2017 ID:

Name: Gender: DOB: AGE:

Your Address: City / ZIP:

E-mail:

Cell Phone:

Other Phone:

Policy Holder Name: DOB:
Insurance ID: Group #:
** Release of insurance policies, HIPAA, and to transmit PHI. **
YES _____ NO_____ INITIAL_____

Is it okay to call and identify or leave message on phone? ☐Yes ☐ No REFERRED BY: _____
Is it okay to contact and identify via e-mail? ☐ Yes ☐ No
Is it okay to text to number above and you release us to do so? ☐ Yes ☐ No

Are you currently having suicidal ideation? ☐ Yes ☐ No Explain:
Suicidal ideation in the past? ☐ Yes ☐ No Explain:

Has client previously seen a Counselor, Psychologist, or Psychiatrist? : ☐Yes ☐No
If yes, on ____occasions. Longest treatment by _____for____sessions, from __/__to__/__
Provider Name

Prior Provider Name	City	State	Phone	Diagnosis	Intervention	Helpful?
_____	_____	____	_____	_____	_____	_____
_____	_____	____	_____	_____	_____	_____

Why did you discontinue services with this provider? _____
May we contact this provider: ☐Yes ☐No

What do you want to see counselor about/ goals?

How long has this been a problem? (days, weeks, months, etc.)?

How would you estimate the severity of the problem (place "X" on the line)

Mild Moderate Serious Severe

How can counseling / group be most helpful to the client? What would you like to change about the situations?

Write any other helpful information such as hobbies and interest:

What Symptoms are related to this problem? Please check all that apply for you now?

Depressed Mood	Aggressive behaviors	Appetite Disturbance
Conduct problems	Sleep Disturbance	Oppositional behavior
Elimination Disturbance	Sexual dysfunction	Fatigue/ low energy
Grief	Psychomotor retardation	Isolation
Poor grooming	Worthlessness	Mood swings
Guilt	Agitation	Elevated mood
Emotionality	Hyperactivity	Irritability
Dissociative states	generalized anxiety	Somatic complaints
Panic attacks	Self-mutilation	Phobias
Significant weight loss	Obsessions/ compulsions	Significant weight gain
Laxative/ diuretic abuse	Crying	Anorexia
Anxiety	School problems	Delusions
Substance abuse	Family Problems	Hallucinations

Other:

Prior inpatient treatment for a psychiatric, emotional, or substance use disorder? ☐Yes ☐No
If yes, on ____occasions. Longest treatment by _____for____sessions, from __/__to__/__ Prior Provider

Name	City	State	Phone	Diagnosis	Intervention	Helpful?

Family significant health or mental health history (explain):

Explain any significant family dynamics such as loss of a parent?

Information Check list: Check all that apply **Current Functioning**

1. My family and I are: ☐ In an unsatisfactory relationship ☐ Unable to talk about personal issues ☐ Not emotional close ☐ Emotional close

2. My family has a history of: ☐ Poor communication ☐ Counseling ☐ Depression ☐ Abuse
☐ Eating disorders ☐ Bipolar ☐ Hospitalization ☐ Alcoholism ☐ Gambling
☐ Addiction to drugs ☐ Other

I gamble: ☐ Less than once per week ☐ More than once per week ☐ Never
I have been in trouble with the legal system: ☐ Yes ☐ No
I have had an unwanted sexual experience: ☐ Yes ☐ No
I have experienced: ☐ Emotional abuse ☐ Sexual abuse ☐ Physical abuse
I've tried to control my weight with: ☐ Vomiting ☐ Laxatives ☐ Not eating ☐ Diet pills ☐ Excessive exercise ☐ Other

I have thought or tried to harm myself in the past? ☐ Yes ☐ No
I have thought of harming myself in the present? ☐ Yes ☐ No
I have thought of harming other people? ☐ Yes ☐ N0
At times I acted in a violent manner? ☐ Yes ☐ No
if yes, please explain:

Immediate Family

1. Currently I live with:
2. Is there a custody agreement? ☐ Yes ☐ No *If yes, provide and explain the agreement:
3. Describe any past of current significant issues with immediate family and/or intimate relationships:

4. List all persons currently living in client's household:

Substance Use History

Family alcohol/drug use history: Substance use status:
Explain:

The following have resulted from my use of alcohol / drugs:
☐ Traffic violation ☐ Black outs ☐ Seizures ☐ Overdose ☐ Hangovers ☐ Assaults
☐ Withdrawal symp ☐ Sleep disturbance ☐ Medical complications ☐ Binges
☐ Fight with friend ☐ Ruined relationship ☐ Job loss ☐ Arrests ☐ Tolerance changes
☐ Academic problems ☐ financial problems ☐ Disciplinary action ☐ Suicidal impulse
☐ Loss of control of amount used ☐ Other: _____

Substances Used:	First use age	Last use age	Current Use? Yes/no	Current frequency	Current amount
☐ Alcohol					
☐ Amphetamines (speed)					
☐ Barbiturates (downers)					
☐ Other : (list)					

Socio-Economic History

Living Situation:
☐ housing adequate
☐ homeless
☐ housing overcrowded
☐ dependent on others for housing
☐ housing dangerous/deteriorating
☐ living companions dysfunctional

Social Support System:
☐ supportive network
☐ few friends
☐ substance-use-based friends
☐ no friends
☐ distant from family of origin
☐ unstable work history

Employment:
☐ employed and satisfied
☐ employed but dissatisfied
☐ unemployed
☐ coworker conflicts
☐ supervisor conflicts
☐ disabled: _____

Sexual History:
☐Sexual orientation_____
☐ currently sexually active
☐ currently sexually satisfied
☐ currently sexually unsatisfied
☐ age of first sex experience ___
☐ age of first pregnancy/fatherhood _____
☐ history of promiscuity age ____ to _____
☐ history of unsafe sex age ____ to _____
☐ sexually abused

Military History:
☐never in military
☐served in military- no incident
☐served in military with incident:

Financial Situation:
☐no current financial problem
☐large indebtedness
☐ poverty or below poverty
☐impulsive spending
☐relationship conflicts over finances

Legal History: ☐no legal problems ☐now on parole/ probation ☐arrest(s) non-substance related
☐arrest(s) substance related ☐court ordered to treatment ☐jail/ prison time(s) Time served:
Explain including last legal incident:

Cultural identity: (ethnicity, religion)
☐yes ☐no currently active in community/recreational activities?
☐yes ☐no formerly active in community/recreational activities?
☐yes ☐no currently engage in hobbies?
☐yes ☐no currently participate in spiritual activities?
If answered "yes" to any of the above, describe: _____

Medical History
Describe current physical health: ☐ Good ☐Fair ☐Poor
_____
List any know allergies:
_____
_____
Date of last primary care doctors visit _____

Describe any serious hospitalizations or accidents:
Date_____ Age____ Reason_____
Date_____ Age____ Reason_____
Date_____ Age____ Reason_____

Is there a family history of any of the following?
☐ mental retardation ☐ heart disease
☐ birth defects ☐ alcoholism
☐ emotional problems ☐ drug abuse
☐ behavior problems ☐ diabetes
☐ thyroid problems ☐ dementia
☐ tuberculosis ☐ stroke
☐ Alzheimer's disease ☐ cancer
☐ high blood pressure
☐ other: _____

By signing I, _____ agree that the information provided is accurate and current to the best of my knowledge. I understand that I am releasing the information on this form to be used for insurance benefits, billing, scheduling purposes and may be used unencrypted. It is my responsibility to inform the counselor of any changes in phone numbers, address, email, insurance etc.

_____ _____ _____
Client's Printed Name Client's Signature Date

POLICIES

Informed Consent for Therapy

Thank you for choosing iChange. We realize that starting counseling is a big decision. The counseling relationship is a partnership in which you, the client, are the best advocate for your care while the counselor offers tools and support. Ichange providers provide outpatient mental health services for many conditions. Techniques used may vary depending on need. Your therapist can provide you with their particular approach to therapy if requested. The main responsibility for change rests with the client. You have the right to decline any technique or procedure. It is the client's responsibility to discuss any concerns with the staff and to be aware that we are here to support and are not liable for emotional health. If there are signs of crisis, the client should see a psychiatrist or be assessed by a local hospital. This document is intended to inform you of our policies, State and Federal laws and your rights. Ichange and name Amber Kuntz are used interchangeably.

POTENTIAL BENEFITS OF COUNSELING
Improved understanding of self and others
Progress towards defined goals and objectives
Greater sense of control over moods and behavior
Improved self-esteem
Improved relationships with others

POTENTIAL RISKS OF THERAPY
Lack of progress
Change in relationships
Upsetting insight
Feelings of distress

Counseling Relationship:
Sessions are usually held on a weekly basis and are approximately 45-50 minutes long. Sessions vary upon need. Although your sessions may be personal and intimate in nature, the relationship between you and your counselor is a professional one.

24-Hour Cancellation Policy: **You will be required to pay a no show fee for an appointment that is not cancelled within 24 business hours prior to the session or missed without notice.** Insurance does not pay for missed or late rescheduled appointments. If you are 10 minutes late, it is considered a "no show." The 24-hour cancellation policy will apply and you will be charged for that session.

Rescheduling: You may reschedule an appointment 24 **business** hours in advance. Anything cancelled the day of will be charged a counseling no-show or late fee.

Telephone and Email Policy: Ichange staff returns phone calls on a regular basis during office hours from 9:30 AM-4:00 PM. Any call after 3:45 may be returned the next business day. Phone calls over 10 minutes will be billed at $2.00 per minute. For appointments, call your counselor directly or go to our website: www. ichangetx.com and (if you feel comfortable) fill out the online form, or email help@ichangetx.com.

By signing, you authorize and consent to Ichange business and it's providers to contact you. I understand that if I choose to be contacted by email, text, or leave voice messages **confidentiality and encryption cannot be ensured.** Furthermore, if I choose to be contacted via telephone I understand that an Ichange designee will take the necessary efforts to preserve your confidentiality.

May contact by telephone	☐Yes	☐No	May contact via email	☐Yes	☐No
May contact via text	☐Yes	☐No	May leave a message	☐Yes	☐No

Client Printed Name _____ Signature _____ Date _____

COORDINATION OF TREATMENT:
It is important that all health care providers work together. As such, we would like your permission to communicate with your teachers, supporters, primary care physician, and/or psychiatrist. Your consent is valid for the term of your time as a client with Ichange unless requested otherwise. Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization. If you prefer to decline consent, no information will be shared.

☐You may inform my physician (s) ☐I decline to inform my physician

1.Physician Name & Info:
_____

2.Physician Name & Info:
_____

ASSESS OF CURRENT SUBSTANCE/ALCOHOL ABUSE
Under no circumstances will a counselor treat a client in the event that the client is under the influence of drugs, alcohol, or any illegal substances of any kind. If the counselor suspects that the client is under the influence, the client will be asked to leave. At this time the client will be required to pay the designated amount for the session, as it will be qualified as a missed session. The counselor has a legal duty to inform the proper authorities if it is suspected that the client is in danger of harming one's self or another by driving from the office. A cab or your emergency contact can be called for you. This policy is made for the protection of the clients.

*We are a no record practice. Taping of sessions or conversations is prohibited.

Client Bill of Rights

Ichange providers earnestly wish to provide you with the best possible services while you are a client and to treat you with the utmost respect. We have listed the considerations you may expect while a client at Ichange. Please see full Bill of Rights and Grievance policy on our website for you to print out and have at anytime.

- You have the right to be treated with respect by Ichange staff.
- You have a right to the highest quality of services available, regardless of your race, nationality, age, sex, disability, sexual orientation or religion.
- You have the right to be told about services and recommendations in terms you can understand.
- You have the right to have all releases and other forms requiring your signature explained to you before signing.
- You have the right not to be exploited or abused in any way while you are a client of Ichange
- You have the right to refuse to participate in surveys, evaluations, assessments, and research projects.
- You have a right to have your civil and legal rights protected.
- You have the right to have your privacy and confidentiality respects, except when the information disclosed is subject to mandatory reporting as required by laws and regulations.
- You have the right to stop counseling when you want, whether or not your therapist agrees with your decision.
- You have the right to be provided with personalized services, including referrals that are in your best interest.
- You have the right to refuse any services offered.
- You have the right to choose your therapist and reserve the right to seek another therapist if you so choose. You have the right to file a client grievance procedure if you feel your rights have not been respected.

Grievance

Ichange staff is committed to providing the highest quality of services to all clients. If a person receiving services is not satisfied with the services being provided or experience a situation that cannot be resolved satisfactorily between themselves and a counselor, staff member, intern, or other office staff, he or she will be provided the opportunity to initiate a grievance by first sharing concerns with business owner.

Each step of the outlined procedure should be carried out within a timely manner. In addition to an oral conference throughout this process, the client shall submit in writing a statement of the grievance issue to Ichange designee. **The client should implement the following procedure:**

1. Discuss the matter with the staff, counselor, dietician, volunteer, intern or representative of the private practice to seek a satisfactory resolution, which may include referral.
2. In the event that a satisfactory resolution cannot be achieved, the client reserves the right to file a grievance with the Texas Department of State Health.

The information below is provided in the event the client finds it necessary to file a grievance with the Texas Department of Health and Human Services and/or the counselor's licensing board.

Texas Department of Health and Human Services
701 W. 51st Street
Austin, Texas 78751
512-438-3011

Texas State Board of Examiners of Professional Counselors
P.O. Box 141369
Austin, Texas 78714-1369
1-800-942-5540

HIPAA

Health Insurance Portability and Accountability Act Privacy Rule (45C.F.R, parts 160 and 164)

*FULL POLICIES AVAILABLE ONLINE AT ALL TIMES

The federal government mandated that as of April 14, 2003 all health care patients are to receive from their clinicians a notice (hereafter referred to as "Notice") regarding the protection of their private health care information in compliance with the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule (45 C.F.R. parts 160 and 164).This form documents that Mrs. Amber Kuntz, LPC, NCC, NBCCH, MS has given you the "Notice" that is required. HIPAA covers what is called "protected health information" (PHI) that is used for treatment & payment. PHI is information in your health record that could identify you. The Notice contains information about:

1. How your PHI may be used and disclosed for treatment, payment and health care operations (these terms are defined in the Notice)
2. Which uses and disclosures require authorization from you and which don't
3. How you may revoke an authorization you have made
4. Certain rights you have to restrict use and disclosure of PHI, to receive confidential communications by alternative means and at alternative locations, to inspect and copy your records, to amend your records and to have an accounting of disclosures.
5. A list of my duties to protect the privacy of your PHI, my right to change the privacy policies and practices described in the Notice, and how I will inform you of changes
6. What you can do if you have any complaints about violations of your privacy rights, about decisions about access to your records I may make
7. Any restrictions and limitations you or I wish to put on the use and disclosure of your PHI.

This page documents that you have received a copy of the Notice that can be seen fully on line or where given to you in person. Patient's right to request a restriction on certain disclosures to their health plan if the disclosure is purely for carrying out payment or health care operations and the requested restriction is for services paid out-of-pocket. Practice is required to notify affected individuals of breaches of their unsecured PHI. Uses and disclosures of psychotherapy notes, most uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI can be made only with an individual's authorization; If a health plan intends to use or disclose PHI for underwriting purposes, a statement that the plan is prohibited from using or disclosing genetic information for such purposes; and individual has a right to be notified when a breach of his or her unsecured PHI has occurred.

_____ _____

Client Printed Name Client Signature Date

CONFIDENTIALITY AND EMERGENCY SITUATIONS:

Your clinical records are strictly confidential except for a) in an emergency b) billing / collection. c) collaboration with on-site psychiatrist or counselor, information (diagnosis and dates of service) shared with your insurance company to process your claims, or information necessary for case supervision. If you provide information that informs Ichange that you are in danger of harming yourself or others, information you and/or your child or children report about a threat to National Security or a plot of terrorism, information you and/or your child report about physical or sexual abuse; then, by Texas State Law, I am obligated to report this information to the Department of Children and Family Services or proper authorities.

Client understands that business programs such as Practice Fusion, Google calendar, Google drive, Availity, Trillian, QuickBooks and others are used for scheduling, billing, and charting. Quickbooks may email confidential account information, by signing you acknowledge you are aware of this. Clients release these programs to be used. If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency services in the community **(911**) for those services. Treatment plans are kept in client's chart for documentation and goal purposes though, strategies in plan may change for client's benefit.

* If Ichange / Amber Kuntz, LPCS Counseling or one of the providers becomes incapacitated or dies, I give my consent for Ichange / Amber Kuntz, LPCS and its providers to be custodian of my file and to access it for me. I also give my consent to contact me via telephone or email in the event my therapist becomes incapacitated or dies.

*I understand that Ichange providers may have a duty to warn. Below is a list of people (but not limited to) that may be contacted in order to help prevent harm. **EMERGENCY Contact RELEASE:**

Name: *Relationship:* *Phone:* *Email:* *Consent to Release Information:*

_____

**Printed Name Signature Date

POLICY OF FINANCIAL AND INSURANCE:

- We ask that at each session you pay **100%** of your fees. If fees are not rendered at the time of service there will be a **$25.00 fee.**
- There is a $35 overdraft fee for returned checks, which will be added to the cost of the session.
- If your insurance fails to pay, the **client is responsible for all fees**.
- In the event that an account is overdue and turned over to our collection agency, the client or **responsible party will be held responsible for any collection fee charged to our office to collect the debt owed plus a $50.00 fee.**
- Per your request, if your provider is in network with BCBS PPO, we will file to your insurance. We cannot confirm insurance reimbursement. We will use a diagnosis code for filing insurance. It is your duty to know your benefits and approved services before appointment time. 100% of all fees are client responsibility. If insurance does not reimburse, it is the client's duty to call their insurance. **If iChange issues a reimbursement, you have 30 business from the date of the check to deposit.**

Intake session: $80.00 -$100.00
Half-sessions (30 minutes): $55-$70
Full sessions (45-50 minutes): $80-$100
Family and Couples (45-50 minutes): $90-$120

Sliding scale: To qualify proof of income is required.
Family annual income less than $25, 000 for $68.00
25,000 to$35,000 for $72.00
$35,000 to $40,000 for $76.00

Treatment Reports *$45.00 and 35cents a page*

** Missed or rescheduling less than ***24 business hours: $50***-$120 full session cost. We have the right to waive a portion of fee in emergency crisis situations.

** Copy of chart is **.35 cents per page, $35.00 per hour clerical fee,** $120.00 per hour redacting fee.

** In the event that your session exceeds the allotted time, you will be billed at the rate of $1 per minute, in Addition to the agreed upon session cost.

****There is an additional fee for crisis appointments.**

** We do our best to reimburse credits we are aware of pending on your account. Credits past 365 days or 1 year from last seen session will be voided. It is your duty to request any credit reimbursements in writing.

Counselors at their discretion may travel to accommodate the client's needs, however there is a minimum $25 travel fee plus $0.40 charge per mile traveled fee that will be added to the cost of the counseling session. There is no refund policy. All policies apply in all cases. All fees are dependent on the requirements of the service provided.

Assessments:
Depression:$50 MMPI:$525 ADD/ADHD: $195 / $9085 for additional portions such as teacher, parent or observer.

Disability Forms: $50 plus copy cost

- IF YOU RECEIVE TESTING WITH OUR PRACTICE DUPLIATES MAY BE REPRODUCED FOR SESSION TIME. IF RESULTS ARE SENT DIRECTLY TO SCORING CENTER AMBER KUNTZ LCPS/ Ichange HAS NO WAY OF KNOWING THE RESULTS AND THEREFORE CANNOT PROTECT, PREVENT, OR MAKE EMERGENCY SERVICES AWARE. IF YOU RECEIVE RESULTS AND FEEL UPSET PLEASE CALL OR GO TO YOUR NEAREST PHYSICIAN OR EMERGENCY ROOM. IF TEST IS RETURNED NON-VALID THE FEE IS STILL THE SAME AS THE TEST WAS USED COMPLETELY AND SCORED.

Court Charges (we are not court appointed and typically do not attend court)
Clerical: $55 an hour
Mediation or Consultation: $135.00
Deposition: $175.00 per hour (in court time)
Supervised Visitation: $135.00
Treatment Reports: minimum $225.00

Subpoenaed file record and statements $65.00 plus other above fees apply.

*If Ichange staff are to deliver, expedite, or work on court documents there is a ***$25. 00*** for their hourly time. Patient also acknowledges and agrees to all financial fees accrued for company lawyer, collaboration, and guidance.

I have received a copy of my fee schedule

** I agree to my credit card information to be exchanged and swiped over the phone:

ID _____ Intake Form Date:

_____ _____

Client Signature Date ☐Yes ☐No Initial _____

_____ *CONSENT FOR* SERVICE and FINANCIAL FEES: I am aware that ***PAYMENT IS DUE in full at the beginning of the session*** for all services rendered. I agree to pay any **outstanding balances**, attached fees for **late payments ($25), bounced checks ($35), and no show/ late cancel fee ($50).** Appointments are considered No Show / Late Cancel if they are cancelled with less than **24 business hours** notice. **Session rates may change due to length and/or complexity of session.** I am aware that Saturdays, Sundays and Holidays are not business days. I acknowledge that if payment is not rendered, iChange employees and **workers reserve the right to breech confidentiality** by contacting a designated collection agency to ascertain payment. I understand that court, assessments, and other fees may apply and that I am 100% liable. I understand that square reader may not be 100% confidential. If there is a credit on your account you have 12 months from date of service to request reimbursement. All funds after 12 months are forfeited. I release my electronic signature as my original signature.

_____ *STATEMENT OF CONFIDENTIALITY :* I am aware of iChange / Amber Kuntz, MS, LPCS Confidentiality, Consent, HIPAA, Financial, Insurance and Privacy Policy. I understand my rights, the limits to confidentiality, encryption, and the duty to report .I understand the use of 3rd party vendors are used such as Availity, Google, Practice fusion, QuickBooks, scheduling, un- encrypted programs, and emails. I understand that if I have questions, I can approach any iChange staff and receive information at any time. I am aware secretaries abide by privacy act. *STATEMENT OF RECEIPT OF PRIVACY POLICY:* I acknowledge that provider of iChange have given me a copy of the Privacy Notice either by web, email, US Mail, or in person, as required by the federal government's HIPAA legislation. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information. This also applies to any other business in our joined suite. I understand receipts and other information may be emailed through QuickBooks.

_____ I understand insurance may ask for diagnosis, coding or other private information and agree to information being shared. Insurance or EAP may not pay. You **are 100% liable for all fees**. We recommend **YOU** checking your insurance information for deductible, copay, and pre-authorization necessities. I am aware fees may change due to coding changes throughout the year. The front desk and your insurance provider can provide you updates as they happen.

_____ *CLIENT BILL OF RIGHTS:* I understand my rights as a client seeking counseling services and/or other services provided by an iChange provider. We prohibit recording of sessions. Weapons (of any kind with or without license) are strictly prohibited. We do enforce penal codes 30.06-30.07.

_____ If client's parents are separated or divorced we speak directly to parent who has arranged services and request parents to communicate to one another.

_____I understand this office works on an appointment basis therefore calls, e-mail, or other communication may not be handled in 48 business hours. I must plan accordingly. I understand iChange is not a crisis clinic and staff does not return calls after hours. Please call 911. I am aware of iChange client *grievance policy*. If I feel I have been treated less than supportive I will first attempt to resolves any issue with business owner and hold harmless company or sole providers.

_____In the situation a payment is made over the phone, I agree to my **credit card** information being collected, entered, and processed. **Sign:** _____

_____I agree to the use of electronic signatures.

_____I agree to non-encrypted communication via the means listed and initialed below although encryption cannot be guaranteed _____ **Text** _____ **email** _____ **voicemail**.

I have read and consent to the **entire** policy list. I am aware of HIPAA, privacy policy and security. I understand my rights and responsibilities and choose to enter into services with iChange / Amber Kuntz, LPCS or its designee.

_____ _____ _____

Printed Name of Client **Signature of Client** **Date**

**Thank you for choosing our practice. Any concerns can be sent directly to owner: Amber Kuntz