DR. NICCI COUNSELING, LLC.

Client Intake Form

DATE: _____

PERSONAL CONTACT INFORMATION:

CLIENT's NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DATE of BIRTH: _____ AGE: _____ SEX: Male ____ Female _____

PHONE: (Cell) _____ PHONE: (Home) _____

ALTERNATE PHONE: _____ E-MAIL ADDRESS: _____

How did you hear about DR. NICCI COUNSELING, LLC?

_____

_____

EMERGENCY INFORMATION:

Emergency Contact Name: _____

Relationship to you (parent, friend, spouse, other): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ E-Mail: _____

PRESENTING ISSUES:

Why are you seeking counseling at this time? _____

_____

_____

When did these issues begin? _____

What do you hope to accomplish from counseling? _____

_____

_____

How long do you think counseling should last? _____

Have you ever been treated by a mental health professional? (psychiatrist, psychologist, counselor, social worker) Yes: _____ No _____

If Yes, who did you see and on what dates? _____

_____

RELATIONAL INFORMATION:

Current Relationship Status: ___single ___dating ___engaged ___married ___separated ___divorced ___widowed

Date of present marriage: _____ Have you ever separated? _____
If Yes, list dates and for how long? _____
Are you content with your current relationship status? _____
Number of previous marriages? _____ Date of Divorce(s): _____
Name of partner or spouse: _____
Partner/Spouse's Occupation: _____ Length of time employed?:_____
What words would you use to describe your partner? _____
_____

YOUR CHILDREN:

Name	Age	Gender	Relationship (adopted, bio, stepchild)	How would you describe?

How would you describe your relationship with your mother during your childhood years?
_____
_____.

How would you describe your relationship with your mother currently?
_____
_____.

How would you describe your relationship with your father during your childhood years?
_____
_____.

How would you describe your relationship with your father currently?
_____
_____.

Do you have any siblings? _____ If yes, what are their names and ages? _____
_____
_____

Describe each of your siblings: _____
_____
_____.

DR. NICCI COUNSELING, LLC
446 North Dillard Street, Ste #2
Winter Garden, FL 34787
Phone: (407) 702-1141

BACKGROUND INFORMATION:

What is your present employment? _____

How long have you been there? _____

How do you feel about your work? _____

_____

Last year of school completed? (circle one) 9 10 11 12 GED College: 1 2 3 4

Are you currently in school? _____ What degree are you pursuing? _____

SPIRITUAL/RELIGIOUS BELIEFS:

What spiritual or religious beliefs do you practice? _____

Do you want spirituality incorporated into your therapy? _____

MEDICAL INFORMATION:

Describe current medical treatment, if any: _____

_____.

If yes, for what? _____

Please list any medications you are currently taking: _____

_____.

Have you ever received a mental health diagnosis from a counselor or a doctor? _____

_____

If so, what was the diagnosis? _____

Have you ever received inpatient treatment? _____ If yes, please list the dates and name of the inpatient facility: _____

SYMPTOM CHECK LIST:

Check beside any of these emotional symptoms you are experiencing, or have experienced in the last three months:

	Stress		Nervousness		Panic
	Guilt		Apathy		Verbal Abuse
	Recent Death of a Loved One		Changes in Appetite		Hearing Voices
	Headaches		Grief		Aggressiveness
	Feelings of Low Self Worth		Feelings of Inferiority		Racing Thoughts
	Uneasiness Around Others		Fearful		Loss of Control
	Marriage Problems		Communication Issues		Compulsive Behaviors

	Emotional Abuse		Anger		Abortion
	Shame		Concentration		Eating Problems
	Temper		Memory		Job Troubles
	Nightmares		Self-Control		Indecisiveness
	Unwanted Thoughts		Alcohol Use		Financial Problems
	Impulsive Behavior		Anxiety		Difficulty Breathing
	Sexual Problems		Depression		Sleep Trouble
	Legal Problems		Severe Illness		Tiredness
	Problems with Children		Hopelessness		Stomach Problems
	Recent Loss		Lonely		Dizziness
	Infertility		Drug Use		Adoption
	Suicidal Thoughts		Changes in Body Weight		Physical Pain
	Self-Harm		Physical Abuse		Rapid Heart Rate

On a scale of 1 to 10, ten being the highest, how would you rate your distress today? _____

CANCELLATION POLICY:

In order to best serve the needs of all clients in need of counseling services, it is important that we have the opportunity to reschedule for yourself or someone else, sessions that you might not be able to attend. Therefore, we require a minimum of 24 hours' notice for canceled or rescheduled appointments. If sufficient notice is not given, you will be charged at the full session rate for the missed session.

By signing below, I am indicating that I understand and agree to the above.

Client: _____ Date: _____

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DR. NICCI COUNSELING, LLC.

Informed Consent

It is the mission of DR. NICCI COUNSELING, LLC to provide you with the highest quality counseling possible while keeping the content and records of therapy confidential. However, there are certain circumstances when I am legally and ethically required to break confidentiality and make appropriate disclosures. These disclosures are strictly to protect you or someone else from potential harm. These circumstances include serious suicidal or homicidal threats, actions, or ideation of a degree severe enough to warrant medical care, HIV/Aids reporting requirements, Patriot Act reporting requirements, and/or child abuse/elder abuse (physical, sexual, emotional or neglect). Disclosure in these circumstances is rare.

I, _____, understand the limits of confidentiality and I am aware of and give consent that if any of the above situations are discussed in therapy, Dr. Nicole Holloway will be required to make the appropriate disclosures for the safety of myself and those around me. I understand that I am entering into a confidential therapeutic counseling relationship. I understand that I have the right to terminate this relationship at any time upon notice to Dr. Nicci.

_____ Date: _____

Client Signature

_____ Date: _____

Parent/Guardian Signature

_____ Date: _____

Witness Signature

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DR. NICCI COUNSELING, LLC.

Cancellation Policy/Financial Agreement

I understand that it is my responsibility to notify my counselor 24 hours in advance of my scheduled appointment time if the need arises for me to reschedule or cancel my appointment. If I fail to give at least 24 hours' notice, I will be charged a regular session fee for the session you missed. Dr. Nicci requires this minimum of 24 hours in order to provide the opportunity for someone else to receive counseling services in the event that I am not able to keep my scheduled appointment.

I understand that payment for each session will be due at the onset of each session. For my convenience, I may pay for my session by cash, check or credit card. I understand that there will be a fee of $50 for any check that is returned due to non-sufficient funds or non-payable.

I understand that Dr. Nicci does not accept insurance and that any arrangements that I may have for reimbursement for mental health care services through my insurance company will be coordinated directly between myself and my insurance company. I also understand that DR. NICCI COUNSELING, LLC, agrees to provide me with a receipt for my counseling sessions for purposes of obtaining insurance reimbursement.

_____ _____

Client Signature Date

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DR. NICCI COUNSELING, LLC.

NOTICE of PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATON ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of *treatment, payment and healthcare operations:*

- ***Treatment*** means providing, coordinating, or managing healthcare and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc.

- ***Payment*** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services.

- *Health Care Operations* include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment by phone or mail or provide you with information about treatment options or other health-related services.

We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATON to public health authorities that are authorized by law to collect information; to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a court administrative order if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Your written authorization will be required for any other uses or disclosures. Should you choose to revoke your authorization, you may do so only in writing. We will abide by your written request with the exception of information we released upon obtaining the written authorization and releasing information as required by law. You may contact our Privacy Officer in writing to invoke your following rights:

- You may request in writing that wel restrict using and disclosing your PROTECTED HEALTH INFORMATION to family members and relatives, friends, or others you identify. We reserve the right to deny this request.

- You may request an amendment to your PROTECTED HEALTH INFORMATION.

- You may request alternative means or locations in which you receive confidential communications.

- You may request an accounting of disclosures of PROTECTED HEALTH INFORMATION beyond treatment payment, and health care operations.

We are required by law to protect the privacy of your PROTECTED HEALTH INFORMATION and to abide by the terms of the Notice of Privacy Practices. We will make and post revisions to the Notice of Privacy Practices in accordance with the law. You may obtain a written copy of these changes by written request.

You may file a formal written complaint with us at the address below or with the Department of Health & Human Services, Office of Civil Rights, if you feel your privacy rights have been violated.

For more information regarding our Privacy Practices, please contact:

- The Privacy Officer, Nicole Holloway, PsyD
  Licensed Mental Health Counselor
  DR. NICCI COUNSELING, LLC
  446 North Dillard Street, #2
  Winter Garden, FL 34787
  Phone: (407) 702-1141

For more information about HIPPA or to file a complaint, please contact:

- The U.S. Department of
  Health & Human Services
  Office of Civil Rights
  200 Independence Avenue, S.W.
  Washington, D.C. 20201
  (877) 696-6775

DR. NICCI COUNSELING, LLC.

Acknowledgement of Receipt of Privacy Practices Notice

I, _____, have received a copy of the NOTICE OF PRIVACY PRACTICES used by DR. NICCI COUNSELING, LLC.

Name:

_____i

Address: _____

City: _____ State: _____ Zip: _____

_____ Date: _____

Client Signature

_____ Date: _____

Parent/Guardian Signature

_____ Date: _____

Witness Signature

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Authorization for Credit Card Charges

Dear Client,

By signing this form, you are giving DR. NICCI COUNSELING, LLC permission to charge your credit card with any unpaid balances for services rendered.

Please note that your credit card information will be kept confidential and secure. If you choose a receipt for each transaction, that receipt can be emailed to you. Charges will appear on your credit card statement as DR. NICCI COUNSELING, LLC.

I certify that this is my credit card and I am legally authorized to give permission for its use. My signature authorizes the offices of DR. NICCI COUNSELING, LLC to charge my credit card the amount agreed upon for counseling services. I understand it is my responsibility to notify the office of DR. NICCI COUNSELING, LLC of any changes to my account.

This authorization will remain in effect for one (1) year unless I cancel it through written notice to DR. NICCI COUNSELING, LLC.

Cardholder's Signature: _____ Date: _____

****

Name of Client: _____

Cardholder's Name: (as shown on card) _____

Cardholder's Billing Address: _____

City: _____ State: _____ Zip: _____

Card Type:

_____Visa _____Master Card _____Discover

Credit Card Number: _____ Expiration Date: _____

Code: _____ Billing Zip Code: _____

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