I will have to put these into effect.

- If the client is evaluated to be a danger to self/others.
- If your counselor was appointed by the court to evaluate and/or provide treatment to you.
- If the client is a minor, elderly, or disabled and the social worker believes he or she is a victim of, or at risk of, abuse, or, if the client divulges information about such abuse/risk of abuse.
- If the client files suit against the social worker for breach of duty.
- If a court order or other legal proceedings or statute requires disclosure of information.
- If the client waives the rights to privilege or gives written consent to disclose information.
- Anonymous disclosures for audits, evaluations, or research without personally identifying information.
- To third party payers (i.e., insurance companies) or those involved in collecting fees for services.
- Disclosures to other professionals or supervisees directly involved in your treatment or diagnosis.

Record-Keeping

I am required by both the law and the standards of my profession to maintain appropriate treatment records. These may include diagnosis, therapy goals, treatment progression, documentation of mandated disclosures (i.e. report of child abuse), and other information. You have a right to review and/or receive a copy of your records unless in my professional opinion, I find that doing so would be likely to cause you substantial harm, endanger your life or physical safety, or pose a significant risk of harm to another individual. Alternately, I can prepare an appropriate summary of these records. Given their inclusion of professional language, these records may be difficult to interpret or understand. If you wish to review your records, I recommend you review them in my presence so we can discuss their content.

Diagnosis

If a third party such as an insurance company is paying for part of your bill, I am normally required to give a diagnosis to that third party in order to be paid. Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. I will be glad to discuss your diagnosis with you at any time.

Other Rights

You have the right to ask questions about anything that happens in therapy. I'm always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave therapy at any time.

Fees

Individual therapy is \$100 per session, with each session being up to 50 minutes long. You will be asked to pay for each session at the time of the session. Check, cash, or credit cards can be used to make payments. If you receive health insurance benefits, please know that I do accept certain insurances and all co-payments will be due at the time of service. Psychotherapy sessions are scheduled at an ongoing weekly basis, weekly, bi-weekly or as needed basis. Sessions usually last between approximately 50 minutes.

Ending Therapy

Therapy is an intimate process that goes through several distinct phases. Termination is a significant part of the therapeutic process. I want to make your therapy as successful as possible. For that reason, it works best to find a rhythm and structure to the beginning stages of sessions that meet regularly. If you are thinking about ending therapy for any reason, please share those thoughts with me as soon as possible. If I initiate termination of therapy, it will be because I feel that I am not able to be helpful to

you. I will offer you referrals to other sources of care, but cannot guarantee that they will accept you for therapy. You are free to leave therapy at any time.

Your Responsibilities as a Therapy Client

You are responsible for coming to your session on time and at the time we have scheduled. Sessions last up to 50 minutes. If you are more than 15 minutes late, we will be unable to meet. If you are late, we will end on time and not run over into the next scheduled session. All cancellations must occur at least 24 hours before the scheduled appointment time. If you cancel your appointment with less than 24 hours notice you will be responsible for the co-payment for that session or \$20 if no co-pay is required. Please note that after 3 missed appointment times, your scheduled sessions may no longer be reserved for you.

Complaints

If at any time you feel that your needs are not being met or you are not getting what you want out of our sessions, please tell me, so we can discuss your needs and adjust your therapy treatment plan. If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, please discuss these with me. If you are dissatisfied with the outcome of that discussion, you may send a written complaint to the Idaho Board of Occupational Licensing.

Client Consent to Psychotherapy

I have read this statement, had sufficient time to considered it carefully, ask any clarifying questions necessary to aid my understanding, and now fully understand the spirit and letter of the policies and procedures described here. I understand the limits to confidentiality required by law. I understand the fee per session and my rights and responsibilities as a client, and my therapist's responsibilities to me. I know I can end therapy at any time I wish. My signature below indicates understanding and intent to comply with these policies and procedures.

Client/Guardian Signature

Date

Chris J. Graham MS, LPC

Date

Chris J Graham MS, LPC at the
 Meridian Counseling Center
 849 E. Fairview Ave.
 Meridian, Idaho 83642

Insurance Information Sheet

Name				DOB	
Sex		SSN		Email	
Street Address					
City		State		Zip	
Home Phone			Mobile		
Name of Insured				DOB	
Sex		SSN		Email	
Insurance				ID #	
Insurance Phone				Group	
Insurance Address					
City		State		Zip	
Home Phone			Mobile		
Relationship to Insured	Self	Spouse	Child	Other	
Employer				Phone	
Employer Street Address					
City		State		Zip	
I, as a Client or Insured Family Member, give consent and acknowledgement that this and other client information will be released to Insurance Carriers that provide financial reimbursement for requested services by Chris J Graham					
Signature				Date	

*Chris J Graham MS, LPC at the
Meridian Counseling Center
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208-860-9868 cell*

Notice of Privacy Practice

Your Information. Your Rights. Our Responsibilities.

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

Your Rights: You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices: You have some choices in the way that we use and share information as we:

- Talk with your family about your condition (as needed)
- Provide disaster relief
- Provide mental health care

Our Uses and Disclosures: We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

- 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. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Most sharing of psychotherapy notes

Our Uses and Disclosures: we never market or sell personal information

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you: We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues: We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research: We can use or share your information for health research.

Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- **We are required by law to maintain the privacy and security of your protected health information.**
- **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**
- **We must follow the duties and privacy practices described in this notice and give you a copy of it.**
- **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

See Attached Informed Consent for further details about confidentiality and client information.

Please ask questions if desiring further information. Please sign below, acknowledging your receipt of this notice. Thank you.

Client Signature

Date