New Client Information

Today's Date________________

Preferred Name: ______________ Full Legal Name: ____________________________________

DOB: ______________________ Age: ______ Sex: ________ SSN: _______________________

Street Address: ____

City:______________________________ State:_________ Zip Code:_______________

Primary Contact Phone: ___________________ Secondary Contact Phone: __________________

E-mail: ____

Marital Status: Single Divorced Married Other ______

Anniversary Date (if married) __________

Whom may I thank for referring you?

Name : _________________________________ Contact Information:_______________________

My Employer is:

____

In case of Emergency, who would you like contacted?

Name: ________________________Phone:________________Relationship:___________________

I understand the limits of confidentiality with my counselor. Reports will be made regarding neglect and abuse to proper authorities, if applicable.

I understand Advanced Counseling LLC's Informed Consent and other information is available online at communicatinglove.com/confidentiality or I may request a printed copy of the Full Disclosure.

I understand to be responsible to pay full amount any missed appointments and charged ½ of late cancelled or rescheduled appointments not 24 hours before a scheduled appointment.

I consent notification of future appointments by email &/or text understanding this may compromise my confidentiality of my attending counseling if someone reads my email or texts.

I understand my insurance does NOT cover all services provided by Advanced Counseling LLC.

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1426 N Carol Street Meridian Idaho 83646
Ph: 208-887-6283

Reason for Seeking Services

Personal Stress   Relationship Stress   Family Issues   Work Stress   Hypnotherapy

Main Goal:

____

____

Name of Client:____

Authorizing Signature*:____________________________ Date: _________________________

(If Parent/ Guardian) Name: _________________Relationship to Client: ___________________

(*Signing Parent or Guardian of Minor is Responsible for Incurred charges.)
By signing this form I understand that all services to me or my minor children I am fully responsible directly for making full payment as charged. In the unlikely event of non-payment I understand I may be additionally responsible for added cost of collection fees; this is typically 25%.

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HIPAA CONSENT FORM

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Advanced Counseling LLC (also DBA Communicating Love) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of ADVANCED COUNSELING LLC. I understand that my insurance will not be used and that Treatment is on a cash basis only.

I understand Rodney Limb of Advanced Counseling may consult with other health care practitioners he works with for the purposes of supervision regarding your health concerns. Your identifying information will not be used. In any event you may need Urgent Services your confidentiality may be breached for the purposes of helping you obtain your requested or associated needs.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. ADVANCED COUNSELING LLC is not required to agree to the restrictions that I may request. However, if ADVANCED COUNSELING LLC agrees to a restriction that I request, the restriction is binding on ADVANCED COUNSELING LLC staff and Rod Limb.
I have the right to revoke this consent, in writing, at any time, except to the extent that Rodney Limb or ADVANCED COUNSELING LLC has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review ADVANCED COUNSELING LLC's Notice of Privacy Practices prior to signing this document. The ADVANCED COUNSELING LLC Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of ADVANCED COUNSELING LLC. The Notice of Privacy Practices for ADVANCED COUNSELING LLC is also provided on the website www.CommunictingLove.com This Notice of Privacy Practices also describes my rights and ADVANCED COUNSELING LLC duties with respect to my protected health information.

ADVANCED COUNSELING LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. Changes will be posted and kept up to date on www.CommunicatingLove.com. I may obtain a revised notice of privacy practices by calling the office and requesting a copy be sent in the mail or asking for one at the time of my next appointment. If you want to learn more about HIPAA go to: http://www.hhs.gov/

Name of Client:____

Authorizing Signature ____________________________ Date:______________
If Parent/ Guardian)Print Name:

____

Relationship to Client: __________________

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PATIENT HEALTH DATA

Name: ______________________ Birth Date: __________ Age: _______ Sex: M / F

Current Medical Concerns/treatment ____

Do you currently take any nutritional supplements? ______ Please describe ________________

____

Please list all current medications. Include over the counter medications.

Medications	Date Started	Purpose	Prescribed by

Health history (Check any that apply)

History of physical abuse	[ ]	Recent loss/death in family	[ ]
History of sexual abuse	[ ]	Change in Appetite	[ ]
Psychological abuse	[ ]	Stomach Ulcers	[ ]
Thyroid Problem	[ ]	Stroke	[ ]
Fainting	[ ]	High Blood Pressure	[ ]
Shortness of breath	[ ]	Chest Pain	[ ]
Cancer	[ ]	Divorce	[ ]
Liver Disease	[ ]	Motor Difficulties	[ ]
Sleep Difficulties	[ ]	Head Injury	[ ]
Seizures	[ ]	Loss of consciousness	[ ]
Nausea/vomiting	[ ]	Bed wetting	[ ]
Blood Disease	[ ]	Recurring headaches	[ ]
Vertigo/dizziness	[ ]	Any Other Concern?	[ ]
Skin Ulcers/lesions	[ ]	Pregnant	[ ]

Prior Psychiatric/psychological treatment

Psychiatric hospitalizations: (dates and reason) ______________________________

Prior psychiatrists: (dates) ____

Prior therapists: (dates) ____

Family History: (If yes, who)

Nervous or mental illness ______________________________________

Alcohol or drug use ______________________________________

Diabetes ______________________________________

Drug Use: N / Y (How much? How often)

Smoke		
Alcohol		
Marijuana		
Caffeine		

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Marriage and Family Disclosure

My philosophy of therapy is that in working with couples and families' Transparency between individuals is important, and keeping certain secrets is typically damaging or counterproductive to relationships. While every effort will be made to provide a safe and confidential environment for each client (even minor children) to facilitate effective therapy, having the option to discuss information from individual sessions may be necessary to help your marriage/family overcome their challenges and resolve issues.

In the case of minor children, parents are seen as having the primary responsibility for the well-being and rearing of their children, and can be a valuable asset to the counseling process. Taking a family-friendly approach means that parents may be included in the counseling process when it is deemed to be of greatest benefit to the minor child/client.

I reserve the right to use my best clinical judgment in regards to sharing information in couple and family sessions in collaboration with the best interests of each client. And sensitive disclosures will generally be made after consultation with and in collaboration with you the client taking into consideration any safety issues.

I am an advocate of all parties involved in the counseling process. In the event that one or more parties seek legal action, please be advised that I do not provide character references or clinical evaluations. Please note that I am here for each of you.

Confidentiality cannot be guaranteed by me that your friends or family members may not keep confidential what is discussed in Therapy.

I understand the information I share with Rodney Limb in an individual session may not always be kept confidential from my partner or other family members.

By inviting others to participate in Therapy or joining in couples, family, or group I acknowledge work with couples and families and friends require certain additional compromises in privacy as outlined above.

Client Signature: ___________________________________ **Date:** ______________________

The following listed individuals have my authorization to be participants in counseling to my confidential information as the Counselor deems supportive to my purposes for seeking Counseling.

Initials:	Name:	Date:	Relationship

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Telehealth Informed Consent Form

I ____, If needed - consent to engaging in telehealth with Advanced Counseling Services as a part of the therapy process and my treatment goals. I understand that telehealth psychotherapy may include mental health evaluation, assessment, consultation, treatment planning, and therapy. Telehealth will occur primarily through interactive audio, video, telephone and/or other audio/video communications.

I understand I have the following rights with respect to telehealth:

1) I have the right to withhold or remove my consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.

2) The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions is generally confidential. There are both mandatory and permissive exceptions to confidentiality including but not limited to reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent,

3) I understand that there are risks and consequences from telehealth including but not limited to, the possibility, despite reasonable efforts on the part of Advanced Counseling Services that: the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons.

   In addition, I understand that telehealth-based services and care may not be as complete and in-person services. I understand that if my therapist believes I would be better served by other interventions I will be referred to seek a mental health professional who can provide those services in my area. I also understand that there are potential risks and benefits associated with any form of mental health treatment, and that despite my efforts and efforts of my therapist, my condition may not improve, or may have the potential to get worse.

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4) I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured. I use a business Zoom account for Telehealth. For confidentiality some platforms are not 100% secure and may have issues with Wi-Fi connectivity. All attempts to keep information confidential while using these systems will be made but a guarantee of 100% confidentiality cannot be made with inherent issues with these communication systems. Signing this form shows an awareness of these issues and a decision by this client to use these systems for telehealth services. I will not hold Advanced Counseling Services or its staff liable for the gathering or use of client information by these service providers.

5) I understand I have the right to access my personal information and copies of case notes. I have read and understand the information provided above. I have discussed these points with my therapist, and all of my questions regarding the above matters have been answered to my approval.

6) By signing this document, I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 911 or go to the nearest hospital or crisis facility. By signing this document, I understand that emergency situation may include thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, if I am in a life threating or emergency situation, and/or if I am abusing drugs or alcohol and are not safe. By signing this document, I acknowledge I have been told that if I feel suicidal, I am to call 911, local county crisis agencies or the National Suicide Hotline at 1-800-784-2433.

____

Signature of client/parent/guardian — Date

____

Printed name of client/parent/guardian — Relationship (If applicable)

____

Fee Schedule and Billing Practice Policies

Typical is *Cash: $175 for the first intake appointment. $150 per session thereafter. Fees are subject to change every 6 months.*

Insurance and EAP's are no longer available. Cash / Credit only.

Discounts: Scheduled and Pre-paid appointments may be discounted up to 20% when 4 or more are conducted in a calendar month time. Prepaid and scheduled can only be re-scheduled 48 hours in advance.

The standard meeting "Therapeutic Hour" is 47-52 minutes. Generally, your session will end at 10 minutes before the Hour allowing the Counselor a chance to return phone calls and a quick bathroom break before the next client to begin on time "on the Hour."

If you are late, your time still starts on the hour and will conclude at 10 minutes before the hour. Note: Being late and having a shorter session is still preferred over a cancellation or re-schedule. Often a 20-minute focused session can still be very worthwhile. If you cannot make your appointment in-person and call; you may request to use the remaining time as soon as connections can be made via a Zoom call. This telehealth connection can usually be substituted in less than 5 minutes.

Re-schedules AND CANCELLATIONS Please remember to cancel or reschedule 24 hours in advance. If you cancel less than 24 hours you will be charged $50% of your scheduled appointment fee. If you no-show for your appointment, you will be charged for the entire fee of your appointment. You may be considered for a refund of a late or missed fee by providing documentation of an emergency which caused the missed appointment.

By scheduling, I have agreed to Advanced Counseling LLC terms of billing and fees as a contract with myself and give permission to automatically charge my credit card on file at the end of my appointment time.

Impromptu extended sessions or special services are available as mutually agreed upon availability. If you come for a one-hour session and an extended session is held, you will be charged the standard rate for the whole meeting time. i.e. A one-hour session scheduled and a two-hour session is held, you will be charged for a two hour session.

EVOX, Rezzimax, EFT, BrainSculpt or other methodologies such as brief informal hypnosis and other services are included unless otherwise specified.

As the responsible Party: I have read and understand my contract agreement and have clarified any questions I may have had regarding my financial responsibility for counseling / coaching services.

Print Name: ____ Date: __________________

Signature:

____

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