Healing Path Counseling Center

Main Office: 603 Old Liberty Rd. STE 1. Sykesville, MD 21117
Phone: 410-921-9004 Email: healingpathcounselingcenter.com
Rachel Cochran LCSW-C

CLIENT INTAKE FORM

PERSONAL INFORMATION

Name: _____ Date: _____

Address, City, State, Zip: _____ Email: _____

Sex: □ Male □ Female Date of Birth: _____ Age: _____

Home phone: _____ Work phone: _____

Cell phone: _____

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

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

Employer/School: _____

Occupation/Grade: _____

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?

Type of Residence? □ Homeless □ Renting □ Own Home □ Staying with Someone

Briefly Describe Living Situation: (Who lives with you, are your children living with you?)

_____

_____

_____

_____

_____

_____

_____

Family dynamics/Support System

_____

_____

_____

_____

_____

_____

_____

Family History: Please list any family member who had a significant impact on your life (Either positive or negative).

Name	Sex	Age/ yr. of Death	Relationship to you	Describe him/her (angry, outgoing, supportive, controlling)

Please describe your childhood:

_____
_____
_____
_____
_____
_____

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: _____

COUNSELING HISTORY

Are you seeing a Psychiatrist? □ Yes □ No

Psychiatrist: _____ Phone Number: _____

Duration of treatment:_____ Last Visit: _____

Previous Out-Patient Treatment? □ Yes □ No

(Names, Dates,
Locations)_____
_____
_____
_____

Previous In-Patient Treatment? □ Yes □ No

(Names, Dates, Locations)

_____
_____
_____
_____

MEDICAL HISTORY

Current Medication:

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

Previous Drug/Alcohol Treatment (Detox, In-patient or Out-patient)?

□ Yes □ No

If yes, please list the names, dates, locations. Also list the reason behind the treatment:

Current Medical Problems? □ Yes □ No

If yes, please list medical problems:

Legal History: □ Yes □ No

(Describe any history of legal problems, current charges, probation/parole, court dates pending.)

PRESENT ISSUES AND GOALS

Please describe why you are coming to counseling.
(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:

□ 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 _____

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

[----------]

Very Minimally Distressed | Moderately Distressed | 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/Parent Signature Date

Healing Path Counseling Center

Main Office: 603 Old Liberty Rd. STE 1. Sykesville, MD 21117
Phone: 410-921-9004 Email: healingpathcounselingcenter.com
Rachel Cochran LCSW-C

POLICIES AND PROCEDURES

Welcome to Healing Path Counseling Center. 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 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. Your signature on this form will allow this process to proceed smoothly.

2. TELEPHONE CALLS

If there is an emergency and your therapist is unable to be reached, call 911 or go immediately to your local Emergency room. Please give your therapist at least 24 hours to get back with you. Telephone sessions are available if needed for an additional charge.

3. LENGTH OF SESSION

Length of sessions are 45 minutes to an hour unless you and your therapist have made other arrangements. Please ensure you arrive a few minutes in advance of the appointment time to ensure prompt time of appointment.

4. FEES AND PAYMENT

Payment is due at the time of service. We accept cash, all major credit cards, and checks made payable to Healing Path Counseling Center LLC. A $30.00 service charge will be levied on all checks returned by a bank for insufficient funds. Our current fee per session is $120 per hour. If any or all outstanding balances are not paid, Healing Path Counseling Center 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. If you are having problems financially please talk to your therapist.

5. INSURANCE

Healing Path Counseling Center is an out of network provider. Some insurance companies pay for out of network services. Your therapist will fill out any out of network insurance forms, which the client is then responsible for submitting to insurance companies. Client is responsible for entire charge of session, and if insurance accepts out of network benefits, insurance will reimburse client directly.

6. CANCELLATIONS AND MISSED APPOINTMENTS

A cancelled appointment delays our work. When you must cancel, please give us at least 24 hours' notice. If you are unable to provide at least 24 hours' notice when you cancel, you will be charged the full fee for your session. (You should note that insurance companies do not reimburse for missed appointments). The only time we will waive this fee is in the event of serious or contagious illness or emergency.

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.

This is to certify that I have read, understand, and agree to the terms stated in this document.

_____ _____

Client/Parent Signature Date

Healing Path Counseling Center

Main Office: 603 Old Liberty Rd. STE 1. Sykesville, MD 21117
Phone: 410-921-9004 Email: healingpathcounselingcenter.com
Rachel Cochran LCSW-C

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have

a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.

Abuse and Neglect	**Judicial and Administrative Proceedings**
Emergencies	**Law Enforcement**
National Security	**Public Safety (Duty to Warn)**

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission. We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to Rachel Cochran, at Healing Path Counseling Center, LLC:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions. .** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Breach Notification.** If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Rachel Cochran LCSW-C, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

Healing Path Counseling Center

Main Office: 603 Old Liberty Rd. STE 1. Sykesville, MD 21117
Phone: 410-921-9004 Email: healingpathcounselingcenter.com
Rachel Cochran LCSW-C

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Light of Hope Counseling, LLC Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Tina Baublitz, LCPC.

_____
Signature of Patient/Client

_____
Signature or Parent, Guardian or
Personal Representative*

_____
Date

---

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Healing Path Counseling Center

Main Office: 603 Old Liberty Rd. STE 1. Sykesville, MD 21117
Phone: 410-921-9004 Email: healingpathcounselingcenter.com
Rachel Cochran LCSW-C

IMPORTANT INFORMATION AND CLIENT CONSENT: Please read and sign at the end stating you have fully read and understand the information below.

Professionals Include:

AVAILABLE SERVICES: Healing Path Counseling Center LLC offers a wide array of counseling services, including individual, family, and couples counseling. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. It is our intent to convey the policies and procedures used in our practice, and we will be pleased to discuss any questions or concerns you may have.

RISKS AND BENEFITS: Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh any discomfort encountered during the process, however. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. We cannot guarantee these benefits, of course. It is our desire, however, to work with you to attain your personal goals for counseling and/or psychotherapy.

COUNSELING: The goal of Healing Path Counseling Center, LLC is to provide the most effective therapeutic experience available to you. If at any time you feel that you and your current Therapist are not a good fit, please discuss this matter with your Therapist to determine if transferring to a more suitable Therapist is right for you. If you and your Therapist decide that other services would be more appropriate, we will assist you in finding a provider to meet your needs.

CONFIDENTIALITY: Healing Path Counseling Center, LLC follows all ethical standards prescribed by state and federal law. We are required by practice guidelines and standards of care to keep records of your counseling. These records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to you.

Discussions between a Therapist and a client are confidential. To ensure your confidentiality, recording audio or video in your session without the written consent of your therapist is prohibited. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the

Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of the Therapist when you and the Therapist discuss this matter further. By signing this Information and Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT: If my Therapist believes that I (or my child if said child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my Therapist to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my Therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name	Telephone Number
_____	_____
_____	_____

INCAPACITY OR DEATH: I understand that, in the event of the death or incapacitation of the undersigned Therapist, it will be necessary to assign my case to another Therapist and for that Therapist to have possession of my treatment records. By my signature on this form, I hereby consent to another licensed mental health professional, selected by the undersigned Therapist, to take possession of my records and provide me copies at my request, and/or to deliver those records to another therapist of my choosing.

CONSENT TO TREATMENT: By signing this Client Information and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child if said child is the client), and I understand that I may stop such

treatment or services at any time. NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child, or impacting your rights with respect to consent to the child's mental health care and treatment, Healing Path Counseling Center, LLC will not render services to your child until the Therapist has received and reviewed a copy of the most recent applicable court order.

_____	_____
Signature – Client/Parent	Date
_____	_____
Signature – Spouse/Partner/Parent	Date
_____	_____
Therapist	Date