Manifest Joy
COUNSELING

CLIENT INFORMATION

Confidential
(Please Print)

Date: _____

Type of Therapy: ☐ Individual ☐ Couples Therapy ☐ Family Therapy

Name of Client: _____ Date of Birth: _____
First Last

Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Non-binary ☐ Gender Fluid

Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them

Address: _____
P.O. Box or Street City State Zip

Phone Number: _____ ☐ Cell ☐ Home ☐ Work

Email Address: _____
We can provide courtesy appointment reminders

Employed: ☐ Yes ☐ No If yes, Employers Name: _____

Student: ☐ Yes ☐ No If yes, Name of School: _____

Family Physician and/or Other Healthcare Provider: _____

How did you learn about us? _____

HEALTH INSURANCE (if applicable)

Primary Insurance Company: _____

Insured's ID Number: _____ Group Number: _____

Primary insured's Name: _____ Date of Birth: _____

Insurance Company Phone Number: _____

Primary Insured's Employer: _____

Primary Insured's Phone Number: _____

Primary Insured's Address (if different): _____

Emergency Notification

Name: _____ Relationship: _____

Phone Number: _____ Secondary: _____

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Current Symptoms and Concerns

Please check all below that describe your current concerns and or symptoms.

☐ Employment/School difficulties
☐ Relationship difficulties
☐ Substance abuse/dependence
☐ Addiction (sex, porn, shopping, gambling, etc.)
☐ Depression/Sadness
☐ Crying spells
☐ Loss of interest in activities
☐ Decreased motivation
☐ Difficulty enjoying things
☐ Angry/Irritable
☐ Mood Swings: How often? _____
☐ Withdrawing from people or isolating
☐ Negative thinking
☐ Change in appetite
☐ Difficulties sleeping
☐ Self harm/cutting/burning/head banging
☐ Anxious/nervous/tense feelings
☐ Suicidal thoughts or plans of hurting yourself
☐ Homicidal thoughts or plans of hurting others
☐ Poor concentration/difficulties focusing
☐ Hopelessness or worthlessness
☐ Panic attacks
☐ Racing thoughts
☐ Bad or unwanted thoughts
☐ Flashbacks or nightmares
☐ Muscle tension, aches and pains
☐ Hearing voices/seeing things that are not there
☐ Paranoia or fear of being watched or harmed
☐ Worries of being cheated on
☐ Perfectionism
☐ Rituals of counting, washing hands, checking locks, doors, etc.
☐ Strong concern about germs
☐ Concerns about dieting
☐ Excessive exercise
☐ Feelings of loss of control over-eating
☐ Binge Eating or purging
☐ Worries about parenting
☐ Infertility issues
☐ Grief and loss
☐ Difficulties communicating or connecting with others

☐ Other: _____

Previous Therapy Experience

Have you previously participated in counseling and or therapy? ☐ Yes ☐ No

If yes, what did you find helpful about the experience?

If yes, what did you NOT find helpful about the experience?

Have you had hospital stays for mental health difficulties? ☐ Yes ☐ No
Have you in the past experienced thoughts of harming yourself and or others? ☐ Yes ☐ No
Have you in the past harmed either yourself or others? ☐ Yes ☐ No

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Medical History

List any current, past, or significant:

Medical concerns _____

Medications _____

Serious health concerns, major operations and or hospitalizations for medical conditions _____

_____

What was the date of your last physical? _____

Family History

Birth Location: _____

Raised by: ☐ Mother ☐ Father ☐ Step-mother ☐ Step-father ☐ Other

Relationship with parental figures:

Family history of neglect, and/or physical, verbal, emotional, spiritual, or sexual abuse? ☐ Yes ☐ No :

Any family history of substance abuse, mental illness, suicide or violence? ☐ Yes ☐ No

Please explain any Yes answers from above:

Please list those who you feel are your supports at this time:

Marital History

Which best describes your marital status?

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Engaged ☐ In a relationship

If you are married or in a relationship, which best describes your satisfaction in this relationship?

☐ Poor ☐ Fair ☐ Good ☐ Great

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Substance Abuse History

Are you currently or have you ever struggled with substance abuse? ☐ Yes ☐ No

If yes, please complete the substance abuse history chart:

Substance	**Age of first use**	**Frequency (daily, weekly/monthly)**	**Method of Use (smoke, inhale, injection)**	**Date of Last Use**
Marijuana				
Alcohol				
Cocaine				
Prescription Pain Killers				
Heroin				
Methamphetamine				
Inhalants				
Ecstasy (MDMA)				
Benzodiazepines (Valium, Xanax)				
Phencyclidine - PCP				
Spice				

Have you received treatment for a substance abuse issue? ☐ Yes ☐ No

If yes, please circle the type of treatment: ☐ Inpatient ☐ Intensive Outpatient Program
☐ Partial Hospitalization ☐ Recovery House ☐ Counseling ☐ Methadone ☐ Suboxone.

Date of treatment (month, year): _____

Outcome: _____

Additional Information

Please use this space to provide any additional information you feel important to share with your therapist:

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Consent for Treatment

Thank you for choosing ***Manifest Joy Counseling, PLLC.*** We realize that starting counseling is a major decision and you may have questions. This document is intended to inform you of our policies, State and Federal Laws, and your rights. If you have other questions or concerns, please ask and we will do our best to give you the information you need.

CONFIDENTIALITY **Initial:_____**

Your verbal communication and clinical records are strictly confidential **except for**:

- **a.** Mandatory reporting. That means if we believe **a child or dependent adult has been or will be abused or neglected**, we are legally required to report this to the authorities. In most cases we will inform you if we need or intend to make a report.
- **b.** If you provide information that you are in **serious danger of harming yourself or others**, we are required by law to try to protect you or the other person.
- **c.** In order to provide you with the best treatment, we may **consult with other mental health professionals** about your case.
- **d.** If you send a **health insurance** claim form (Superbill) to your insurance for reimbursement, it will have a mental health diagnosis listed and it will become part of your permanent medical record. Information that may be requested includes, but is not limited to; types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes and summaries.
- **e.** If you are **involved in a lawsuit** and you tell the court that you have been in therapy, we may then be ordered to show the court our records when required by law.
- **f.** Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.
- **g.** We are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

IN CASE OF EMERGENCY **Initial:_____**

If you have an emotional, behavioral, physical, or medical crisis, please call **911** or go to the nearest emergency room. ***Manifest Joy Counseling, PLLC,*** **does not** provide 24-hour crisis services. You can also contact the Crisis Response Network 520-622-6000 or 988 for 24-hour crisis services.

PHONE, TEXT & EMAIL POLICY: **Initial:_____**

Phone calls, texts, and emails regarding appointments or scheduling will not incur additional fees. However, **Manifest Joy Counseling, PLLC,** does not engage in therapeutic discussions via text or email. Phone discussions are also done on a limited basis.

I understand that psychological service offered by Manifest Joy Counseling, PLLC, is voluntary and I am entering treatment (or initiating treatment for my child) of my own free will. **I have received** a copy of the HIPPA privacy practices, and I understand that I am an active participant in any treatment decision, periodic review, or revision of my treatment plan. **I understand** that I have the right to refuse any recommended treatment and be advised of the consequences of such refusal and potential termination of treatment. **I understand** that I may terminate treatment at any time.

I understand, and agree to, the policies as stated above, and I give consent for treatment with Manifest Joy Counseling, PLLC.

Client Name: _____

Client Signature: _____ Date: _____
(Parent or guardian signature if client is under age 18)

Therapist Signature: _____

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Financial Agreement

FEES:
Manifest Joy Counseling, PLLC, offers two fee options.

- Fee For Service – Which ranges from $125 (Individuals)- $175 (Couples/Families) per session. This will be determined by your therapist on your initial visit based on your specific needs.
- Mental Health Benefit of your Health Insurance. Please read below regarding restrictions.

NO SHOW/CANCELLATION POLICY: **Initial**: _____

When cancelling your appointment, please call your therapist 48 hours prior to your scheduled appointment. **If you cancel your appointment with less than 48 hours' notice you will incur a fee for the entire amount of a pay-out-of-pocket session. This is NOT your insurance co-pay**. The full amount owed will need to be paid prior to attending or scheduling any future appointments. Unless you opt out, you will automatically receive appointment reminders via text to the number you put on file. We strongly recommend that you allow appointment reminders in order to notify your therapist that you will be attending your session, and to avoid missing any scheduled session.

PAYMENT POLICY: **Initial**: _____
All payments including session fees, co-pays, co-insurances and fees going towards the deductible are due at the time of service. Accepted forms of payment include cash, credit/debit cards, checks and HSA. There will be a $35 fee for any cancelled check.

BILLING YOUR HEALTH INSURANCE (if applicable): **Initial:** _____
We strongly recommend that you contact your insurance company prior to your initial session for information regarding your mental health benefits, co-pay, and deductible. Should your insurance benefits fail to cover the cost of your sessions; you understand that you are financially responsible for all fees incurred. Your signature on this form below is your agreement to the above terms. Please feel free to contact our office if you have any questions.

RELEASE OF AUTHORIZATION/ASSIGNMENT OF BENEFITS (if using health insurance): **Initial:** _____
I am electing to use my mental health benefits associated with my health plan and agree to pay all fees that are not covered by this plan, including any costs of collection. In addition, I authorize the release of any medical and psychological information necessary to process my insurance claim(s), including to my primary care physician or referring physician when necessary. I authorize and request payment of counseling benefit from my insurance company directly to my therapist at Manifest Joy Counseling, PLLC.

Client Name/Guardian (if under 18): _____

Client/Guardian Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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Update to No Show/Late Cancelation Policy

This document is intended to inform you of an update to our Financial Agreement with respect to our No Show and Late Cancelation policy. As specified by State and Federal Laws, and as part of your rights as a consumer we are required to inform you of any changes to our office policies. If you have questions or concerns, please ask your therapist or front desk staff and we will provide you any additional information you may need. Please remember that should our update not align with your needs; you have the right to end services and can be provided referrals for new providers. No guarantees can be made regarding the availability of new providers or their ability to accept new clients.

No Show and Late Cancelations

A "**No Show**" is any occasion in which you do not show up for your scheduled session and do not inform the office prior to missing the session.

A "**Late Cancelation**" is any occasion in which you do not inform the office 48 hours in advance of your scheduled session that you will not be able to attend.

In the event of either a "No Show" or a "Late Cancelation" you will be charged the full amount of the session, **not your copay.** Individual sessions are $125/50 minute session for individuals and $175/50 minute session for couples/family. We are unable to bill your insurance provider for missed sessions.

If you do not give us 48 hours' notice for your cancelation OR don't appear at the time of your scheduled appointment, the card we have on file for you will be charged according to the fees listed above. This fee must be paid prior to scheduling your next session.

We strongly suggest that you utilize email or text confirmations as part of your reminder options. If you are getting email or text reminders already and are not using them, please start. If you are not getting text reminders (48 hours) prior to your appointment, please list your preferred number/email below so we can add the preference to your chart.

My signature below indicates that I authorize Manifest Joy Counseling, PLLC to charge my credit card on file at the close of business (6:00 pm) on the day of my missed appointment.

CREDIT CARD INFORMATION:

Client Name: _____

Cardholder's Name (Exactly as it appears on the card): _____

Type of Card: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Credit Card Number: _____Exp Date: _____ CVV Code: _____

Cardholder's Billing Address for The Card Listed Above:

_____

Address City State ZIP

Preferred Cell Number for Text Notifications: _____

Preferred Email Address for Text Notifications: _____

I understand, and agree to, the policies as stated above, and I give consent for Manifest Joy Counseling, PLLC to charge my card on file for any No Show or Late Cancelations. I understand that I am responsible for having a sufficient credit line available, and that I am responsible for all charges incurred by Manifest Joy Counseling, PLLC due to rejected credit card transactions. This authorization will expire upon termination of therapy and when the above-named client's account with Manifest Joy Counseling, PLLC, is settled.

Client Name: _____

Client Signature: _____ Date: _____
(Parent or guardian signature if client is under age 18)

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Court Policy

In the event we receive a subpoena to appear in court to testify on behalf of you or your child, there will be a fee of $600 per appearance. We do not voluntarily testify in court cases. You understand that your therapist is not responsible for the outcome, or any judgments made, regarding your court case.

This fee is due seven (5) days prior to your court date. Since your therapist will be required to clear their calendar of all appointments and prior engagements so that they may be available to appear in court, this fee is non-refundable. If your court date is postponed and we must again clear our calendar to attend court, you will again be charged the full fee. If your court date is cancelled the fee is non-refundable. No further appointments will be scheduled until this fee is paid in full. Other fees include: $100 per hour to prepare for court, $100 per hour for depositions and phone contacts, and all attorney costs incurred by therapist as result of legal action.

Divorce/Custody Cases
Please be advised that, if we receive a subpoena to testify in a divorce/custody case, we will not make a custody recommendation, or a recommendation of where a child should live, nor will we make a determination as to one's fitness as a parent.

Confidentiality
Your rights to privacy and confidentiality are important for us, and we work hard to protect them. There are also laws in place to protect you. Please note there are situations during court and legal proceedings where they may be compromised. Examples of this include you waiving confidentiality by agreeing to disclosure of your or your dependent minor's mental health records in a lawsuit for emotional distress; your decision to pursue a lawsuit where your or your dependent minor's mental or emotional condition is relevant or critical; if client records are requested by a valid subpoena or court order it is your responsibility to learn how your confidentiality and privacy may be compromised as a result of legal or court proceedings.

Non-Payment
If you have not paid your court-related fees and do not respond to our attempts to contact you and work out a payment plan. We have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. A late fee of 20% of the unpaid balance will be charged each month that a balance remains unpaid.

Client Name: _____

Client Signature: _____ Date: _____

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Acknowledgement of Receipt of Privacy Notice

By signing below, I indicate that I have been provided access to the Privacy Practices and HIPAA – Federal Law information written in plain language. The notices provided below detail the uses and disclosures of my protected health information (PHI) and how it may be used, my individual rights, how I may exercise these rights and Manifest Joy Counseling, PLLC's legal duties with respect to my information.

I also understand that Manifest Joy Counseling reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all Protected Health Information we are in receipt of and if changes to the policy occurs Manifest Joy Counseling will provide me a revised Notice of Privacy Practices.

I am also aware that should I lose or choose to not print the Privacy Practices and HIPAA forms at this time I can access the forms on the website in the client forms section and can refer to them at any time.

Printed Client name/Guardian (if under 18) Date

Signature Client/Guardian (if under 18)

Printed Client name/Guardian (if under 18) Date

Signature Client/Guardian (if under 18)

NOTICE OF PRIVACY PRACTICES (HIPAA- Federal Law)

(Please print and keep for your records)

This notice describes how health information may be used and disclosed and how you can access this information. It also contains information regarding our rights and summary information about the Health Insurance Portability and Accountability Act (HIPAA). **Manifest Joy Counseling, PLLC** is dedicated to maintaining the privacy of your Personal Health Information as part of providing professional care and are required by law to keep your information private. The Federal Law requires that Manifest Joy Counseling, PLLC obtain each client's signature acknowledging that we have provided him/her with this information.

Protected Health Information (PHI) is any information that is collected about client's health conditions, treatment or any information that could identify the client. It includes any information whether oral, recorded, written or sent electronically, and in this office it is likely to include but is not limited to:

- Your personal history and demographic information
- Reasons you came in for counseling
- Diagnoses
- Treatment plan
- Psychotherapy notes
- Records we get from others who treated or evaluated you
- Information about medications you took or are taking
- Billing and insurance information

The Law states that this information can only be used or disclosed if the client signs a written authorization. There are other situations that require only that the client provides written, advanced consent, and the client's signature on this agreement provides that consent for those activities as outlined in this notice. If any disclosure is needed beyond what is listed in this notice, the client will be asked to sign a separate release of information form before any PHI is disclosed.

How we may use and disclose your health information

The HIPAA law allows for the following disclosures of a client's PHI to an outside entity for the following purposes:

For treatment purposes: including but not limited to: providing, coordinating or managing a client's health care and other services related to your healthcare. For instance: coordinating care with your primary care physician.

For Payment: Obtaining reimbursement for a client's healthcare or billing a client for services rendered. For instance: To verify a client's insurance eligibility and coverage or for disclosing PHI to obtain payment for services.

For Health Care Operations: Activities that relate to the performance and operations of our practice. For instance: quality assessment and improvement activities, audits, administrative services and clinical peer review.

Limits of Confidentiality

If the therapist believes that a child or any adult client who is either vulnerable and/or incapacitated has been the victim of injury, abuse, neglect, financial exploitation or deprivation of necessary medical treatment, the law requires therapist to report it to the proper law enforcement authority. The therapist may be required to provide additional PHI information following report.

If the client communicates an explicit threat of imminent, serious or physical harm, to a clearly identified or identifiable victim(s), and the therapist believes the client has the intent and ability to carry out such a threat, the therapist must take protective actions that may include notifying the potential victim(s), contacting the police or seeking hospitalization for the client. Additionally, if the client threatens to harm him/herself the

therapist may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

A therapist may occasionally find it helpful to consult with other healthcare and mental health professionals about a case. During a consultation, every effort will be made to avoid revealing the identity of the client. The other professionals are also legally bound to keep information confidential. The therapist will note all consultations in client's clinical record.

If a government agency is requesting information for health oversight activities, a therapist will be required to provide it for them.

If a client files a complaint or a lawsuit against a therapist, relevant information regarding that client may be disclosed in order to defend against the suit or complaint.

If a client files a worker's compensation claim and a therapist is providing services related to that claim, the therapist must, upon appropriate request, provide appropriate reports to the Worker's Compensation Commission or the insurer.

If the client is involved in a court proceeding and a request is made for information concerning the professional services provided to them, such information is protected by the therapist-client privilege law. The therapist cannot provide any information without the client or their legal representative's written authorization, or a court order. If the client is involved in or contemplating litigation, he/she should consult with their attorney to determine whether a court would be likely to order such disclosure.

For appointment reminders and health related benefits or services, the therapist may use and disclose your PHI to contact you to remind you that you have an appointment.

Minors and Parents

Clients under 18 years of age, who are not emancipated, and their parents should be aware the law may allow parents to examine their child's records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes the therapist's policy to request an agreement from parents that they consent to give up access to their child's records. If they agree, during treatment the therapist will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. The therapist will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless the therapist feels that the child is in danger or is a danger to someone else, in which case the therapist will notify the parents of the concern. Before giving parents information, the therapist will discuss the matter with the child, if possible, and do his/her best to handle any objections the child may have.

Client's Rights

You have the right to request restrictions on specific uses and or disclosures of your PHI. However, therapists are not required to agree to a restriction that a client requests.

You have the right to inspect and/or obtain a copy of PHI in mental health and billing records. Therapists may deny your access to PHI under certain circumstances.

You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. The therapist may deny your request if they believe the original information is accurate.

You have the right to request an accounting of disclosures that Manifest Joy Counseling, PLLC has made of your PHI. Some exclusions do apply.

You have the right to determine the manner and location to which PHI is sent. This includes appointment reminders and billing statements. For instance, calling a client at a work number instead of home number or to have billing statements emailed instead of sent via USPS mail.

You have the right to have any complaints about a therapist's policies and procedures recorded in your record.