Calm Waters Counseling, PLLC

Counseling, Case Management, Peer Support & CBRS
Services for Children, Adolescents, and Adults

CLIENT DETAILS					
Last Name:	First:			MI:	
Address:	City:		State:	ZIP:	
☐Home Phone:	☐Cell Phone:		☐Work Phone:		
Please check the box next to the contact number you would like us to use for verbal communications.					
Date of Birth:	☐Male ☐Female		SS#		
Emergency Contact:	Relationship:			Phone:	
Employer:	Address:				
Primary Physician:	Referred by:				
Responsible Party (If not patient)					
Last Name:	First:			MI:	
Address:	City:		State:	ZIP:	
☐Home Phone:	☐Cell Phone:		☐Work Phone:		

INSURANCE DETAILS				
1st Insurance Company:	Phone:			
Address:	City:	State:	ZIP:	
∗Name of Subscriber (policy holder):		Relationship:		
∗ID#	Group#			
∗Subscriber's Date of Birth:	☐Male ☐Female			
∗Required to process insurance claims				
2nd Insurance Company:	Phone:			
Address:	City:	State:	ZIP:	
∗Name of Subscriber (policy holder):		Relationship:		
∗ID#	Group#			
∗Subscriber's Date of Birth:	☐Male ☐Female			
∗Required to process insurance claims				

I authorize Calm Waters Counseling, PLLC to release any and all medical information deemed necessary for the purpose of processing insurance claims on my behalf. I understand that I am responsible for all charges not covered by insurance. I authorize the assignment benefits for all covered claims to be paid directly to Calm Waters Counseling, PLLC. A photocopy of this authorization shall be considered as valid and effective as the original.

Signature	Date

5223 W. Overland Rd. / Boise, Idaho / 83705
Phone – 208.331.4592 / Fax – 208.344.0838

Mental Health History (Past therapy, mental health hospitalizations, etc.).		
PERSONAL AND MEDICAL HISTORY		
Thank you for choosing Calm Waters Counseling, PLLC. You will be treated with courtesy and respect and we will do our very best to assist you in any way we can. Today we need your cooperation in giving us information that will assist your therapist with providing effective service delivery. Thank you for taking the time to answer the following questions fully and accurately.		
Client Name:	DOB:	Age:
Reason for scheduling this appointment:		
Personal History		
Military History: ☐ Yes ☐ No	Dates of Services:	Branch:
Highest Level of Education:		
Work/Occupational History: ☐ Retired ☐ Disabled ☐ Student ☐ Unemployed ☐ Other		
Legal History: ☐ None ☐ Yes – ☐ Diversion ☐ Probation ☐ Parole (☐ Current ☐ Past)		
Crime Victim: ☐ No ☐ Yes – Referral needed for legal services: ☐ No ☐ Yes – Discuss this with your counselor		
Medical History		
How would you rate your overall health? ☐ Excellent ☐ Good ☐ Average ☐ Poor		
Do you have any ongoing health issues? ☐ No ☐ Yes (please describe)		
History of major surgeries or illnesses:		
Date of last physical examination:		
Date of last treatment by a physician:	Reason:	
Allergies: ☐ None ☐ Food ☐ Drugs ☐ Environmental ☐ Other (please specify for all items checked)		

All Current Medications	*Dose*	*For what condition*
Prior Psychiatric/Behavioral Medications	*Dose*	*For what condition*

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Nutrition
Do you have any concerns about your nutrition? ☐ No ☐ Yes (please describe)
Briefly describe your daily diet (meals and snacks):
Have you experienced an unexplained weight gain or loss in the past 6 months? ☐ No ☐ Yes (please describe)
Pain Assessment
Do you experience ongoing pain? ☐ No ☐ Yes If yes, is it constant pain? ☐ No ☐ Yes (please describe your pain and its location:
Are you receiving treatment for your pain? ☐ No ☐ Yes (please describe the treatment and by whom:
Drug / Alcohol / Addictions Information
Do you or someone close to you have a problem with drugs, alcohol, gambling or other addictions? ☐ No ☐ Yes (please describe)
How much of the following do you consume in an average week? ☐ Beer ☐ Wine ☐ Mixed Drinks Drugs not prescribed for you (please list)
Do you have a problem with other drugs? ☐ No ☐ Yes – Please describe
Do you have a problem or concerns with the following: ☐ Tobacco ☐ Food ☐ Pornography ☐ Internet ☐ Sex ☐ None
Do you consider yourself in recovery? ☐ No ☐ Yes – Length of time in recovery
Mental Health
Prior mental health outpatient services used or hospitalizations:

Where	*When*	*Purpose*	*Outcome*

Do you have any other issues or concerns that you would like your therapist to know about? Please describe:

Informed Consent

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☐ FEE AGREEMENT

I acknowledge that the full fee for Calm Waters Counseling, PLLC sessions are as follows:

Initial Assessment -	$150.00	Individual Session –	$150.00
Family Session -	$150.00	In Home Family Session -	$150.00

- Fees are per session unless otherwise noted.
- I agree that the entire amount paid by my insurance company is to be paid to Calm Waters Counseling, PLLC since subsidy money is not available when insurance applies. I agree that I will not receive a refund unless the total amount paid by my insurance company and my co-pay exceed the rate of $150.00 per session.
- I authorize the release of any information necessary to process claims for services rendered to me by Calm Waters Counseling, PLLC.
- Copays and deductibles are to be paid at the time of appointment.

☐ CLIENT RIGHTS AND RESPONSIBILITIES

As a client of Calm Waters Counseling, PLLC you have the right to:

- Receive counseling services without regard to race, religion, sex, national origin, sexual orientation, age or disability.
- Be treated with dignity and respect at all times.
- Be accepted for counseling only if the agency has the professional staff to meet your needs.
- Be referred appropriately when the agency is not able to meet your needs in a reasonable and timely manner.
- Be referred for appropriate assessment and management of pain.
- Participate in the development of an individualized treatment plan including goal setting, treatment methods and duration of counseling.
- Participate in periodic review of the Treatment Plan.
- Be informed of the cost of the services and receive appropriate care regardless of the source(s) of payment.
- Confidentiality of information as prescribed by law.
- Voice a grievance or complaint about treatment and/or staff without fear of reprisal or discrimination, and have the grievance investigated. The grievance procedure is:
  - Discuss the concern with your therapist.
  - Failing resolution, you may submit a formal grievance to Idaho Bureau of Occupational Licenses.

☐ LIMITATIONS TO CONFIDENTIALITY

- If your clinician has cause to believe that you ate likely to harm yourself, he/she may take action necessary to protect your safety by contacting your significant other, law enforcement officers or a physician.
- If your clinician has cause to believe you are likely to harm another person, he/she may take action necessary to protect their safety by contacting the individual that has been threatened, law enforcement or a physician.
- If your clinician has cause to believe a child has been or may be abused or neglected, the clinician is required to make a report to the appropriate state agency.
- If your clinician has cause to believe an elderly or disabled person has been or may be abused, neglected, or subject to financial exploitation, the clinician is required to make a report to the appropriate agency.
- Information disclosed about a person from whom you sought counseling behaving toward you in a sexually inappropriate manner must be reported (your identity may remain anonymous at your request).
- If your records are requested by a valid subpoena or court order, we must respond.
- If you are a minor (under the age of 14).

☐ CLIENT RESPONSIBILITIES

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- Participate actively in the counseling process.
- Give 24-hour notice if an appointment cannot be kept. Failure to do so will result in Client being billed for the session at $150.
- Notify the office in the event of change of address, phone number or insurance.

☐ INFORMED CONSENT FOR COUNSELING

- As a client, you need to be informed of certain key aspects involving all counseling situations. Counseling attempts to teach you alternative ways of coping with problems in living. As such, no guarantee exists that you will automatically feel better from coming to counseling. I provide the following information and ask that you read it carefully, discuss it with me and ask any questions that you may have. Please sign, acknowledging that you understand this information and give voluntary consent to participate in therapy.
- If the client is a minor child, I understand that as the parent / legal guardian, I will be advised regarding the client's welfare during the course of counseling.

☐ CONSULTATION

- By initialing above, I authorize my therapist to use team consultation to discuss information about my care and treatment, thereby ensuring optimal treatment while engaged in the therapeutic process.

☐ CANCELLATION AND NO-SHOW POLICY

- An agreement will be made between therapist and client / parent(s) / legal guardian regarding the frequency of therapy.
- The frequency of therapy will be developed with the intent of maximizing the therapeutic effect of treatment. Cancellations will compromise progress. Also, cancelled appointment times can be given to other patients.
- When the need arises to cancel an appointment, we request notification as soon as possible, but preferably within 24 hours before the scheduled appointment time if possible.
- Canceling or no showing for three scheduled appointments will result in losing you / your child's appointment times and/or the charge of $150 per missing appointment fee.
- Therapist cancellations will not count against client.

☐ TELEHEALTH SERVICES

- CWC online therapist will use HIPAA compliant video services.
- The client is responsible for securing his or her own computer hardware, Internet access points, and password security.
- The company is not liable for confidentiality preachers when they are caused by client error.
- The company is not responsible for their clients equipment failure, e.g. camera, and or Internet service.
- The company is not responsible for lapses in the confidentiality that are in direct response to the clients actions.
- If video services are not available due to an unplanned equipment or service malfunction, sessions will occur via telephone.
- Client and counselor are not allowed to make an audio or video recording of any portion of the session.
- Online therapy is not a crisis-based clinical service. Online psychotherapy may not be appropriate for clients with active suicidal or homicidal thoughts or clients who are experiencing acute mental health problems such as manic or psychotic symptoms.
- At intake, a client who reports being at risk of harm to self or others, will not be offered online psychotherapy services from Calm Waters Counseling.
- The laws that protect the confidentiality of any medical information also apply to online psychotherapy.

________________________________ ____________________
Client Signature Date

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NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physical certification.

I have read, received and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Calm Waters Counseling, PLLC has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do not agree then you are bound to abide by such restriction.

Client Name: ______________________________

Responsible Party Name (if client is a minor): ______________________________

Relationship to Client: ______________________________

Signature: ______________________________ Date: ______________

OFFICE USE ONLY

I attempted to obtain the client's signature acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Initials: __________ Date: ____________________

Reason: ______________________________

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