HUMAN CARE, LLC
Psychological Services

Providing Personal Assurance in an Unsure World

CLIENT INTAKE INFORMATION FORM

GENERAL INFORMATION (please print)

Date: _____

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____

Address: _____ City: _____ST: _____ ZIP: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Sex: Male: _____ Female: _____ Other: _____

Race: White: _____ Black: _____ Indian: _____ Asian: _____ Hispanic: _____ Other: _____

Marital Status: Single_____ Married: _____ Separated: _____ Divorced: _____ Partner: _____

Employment Status Employed: _____ Unemployed: _____ Student: _____ Retired: _____

Emergency Contact: Name: _____ Relationship: _____

Telephone Number: Home: _____ Cell: _____

Counseling Issues: (Please check next to the areas you would like to discuss)

___Relationship Issues	___Health Concerns	___Death / Loss of Sig. Other
___Racial Issues	___Suicidal Thoughts	___Family Problems
___Cultural Adjustment Issues	___Career Concerns	___Divorce / Separation
___Stress	___Anxiety	___Domestic Violence
___Depression	___Loss of Employment	___Trauma
___Lack of Assertiveness	___Low Energy	___Sexual / Physical Abuse
___Alcohol / Drug Abuse	___Sleeping Problems	___Legal Issues
___Development / Self-esteem	___Religious ./ Spirituality	___Parenting Issues
___Sexuality	___Marriage Concerns	___Eating Concerns

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How much are the issues checked above disrupting your life?

A Little: _____ Somewhat: _____ A Lot: _____

Have you ever participated in counseling of any type? Yes: _____ No: _____

Have you ever been hospitalized for a psychological problem? Yes: _____ No: _____

Have you experienced any type of health problems over the last 2 years? Yes: _____ No: _____

If yes please explain: _____

_____

Are you currently in crisis? Yes: _____ No: _____

If yes please explain: _____

_____

Are you feeling suicidal? No: _____ Yes, with thoughts only: _____ Yes, with a plan: _____

Do you want to hurt someone? No: _____ Yes, with thoughts only: _____ Yes, with a plan: _____

Do you have friends? None: _____ A Few: _____ Many: _____

Do you have someone you can talk to about personal problems? Yes: _____ No: _____

Are you on any medication? No: _____ Yes: _____

If yes, please list:

MEDICATION	DOSAGE	PHYSICIAN

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Professional Disclosure Statement

Welcome to Human Care, LLC and thank you for choosing us. Please carefully read the following information because it will help you utilize our services most effectively. We realize that starting counseling is a major decision and you may have questions. This document is intended to inform you of our policies. If you have other questions or concerns, please ask and we will try our best to give you all of the information that you need.

Professional Credentials

The Program Director and Clinician, Angela M. Holley, earned a Bachelor's degree in Psychology and a Master's degree in Clinical Psychology from Virginia State University in Petersburg, VA. She earned a Doctoral degree in Advanced Studies in Human Behavior at Capella University. She is a Licensed Professional Counselor, a Certified Substance Abuse Counselor, a Certified Clinical Trauma Professional, and a Certified Anger Management Specialist. Angela is qualified by education and experience and is prepared to counsel individuals, groups, parents, children, adolescents, and adults.

Services Offered and Theoretical Approach

Dr. Holley believes counseling is a collaborative effort in which you and she work together to help you change the thoughts, feelings, and behaviors that are interfering with your being able to live a fulfilling life. She utilizes an integrative approach to counseling. She will use the approach that she believes will best facilitate your arriving at answers to your questions and finding solutions to your problems. She will not attempt to impose her values on you.

Counseling Relationship

During the time you work together, you usually will meet weekly for sessions approximately 50 minutes long. Although sessions may be very intimate psychologically, remember that this is a professional relationship rather than a social one. Contact will be limited to the counseling sessions that you arrange, except in the case of an emergency.

Effects of Counseling Relationship

At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, or discontinuing counseling. Although Dr. Holley expects you to benefit from counseling, she cannot guarantee any specific results. Counseling is a personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or our understanding of yourself. You may feel distressed, usually only temporarily, by some of the things you learn about yourself or some of the changes you make. Although the exact nature of changes resulting from counseling cannot be predicted, Dr. Holley intends to work with you to achieve the best possible results for you. Psychotherapy is only one form of treatment. Alternative forms of treatment may include referrals to psychiatry, substance abuse services, inpatient hospitalization, and group therapy.

Dual Relationships

The counseling relationship is a psychologically intimate but professional one. Your association with Dr. Holley will be limited to your sessions together and necessary phone contacts. Please do not offer us gifts or ask us to engage in social activities with you.

Grievances

If you are dissatisfied with any aspect of our work, please talk with us about it. If you think you have been treated unfairly or unethically, and we cannot resolve the problem, you can contact the Virginia Board of Licensed Professional Counselors, 9960 Maryland Drive, Suite 300, Henrico, VA, 23233-1463, for clarification of client's rights as they have been explained to you or to lodge a complaint. All grievances will be attended to within 5-10 business days.

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INFORMED CONSENT

I have read The Professional Disclosure Statement and I understand and accept the policies contained therein. Having read that information, I hereby agree to assessment and treatment. I acknowledge that this consent is truly voluntary and is valid until revoked. I understand that I may revoke this consent at any time by submitting written notice of such revocation except to the extent that based on this consent has already been taken.

If you have any questions, please feel free to ask. Please sign and date of this form. You will receive a copy.

Client Name (please print) _____

If client is a minor, name of legal guardian: _____

Client's/Guardian's Signature_____ Date_____

Counselor's Signature_____ Date_____

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CLIENT RIGHTS

Emergency Situations
Emergency appointments can be made during regular business hours. Every effort will be made to accommodate this need. The clinician is not available for after-hours emergencies. If you feel that you cannot safely wait for a return call, you should call your physician, go to or call the local emergency room, or call 911.

Record Information
Records containing information about your visits are stored on a secured, of-site computer system.

Confidentiality
We realize that the concerns you bring are highly personal in nature. We assure you that all information shared, both verbally and in writing, will be managed within the legal and ethical conditions of confidentiality. This means that information will not be released to anyone except under the following conditions:

- If we believe that you pose a life-threatening risk to yourself or someone else, we must notify responsible individuals to prevent any harm from occurring.
- If you are under 18 years of age and a victim of physical or sexual abuse, we are required to report relevant information to child protective services to prevent further abuse from occurring. Additionally, if you disclose information regarding the physical or sexual abuse of a minor and/or elder, we are also required to report relevant information to child protective services/adult protective services.
- If you are involved in a legal action and a judge determines that clinical information will provide evidence bearing significantly on the case, he or she may subpoena or legally compel the therapist to release information from your records.
- If there is a suspicion that another health care professional has acted unethically according to their governing board or has violated the law.
- In case of any malpractice action against the clinician or staff, the clinician may disclose information from the case that is relevant or necessary to the clinician's defense.
- All case files are property of Human Care.
- Human Care's web page is used for the sole purpose of providing information.
- Privacy cannot be guaranteed in email correspondence. When sending an email to a Human Care staff, please ensure that the information is not sensitive in nature.

In all other situations, information may be released to appropriate individuals or agencies **ONLY UPON YOUR WRITTEN CONSENT.** I have read and understand that these conditions of confidentiality apply to receiving services at Human Care, as well as any information shared verbally or in writing to the clinician.

_____
Print

_____ _____
Signature Date

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RELEASE OF INFORMATION

I do, hereby, give my permission for Human Care, LLC to release the following information:

_____
(Indicate the information you wish to be released.)

To / From:

_____
(Name of Agency or Practitioner)

_____
(Include the address, phone number, and/or fax number, if applicable.)

I understand that this information will only be released to the agency or practitioner indicated above.

Expiration Date:_____

_____
(Print Name)

_____
(Signature) (Date)

_____
(Witness) (Date)

To ensure identity, you must include a copy of your Driver's License to verify your signature if you do not submit the completed Release of Information Form in person.

REVOKING PROCEDURES

Revoking/Canceling this Release of Information Form cannot be done by the telephone.
A signature or a letter is required.

_____
(Print Name)

_____
(Signature) (Date)

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CONTACT AUTHORIZATION

May We Call You?

There may be times when Human Care staff will need to contact you regarding scheduling or other issues. Please indicate the telephone number and address that can be used to reach you below.

Phone: _____

May we leave a brief confidential message? Yes: _____ No _____

Street: _____ Apt# _____

City, State, ZIP: _____

Emergency Contact Information:

In the event of an emergency, whom shall we contact?

Emergency Contact Person: _____

Home Phone: _____ Work Phone: _____

Name (Please Print): _____

Signature: _____ Date: _____

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INFORMED CONSENT CHECKLIST FOR TEMPORARY TELEPHONE/TELEVIDEO SERVICES

Due to the emergent public health crisis, we are offering temporary distance services to our patients. Prior to starting video-conferencing services, we discussed and agreed to the following:

- There are potential benefits and risks of video-conferencing (e.g., limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for tele-mental health services, and nobody will record the session without the permission from the others person(s).
- We agree to use the telephone, or when available, the HIPAA compliant Doxy video- conferencing platform selected for our virtual sessions, and the therapist will explain how to use it.
- You need to use a webcam and microphone, or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- Your therapist will either be using a land-line phone (the most secure type of phone) or be using a HIPAA compliant video service. If staff are at home, your therapist will have a virtual private network which is HIPAA compliant. Staff will document using the exact same method as they use for face-to-face counseling via the VPN if needed.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the therapist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions. You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your therapist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

_____
Print

_____ _____
Signature Date

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PATIENT CANCELLATION AND NO-SHOW AGREEMENT

ln order to provide you with high quality health care it is important for you to keep your scheduled appointments with your therapist. Valuable time has been reserved for you or your family member. A missed appointment or late cancellation of an appointment results in lost time which could have been given to another person waiting to receive care. Every day we get many calls for appointments from both old and new patients. By cancelling your appointment as soon as possible, we can help other patients who are waiting to be seen.

Our office will try to call one day ahead and remind you of your appointment; however, it is your responsibility to keep record of your appointment and to arrive on time. If you need to cancel or reschedule your appointment please call at least 24 hours in advance between the hours of 8:00 am and 6:00 pm. For after hour cancellations we have an answering service for your convenience.

Each cancellation and No-Show visit will be recorded in your chart. Multiple No-Show appointments within a six-month period can end your ability to make appointments and/or receive behavioral health care at Human Care.

Each late cancelation will result in a $25 charge being added to your account which must be paid at your next scheduled appointment.

After One (1) No Show: You will receive a phone call informing you of the No-Show and a $50 No-Show fee will be added to your account which must be paid at your next scheduled appointment. You will be able to continue receiving therapeutic services at Human Care.

After Two (2) No Shows: You will receive a phone call reminding you that this is your 2nd No Show. You will still be able to receive behavioral health services at Human Care; however, you will be charged for the full cost of the session. This charge must be paid prior to your next scheduled appointment.

After Three (3) No Shows: You will receive a letter informing you that your scheduling privileges have been suspended for 90 days but will be treated for acute care only. Depending on provider availability, we cannot guarantee that you will be seen immediately.

We realize that an unforeseen emergency may occur and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact the Practice Manger, who may be able to waive the No-Show fee.

Thank you for working with us to ensure that services are provided to all of our patients in the best possible way.

Acknowledgement of Cancellation & No-Show policy

Print: _____ Date: _____

Signed: _____

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MEDICAL INSURANCE COVERAGE VERIFICATION

Patient Name: _____ DOB: _____

Address: _____
Street City State Zip

Name of Insurance Company: _____

Name of Policy Holder (if different): _____

Member ID/Policy #: _____

(TRICARE) Policy Holder SSN: _____ DOB: _____

PLEASE READ AND SIGN THE FOLLOWING

1. I authorize Human Care to release or receive any information necessary to expedite insurance claims.

2. I hereby authorize Human Care to bill my insurance company directly for their services.

3. I authorize payment directly to Human Care of any insurance benefits otherwise payable to me. I understand that I am directly and fully financially responsible for paying any co-pays, percentages and/or deductibles not covered by insurance. I further understand that such payment is not contingent on any settlement, judgment or insurance payment by which I eventually recover said fee. I realize that if my insurance company fails to pay my balance in full, or there is no payment within 90 days, it is my full responsibility to pay my bill directly. I further understand and agree that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection proceedings; including court costs, filing fees as well as reasonable attorney's fees.

4. Our notice of Clients Rights provides information about how we may use and disclose health care information about you. As provided in our Notice of Clients Rights, the terms of our notice may change. If we change our notice, you may obtain a revised copy at your request. I further acknowledge that I need to notify Human Care, LLC, in writing, of any specific instructions for the release of my healthcare information.

Print: _____

Sign: _____ Date: _____

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THE BURNS ANXIETY INVENTORY

Name: _____ **Date:** _____

Total Score	Degree of Anxiety
0-4	Minimal or No Anxiety
5-10	Borderline Anxiety
11-20	Mild Anxiety
21-30	Moderate Anxiety
31-50	Severe Anxiety
51-99	Extreme Anxiety or Panic

Place a check mark in the box to the right of each category to indicate how much this type of feeling has bothered you in the past several days.

		0 – Not At All	1 - Somewhat	2 - Moderately	3 – A Lot
Category I: Anxious Feelings					
1	Anxiety, nervousness, worry or fear				
2	Feeling that things around you are strange or unreal				
3	Feeling detached from all or part of your body				
4	Sudden unexpected panic spells				
5	Apprehension or a sense of impending doom				
6	Feeling tense, stressed, "uptight" or on edge				
Category II: Anxious Thoughts					
7	Difficulty concentrating				
8	Racing thoughts				
9	Frightening thoughts				
10	Feeling that you're on the verge of losing control				
11	Fears of cracking up or going crazy				
12	Fears of fainting or passing out				
13	Fears of physical illnesses or heart attacks or dying				
14	Concerns about looking foolish or inadequate				
15	Fears of being alone, isolated, or abandoned				
16	Fears of criticism or disapproval				
17	Fears that something terrible is about to happen				
Category III: Physical Symptoms					
18	Skipping, racing or pounding of the heart (palpitations)				
19	Pain, pressure, or tightness in chest				
20	Tingling or numbness of toes and fingers				
21	Butterflies or discomfort in the stomach				
22	Constipation or diarrhea				
23	Restlessness or jumpiness				
24	Tight, tense muscles				
25	Sweating not brought on by heat				
26	A lump in the throat				
27	Trembling or shaking				
28	Rubbery or "jelly" legs				
29	Feeling dizzy, lightheaded or off balance				
30	Choking or smothering sensations or difficulty breathing				
31	Headaches or pains in the neck or back				
32	Hot flashes or cold chills				
33	Feeling tired, weak, or easily exhausted				
Total score for items 1 through 33:					

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Burn's Depression Checklist

Name _____ **Date** _____

Instructions: Please check the box to indicate how much you have experienced each symptom during the last week, including today. Please answer all 25 items

Thoughts and Feelings	Not at All	Somewhat	Moderate	A lot	Extremely
Feeling sad or down in the dumps					
Feeling unhappy or blue					
Crying spells or tearfulness					
Feeling discouraged					
Feeling hopeless					
Low self-esteem					
Feeling worthless or inadequate					
Guilt or shame					
Criticizing yourself or others					
Difficulty making decisions					

Activities and Personal Relationships

Loss of interest in family, friends or colleagues					
Loneliness					
Spending less time with family or friends					
Loss of motivation					
Loss of interest in work or other activities					
Avoiding work or other activities					
Loss of pleasure or satisfaction in life					

Physical Symptoms

Feeling tired					
Difficulty sleeping or sleeping too much					
Decreased or increased appetite					
Loss of interest in sex					
Worrying about your health					

Suicidal Urges

Do you have any suicidal thoughts?					
Would you like to end your life?					
Do you have a plan for harming yourself?					

Total Score: _____

Total Scores	Level of Depression
No Depression	0-5
Normal but unhappy	6-10
Mild Depression	11-25
Moderate Depression	26-50
Severe Depression	51-75
Extreme Depression	76-100

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AUDIT

Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

NOTE: Although these drinks are different sizes, each one contains the same amount of pure alcohol and counts as a single drink.

12**oz of Beer (about 5% alcohol)**

8-9oz of Malt Liquor (about 7% alcohol)

5oz of Wine (about 12% alcohol)

1.5oz of Hard Liquor (about 40% alcohol)

Question	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more	
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year	
					TOTAL	

Have you ever been in treatment for an alcohol problem? ◯ Never ◯ Currently ◯ In the past

I	II	III	IV
0-3	4 -9	10-13	14+

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