Testing Intake 2020

Name: _____ Date of Birth: _____ Age: _____ ☐ M ☐ F

Local Address: _____ City/Zip: _____

Mailing address (if different): _____ City/Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

☐ I consent to digital communications from iChange including emails, voicemails, text reminders and Teletherapy services. (Please provide written notice for any unapproved communication methods.)

*Visit the last page of this document, called the "sign sheet", for **communication consents**.

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Who referred you to us? _____

CARE PROVIDERS:

Provide Names as well as Phone Numbers. Indicate whether you give consent for iChange to contact and collaborate with each provider.

It is important that all healthcare providers work together. As such, we would like your permission to communicate with your supporters, primary care physician, and/or psychiatrist. Your consent is valid for your duration as a client with iChange unless requested otherwise. Please understand that you have the right to revoke this authorization at any time by sending written notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization.

Primary Care Physician: _____ ☐ Yes ☐ No

Date of last primary care doctors visit: _____

List any medications you have taken or are currently taking for psychiatric use: _____

Previous Counselor: _____ ☐ Yes ☐ No

Psychiatrist: _____ ☐ Yes ☐ No

⇪⇪Do you currently feel in crisis, having suicidal ideation or thoughts of harm to yourself or others? ☐ Yes ☐ No

If yes please immediately go to your nearest emergency room or crisis facility. We are a wellness practice and do not perform crisis evaluations. Please seek immediate support.

INSURANCE INFORMATION:

PLEASE verify your insurance and confirm you do have Mental Health Benefits through PPO, not outsourced.

Mental Health Insurance: _____ (include state; i.e. "of TX") Member ID: _____

Group # _____ Phone # on Insurance card: _____ Deductible renewal date: _____

Policy Holder: _____ Policy Holder's DOB: _____ Relationship: _____

Address of policy holder (if different):_____ City/Zip: _____

Are you covered by Medicare? ☐ Yes (if yes, please alert front desk staff) ☐ No We are not Medicare providers.

****Please contact your Insurance to verify testing can be administered by an LPC Licensed counselor rather than an MD psychologist. We are specialized in testing but are not MD psychologists****

Person responsible for financial matters (If address above it is not needed again). May put Self and see above.

Name: _____ Phone #: _____

Address: _____ City/Zip: _____

Email: _____

EMERGENCY CONTACT: *For safety reasons, please provide a contact. This person will be released in an emergency.*

Name: _____ Phone #: _____

Address: _____ City/Zip: _____

Email: _____ Release to be contacted if needed: ☐ Yes ☐ No

Other person(s) you would like released to have access to your iChange information (scheduling, meds, billing, etc.):

Name: _____ Relationship: _____

Tel: _____ Email Address: _____

Address: _____ City/Zip: _____

***Consent to Release Information: ☐ Yes ☐ No**

Are you currently having suicidal ideation? ☐ Yes ☐ No *If yes, please explain:
Suicidal ideation in the past? ☐ Yes ☐ No*If yes, please explain:
Have you previously seen a Counselor, Psychologist, or Psychiatrist? : ☐Yes ☐No

*If yes, on _____occasions. Longest treatment by _____for_____ sessions, from _____/_____ to _____/_____.

Prior Test Name and Results:

Goals from receiving testing?

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

Developmental:

Delivery and Birthday (Normal or list any unordinary experiences like heart defect, etc.):
Around what age did you crawl? _____ Around what age did you walk? _____
Around what age did you write? _____ Around what age did you read? _____
How were friendships through childhood?
Did you have any illnesses often such as ear infections, etc.?
Write any other helpful information such as hobbies and interest:

What symptoms are related to this problem? Please check all that apply.

☐ Depressed Mood	☐ Poor Grooming	☐ Substance Abuse	☐ Aggressive Behaviors
☐ Worthlessness	☐ Obsessions/Compulsion	☐ Appetite Disturbance	☐ Mood Swings
☐ Significant Weight Loss/Gain	☐ Guilt	☐ Laxative/Diuretic Abuse	☐ Low Self-Esteem
☐ Conduct Problems	☐ Agitation	☐Crying	☐ Sleep Disturbance
☐ Elevated Mood	☐ Anorexia	☐ Oppositional Behavior	☐ Emotionality
☐ Isolation	☐ Unmotivated	☐ Hyperactivity	☐ Phobias
☐ Elimination Disturbance	☐ Irritability	☐ Delusions	☐ Sexual Dysfunction
☐ Dissociative States	☐ Family Problems	☐ Fatigue/Low Energy	☐ Generalized Anxiety
☐ Hallucinations	☐ Somatic Complaints	☐ Anxiety	☐ Grief
☐ Psychomotor Retardation	☐ Panic Attacks	☐ School Problems	☐ Self-Mutilation
☐ Trouble starting or finishing tasks		☐ 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 _____ /_____.
Family significant health or mental health history (explain):

Substance Use History

Family alcohol/drug use history, please explain:

Substance Use Status:

Medical History
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. We have the right to release testing information directly to your PCP. Test might return as inconclusive though the test cost still remains.**

_____

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

Informed Consent for Therapy: 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 counselors 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 the 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 cancelled with less than 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 up to 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. *Correspondence through the patient portal may not be checked regularly. Follow up with regular email and/or call your provider directly.

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.

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 the 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 an 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 St. Austin, Texas 78751

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

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 (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 duties to protect the privacy of your PHI, iChange's right to update the privacy policies and practices described in the Notice, and how we will inform you of changes
6. What you can do if you have any complaints about violations of your privacy rights, or about decisions regarding access to your records
7. Any restrictions and limitations put on the use and disclosure of your PHI

This page documents that you understand the Notice can be seen fully online or that a copy was given to you in person. Patient's have a 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. Our 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, d) information (diagnosis and dates of service) shared with your insurance company to process your claims, or e) 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. We do have monitors, videos of waiting areas and doorways. Client understands that business programs such as Practice Fusion, Google Calendar, Google Drive, Availity, Kareo, 3rd party billing, QuickBooks and others are used for scheduling, billing, and charting. Programs 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 assistance. Treatment plans are kept in the client's chart for documentation and goal purposes. These strategies are subject to change for the client's benefit. *If iChange/Amber Kuntz, LPCS Counseling or one of the providers becomes incapacitated or dies, I give my consent for iChange and its providers to be custodian of my file, to access it for me, and to contact me via telephone or email.

*I have provided iChange with my emergency contact(s). I understand that my provider may have a duty to contact them (and others, if needed) in order to help prevent harm. ***Client Signature:***
_____***Date:***_____

FINANCIAL POLICIES 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. Testing fees vary.
● There is a $35 overdraft fee for returned checks, which will be added to the cost of the session.

● If 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 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 the client's responsibility. If insurance does not reimburse, it is the client's duty to call their insurance. If iChange issues a reimbursement, the client has 30 business days from the date of the check to deposit. ***Client Signature: _____ Date:_____***

Initial on line beside each policy and sign where indicated.

____ I have reviewed and agree to the HIPAA policy and Consent Form. I'm aware that these policies and forms are available to me at any time. I understand that 3rd party vendors such as, but not limited to Gmail, Practice Fusion, Square, and Availity are utilized. Though iChange encrypts messages, I understand some of these programs may have access to my information. I am also aware that security cameras are used in common areas of the office. I understand the members of the office staff have associate agreements to protect my privacy and abide by the privacy act and will not share my confidential information.

____ I am aware of the service fee schedule. I am aware that insurance may request diagnoses and other private information and that the practice will need to release this information for payment. I am aware insurance may not pay for all services rendered and that I am 100% liable for any amount the insurance does not pay. Mental health coverage could be contracted out to a 3rd party that iChange is not on panel with. I am responsible for verifying benefits and will be prepared to pay in full. I have read and understand the full policies listed on the intake paperwork. Agreements on this form take precedence over past agreements. By signing this form, I attest to all previous full intake policies.

____ I am aware that I am responsible for the $60 fee applied to no show visits and for appointments cancelled with less than 24 business hours' notice. Weekends and Holidays are not business days. In case a payment is made over the phone, I agree to my credit card information being collected, entered, and processed.

____ I am aware that payment is due for all services rendered at the time of the appointment. I agree to pay any outstanding balances, attached fees for late payments ($25), bounced checks ($35), and no show/late-cancel fees ($60) prior to the next appointment. Reimbursement checks need to be deposited within 30 days or they will be voided.

____ I agree to communicate via the means listed, although encryption cannot be guaranteed. This consent overrides any consent provided in all previous year's versions of office paperwork: Text, email, voicemail, teletherapy and online portal. If I oppose one of these I will give the provider written notification. I understand if a client is a minor that parents must communicate. It is policy that the counselor will speak to the guardian that holds the intake session on any necessary matters.

____ I am aware and understand that weapons of any kind, with or without a license to carry, are strictly prohibited on our premises. iChange does enforce penal codes 30.06-30.07. We are a no record practice. Video or audio recording of sessions is also prohibited.

____ I understand this office works on an appointment basis therefore calls, email, or other communication is handled within 48 business hours. I understand iChange is not a crisis clinic and staff does not return calls after hours. Please call 911 or go to the ER in case of emergencies.

____ I am aware of the iChange client grievance policy. I will first attempt to resolve any issues or grievances with the business owner, Amber Kuntz, by contacting her via email at amber@ichangetx.com. I will allow 30 days for iChange to work with me on resolving any issues. IChange is not responsible for the privacy issues arising from my posting online reviews.

____ My name and electronic signature below are considered to be my legal signature. By signing I consent to entire updated policies. I am aware my consent does not end in one year but when I give written notice to iChange staff of changes.

Name: ____ Signature: ____