Wide River Counseling and Education Center
962 Main St. Suite 3
Dubuque, IA 52001
(563) 213-5449
Derrick@widerivercounseling.com

Adult Intake

Welcome to the Wide River Counseling. Please don't hesitate to ask questions if guidance is needed in answering these questions.

DEMOGRAPHIC INFORMATION

Client Name _____ Birth Date: _____

CONTACT INFORMATION

Address: _____

City, State, Zip: _____

Home Phone: (_____) _____ Emergency Contact: _____

Cell Phone: (_____) _____ Relationship to Client: _____

Work Phone: (_____) _____ Phone: (_____) _____

INSURANCE & MEDICAL INFORMATION

Primary Insurance Information
Insurance Company:
Insurance Address:
Ins. City/State/Zip:
Subscriber's Name:
Subscriber's DOB:
Employer:
Subscriber's ID:
Policy #:
Group #:
Subscriber's Relationship to Client (CIRCLE ONE): Parent Spouse Step-parent Self

SECONDARY INSURANCE (THIS INFORMATION MUST BE PROVIDED)
Insurance Company:
Insurance Address:
Ins. City/State/Zip:
Subscriber's Name:
Subscriber's DOB:
Employer:
Subscriber ID:
Policy #:
Group #:
Subscriber's Relationship to Client (CIRCLE ONE): Parent Spouse Step-parent Self

If you would like your counselor to coordinate treatment with your primary physician, please fill out the following information and request to sign an Authorization to Release Information form.

Primary Care M.D.: _____ Phone #: _____
Other Therapist: _____ Phone #: _____

Assessment

1. Please describe your reason(s) for seeking treatment. If there is a particular event that triggered your decision to seek treatment, please list the event:
   _____
   _____
   _____
   _____
2. Have your received mental health treatment before? If so, please list dates, provider name, and the reason for treatment.
   _____
   _____
   _____
   _____
3. Have you ever experienced emotional, physical, sexual abuse or been witness to domestic violence/abuse? (circle one): Yes No Explain:
   _____
   _____

4. Please list any medications you are currently taking (including dosage and prescriber):

_____
_____
_____

5. Do you experience depression? Yes No Current level of depression: (low) 1 2 3 4 5 6 7 8 9 10 (high)
6. Are you currently experiencing or have had in the past suicidal ideations, thoughts, or attempts? (circle one): Yes No Explain:

_____
_____
_____
_____
_____

7. Do you experience anxiety? Yes No Current anxiety level: (low) 1 2 3 4 5 6 7 8 9 10 (high)
8. Have you had any traumatic events in your life? Yes No Explain when, how, and what?

_____
_____
_____
_____

9. Do you hear or see things that others don't report seeing or have you been diagnosed with schizophrenia? Yes No Explain:

_____
_____
_____
_____

TREATMENT PHILOSOPHY: We are committed to getting you the help that you need. Therapy works optimally when there is a good match between therapist and client and commonly understood goals. Treatment is a collaboration.

CONFIDENTIALITY: All information between provider and client is held strictly confidential unless:

1. The client authorizes release of information with his/her signature, or if client is a minor the parent/guardian's signature.

2. The client presents a physical danger to self.

3. The client presents a danger to others.

4. Child/elder abuse/neglect is suspect.

In the latter two cases, we are required by law to inform potential victims and legal authorities so that protective measures can be taken.

FINANCIAL TERMS: Upon verification of health plan/insurance coverage and policy limits, your insurance carrier will be billed. You will be responsible for any applicable deductibles and co-payments. If you are not eligible at the time services are rendered, you are responsible for full payment.

CANCELLED/MISSED APPOINTMENTS: If an appointment is missed or cancelled with less than twenty-four (24) hour notice, you may be billed for the full amount of the missed appointment. After 3

missed appointments you will not be able to schedule with our administrative staff but must set up a time directly with our therapist to discuss a plan for engaging in treatment.

EMERGENCY PROCEDURES: If you need to contact your counselor, leave a message according to the instructions on the phone service (563) 213-5449 and your call will be returned.

If an emergency arises, call 911, the crisis phones, or go to the Emergency Room.

RELEASE OF INFORMATION: By signing below, you authorize the release of information regarding your care to your health plan for the payment of claims, certifications/case management decisions, and other purposes related to the administration of benefits for your health plan while being seen at Wide River Counseling.

CONSENT FOR TREATMENT: Please read the following statement and sign below: I authorize and request that the professional staff at the Wide River Counseling carry out mental health examinations, therapy, counseling, evaluations, treatments, and/or diagnostic procedures, which now or during the course of my care are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I hereby acknowledge that I am willing and without coercion, taking part in these mental health related procedures.

By signing below, I understand and agree to the above information:

Client Name_____

Signature_____

Date _____

BILL OF RIGHTS

1. Each client shall have reasonable access to care, regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability.

2. Each client has the right to privacy, confidentiality, and security, in accordance with agency, state and federal regulations governing the confidentiality of information. Client confidentiality will be maintained during case consultations, clinical supervision and all internal or external audits of clinical records. All records reviewed by auditors, external entities and business associations, will be noted on the accounting summary form for HIPAA purposes.

3. Each client who seeks services voluntarily has the right to refuse and/or terminate care, treatment or services at any time.

4. Each client has the right to express comments or complaints about any aspect of the care, treatment and service process without being subjected to coercion, discrimination, reprisal or unreasonable interruption of care, treatment or services. The client may express concerns through informal discussions or through the formal grievance procedure. Family and legal guardians have the right to file the grievance as well.

5. If one parent brings a child in for counseling and the parents have joint legal custody, whether a parent has shared care or primary care, the parent must inform the other parent that their child has entered counseling with Wide River Counseling.

6. The parent who brings the child for counseling agrees that Wide River may send a generic letter to the other parent, stating that their child will be receiving services at Wide River.

7. The other parent does have a right to be aware of session dates, treatment goals and participate in counseling if so desired.

8. However, it is within the therapist's discretion concerning how the parents participate in counseling to best meet the child's treatment goals. For example, is it better for the child to begin with individual therapy vs. family therapy? Is it better for the child to alternate coming to therapy with one parent one week and then another week with the other?

9. Treatment goals and therapy modes can change over time. For example, we may begin with individual therapy and work towards family therapy. While working individually with a child, we may meet with the parent individually to work on how to best work towards the treatment goals.

10. Client records are both the property of Wide River and the client. To review your child’s written records, first we must receive a written request from you. The parent agrees that the counselor and parent will then schedule a time to review the written records, in case there are any questions about the records. Since the child is our client, the parent has the right to review their child's records. However, the State of Iowa does allow us the option to protect a child's records and not release the child's records to either parent, if we determine that it would not be in the child’s best interests to release the records. We do not wish to release written records, so that we may protect a child's confidentiality. We would hope that you enter therapy to truly help your child and give them a place of sanctity to explore themselves and their

feelings. Our goal is to bring families together; it is not to exclude anyone. For a child, each family member is important to them.

11. The client, parents, and legal guardians, agree and acknowledge that the counselor will not be asked to testify on behalf of client, parents, or legal guardians, at any judicial proceedings or depositions, in which the client, parents, or legal guardians may be involved. However, if the counselor later agrees to testify at future judicial proceedings or depositions, or is properly served a subpoena, the client, parents and legal guardians hereby agree to pay expert witness fees to procure counselor's testimony. Wide River will require, and the parent or parents agree to pay, a $500.00 deposit toward expert witness fees prior to the counselor undertaking testimony at a judicial proceeding, deposition, preparation, consultation, testimony, or travel time. Expert witness fees shall include a minimum fee of one hour. The counselor may charge a reasonable expert witness fee, based on the counselor's usual and customary hourly rate. It is possible that the counselor's fee may exceed $500.00. If the counselor's reasonable expert witness fee does not exceed $500.00 at the conclusion of the counselor's litigation-related services, any excess funds will be returned to the parent who paid the deposit.

12. The parents agree that they will not request the child's written records to be submitted to their attorney, opposing attorneys, or submitted to the Court. In consideration of the parent's promise, Wide River agrees to provide counseling services for your child. Our experience is that verbal testimony is more helpful than having our records submitted to the Court, as there is the possibility that the records may be taken out of context. Again, our goal is to help your child find peace in a difficult situation, rather than create a more adversarial situation.

X_____ X_____

Client Name/Signature Date Parent/Legal Guardian Signature Date

PRIVACY NOTICE ACKNOWLEDGEMENT

Wide River Counseling and Education Center
962 Main Street, Suite 3
Dubuque, IA 52001

I hereby acknowledge that Wide River Counseling and Education Center has provided the Privacy Notice as required by the Health Insurance Portability and Accountability Act of 1996.

_____	_____
Client Name	Signature Date
_____	_____
Parent/Guardian Name	Signature Date
_____	_____
Witness*	Signature Date

* If client refuses to acknowledge receipt of the Privacy Notice