Life Practice Counseling Group

a non-profit agency Sliding-Fee

"*Life* is comprised of continuous opportunities to *practice*."

3820 Auburn Blvd. Ste.100, Sacramento, CA 95821 / 3336 Bradshaw #215, Sacramento, CA 95827
Main Line: (916) 300-6576

CLIENT INTAKE FORM

Confidentiality: What is revealed in this setting is protected by professional and ethical standards. All material is confidential and not released without your written consent except information related to child abuse, elder abuse, threatened homicide or suicide, threatened or real fatal harm to self or harm to others, or to consult with health care professionals you are seeing in regards to your health.

_____ Initials For couples/family therapy your counselor may utilize a "No Secrets" Policy. This means that if you participate in family/marital/couples therapy, your counselor is permitted to use information obtained in an individual session with other members of the family unless you specifically tell your counselor not to disclose certain information.

_____ I AGREE or _____ I DO NOT AGREE to a "No Secrets" Policy.

Email/Text Disclosure: If you choose to correspond with us using email or text, please be advised that although we take responsible precautions to ensure confidentiality through email or text, we cannot guarantee secure electronic transmissions arising from the use of email or text or any attachments.

Counselors: Counseling is provided by counselors who are in training to become Licensed Marriage & Family Therapists (MFT), Licensed Professional Clinical Counselors (LPCC), or Licensed Clinical Social Workers (LCSW) and are in a weekly group supervision to discuss cases with a qualified licensed therapist. Please initial that you received a copy of the NOTICE TO CLIENTS _____ Initials

Fees and Payments: Your fee is based on a sliding fee scale according to your household income. We request you pay your fee at the time of each session. You are responsible for any bank fees incurred due to returned or re-deposited checks. If you prepay, credits will be applied or we can offer a tax-deductible receipt for overpayments as a donation, there are no refunds given. _____ Initials

Cancellations: Cancellations need to be made at least 24-hours in advance. If an appointment is canceled or missed without at least a 24-hour notice, you may be charged for the fee. _____ Initials

Your Session: The therapy session is 53 minutes in duration.

Counseling Process: Counseling is a partnership between you and your counselor and progress depends on many factors that include motivation, effort, and a willingness to participate and cooperate. You have a right to agree or disagree with your counselor and ask questions about the process. During counseling there may be times that you remember unpleasant or disturbing events from your past and it can bring about some intense emotions. The benefits of counseling can include the ability to better cope with your relationships, increase in your self-awareness, personal growth, and you may achieve your personal goals. Counseling can bring resolution of the presenting problem or can bring unwanted and unexpected changes. Our counselors bring expertise and knowledge to help you make healthy and appropriate decisions and choices for yourself.

We hope your experience at Life Practice Counseling Group is a positive one and assists you in the development of your life. Signing says you agree to and fully understand the contents of this intake.

Client's Signature_____ Date _____

Counselor's Signature & Printed Name _____ Date _____ 6/19/23

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NOTICE TO PSYCHOTHERAPY CLIENTS AT A NON-PROFIT COUNSELING AGENCY

NOTICE TO CLIENTS OF TRAINEES:

The Clinical Supervisor of Life Practice Counseling Group receives and responds to complaints regarding the practice of psychotherapy by any unlicensed or unregistered counselor providing services at Life Practice Counseling Group. To file a complaint, contact us by email at info@lifepractice.org

NOTICE TO CLIENTS OF REGISTERED ASSOCIATES:

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of Marriage and Family Therapists, Licensed Educational Psychologists, Clinical Social Workers, or Professional Clinical Counselors. You may contact the board online at www.bbs.ca.gov, or by calling (916) 574-7830.

Client Copy

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Signature Acknowledging Receipt**:**_____

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NEW CLIENT INFORMATION

Welcome. So that we may assist you, please complete the following:

Date: _____ Marital Status: _____ Occupation: _____

Name:_____ Date of Birth: _____ Age:_____

Name of Significant Other:_____ Date of Birth: _____ Age: _____

Home Address: _____City/Zip: _____

Home phone: ( ) _____ Cell phone: ( ) _____

Work phone: ( ) _____ Fax: ( ) _____

If we call, can we identify ourselves as counselors from Life Practice Counseling? Yes___ No ___

Can we contact you by email? Yes__ No__ Email Address: _____

Emergency contact: _____Phone: _____

Emergency contact: _____Phone: _____

Highest Grade Completed in School: _____ Monthly Income: _____ (Couples combine)

Physician: _____ Phone: _____ Last Checkup Date: _____

Medications currently taking: _____

Reason for Counseling:_____

Previous psychotherapy? Yes ___No ___Year and reason: _____

On average how many days/week do you drink alcohol? _____ **How many drinks/day?** _____

Have you ever tried drugs? ___ **What types?** _____ **Currently using?** ___ **How often?** _____

How did you find us? Yahoo Google Yellowpages.com Craigslist Facebook Other:_____

May we know who referred you? _____

Termination of Therapy: You have the right to terminate therapy at any time and as you reach the end of your goals, you and your counselor will discuss termination. Therapy can be terminated if either of you feel you are not benefiting from therapy, if the counselor can no longer be objective, if you have not paid for the last two sessions, or failed to provide a 24-hr notice of cancellation two or more times. Treatment alternatives will be provided.

Your signature: _____ Date:_____

7/12/10

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HIPAA Notice of Privacy Practices

1. This notice describes how medical information about you may be used and disclosed electronically and how you can get access to this information. Please review it carefully.

2. I have a legal duty to safeguard your protected health information (PHI) when I transmit information electronically. I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care.

I must provide you with this Notice about my privacy practices, and such Notice must explain how, when and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made.

By signing this notice you acknowledge we may use your PHI, but may not disclose your PHI without further written authorization by you. We do not keep separate treatment notes and psychotherapy notes, all of our notes are treatment notes and can be found in the client file. Your PHI will not be disclosed for marketing purposes. Your PHI will not be sold without your authorization. You will not be contacted for fundraising purposes. If you pay for any service out-of-pocket, then you have the right to restrict disclosures of PHI to health plans from that service. If there is a breach of your unsecured PHI, you will receive notification.

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website. You can also request a copy of this Notice from me, or you can view a copy of it in my office or at my website.

Please sign this Notice, stating that you acknowledge receipt of this Notice of Privacy Practices of Life Practice Counseling Group.

I _____ was or _____ was not offered a copy of this notice.

Signature: _____ Date: _____

_____ Initial here if you decline to receive a copy of this notice.

6/19/23

Please check the feelings that apply to you today:

Client Name:_____

AI

_____ 1. I feel tense most of the time.

_____ 2. I have a lot of physical problems that can't be explained.

_____ 3. I worry most of the time.

_____ 4. I have compulsions such as constant hand washing, checking the door locks repeatedly, or other rituals that interfere with my daily activities.

_____ 5. I have nightmares and/or "flashbacks" that I can't get out of my head.

_____ 6. I have experienced sensations of shortness of breath, heart palpitations or shakiness while resting.

_____ 7. I avoid social situations because I am fearful.

_____ 8. There are some things I am really afraid of.

_____ 9. I am afraid to leave my house.

_____ 10. I think about dying or killing myself.

_____ 11. I have thoughts constantly in my mind, which interfere with my ability to concentrate and function effectively.

DI

____ 1. I no longer have any interest in the things that used to interest me.

____ 2. I feel hopeless about the future.

____ 3. I can't make decisions because I have a difficult time concentrating.

____ 4. I feel sluggish or restless.

____ 5. I am gaining or losing weight without trying to.

____ 6. I get tired for no reason.

____ 7. I am sleeping too much, or too little.

____ 8. I feel unhappy.

____ 9. I become irritable or anxious easily.

____ 10. I think about dying or killing myself.

____ 11. I have spontaneous urges to cry.

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I must provide you with this Notice about my privacy practices, and such Notice must explain how, when and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made.

By signing this notice you acknowledge we may use your PHI, but may not disclose your PHI without further written authorization by you. We do not keep separate treatment notes and psychotherapy notes, all of our notes are treatment notes and can be found in the client file. Your PHI will not be disclosed for marketing purposes. Your PHI will not be sold without your authorization. You will not be contacted for fundraising purposes. If you pay for any service out-of-pocket, then you have the right to restrict disclosures of PHI to health plans from that service. If there is a breach of your unsecured PHI, you will receive notification.

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website. You can also request a copy of this Notice from me, or you can view a copy of it in my office or at my website.

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Signature: _____ Date: _____

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Health Insurance Agreement/Patient Responsibility

Life Practice accepts multiple commercial, Medi-Cal, and EAP Managed Healthcare plans.

I _____(print your name) am using _____ Managed Health Plan to cover the cost of my services. My subscriber ID is _____ and my date of birth is _____. Medi-Cal/EAP there is no co-pay I have to pay at the time of my service. My Commercial Plan has a Co-Pay of $_____ per session that I must pay by the end of each session. I understand that if I have a primary insurance other than the plan above that I do not know about or that I am not revealing that I will be responsible for the session fee of $_____ for each session conducted that I will pay for out of pocket via cash/check/credit card. If I cancel my plan or for some reason I am no longer covered, I understand it is my responsibility to let my counselor know. _____ I understand that I am responsible for any fees that are not covered by my plan. _____ I understand that Life Practice will bill my plan and will make every effort to insure the Managed Care company reimburses for the services, but I fully understand that if the Managed Care company does not pay for the service, that I am responsible for the fees incurred and will pay for the unpaid balance out of pocket via cash/check/credit card. _____

Initials Initials Initials

I understand that my plan only covers the cost of the services provided IF I attend my counseling appointment. For late cancels or no shows the following applies:

For Medi-Cal or EAP: I understand that if I do not show up for my appointment, do not provide the 24-hour notice of cancellation, or show up more than 43 minutes late for ANY 2 scheduled appointments that my services will be terminated with Life Practice. _____

Initials

For Commercial Plans: I understand that if I do not show up for my appointment, do not provide the 24-hour notice of cancellation, or show up more than 43 minutes late that I will be charged a flat fee of $100 for the missed appointment or late cancel. _____

Initials

"I _____ (print name) have read and understand the terms of using my Managed Healthcare Plan. I fully understand everything listed above as evidenced by my initials and signature. Any questions I have about this practice have been answered and I give my full consent and agree to pay out of pocket if my plan does not reimburse for the services provided."

_____ _____

Your Signature Agreeing to the Patient Responsibility Today's Date

1/23/24

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Credit Card Agreement

Please Note: New clients are required to keep a valid credit card number on file. Please complete the following information and provide your credit card to your therapist at your initial session.

Credit Card Type: MasterCard Visa American Express Discover Other:_____

Name as shown on card:_____

Credit Card Number:_____exp: _____/_____

3 digit security code on back of the card:_____

If American Express, code on front of the card:_____

Billing Address associated with the card:_____

City, state, zip: _____

Email Address: _____

This card will be charged by Life Practice or Sierra Pacific Medical Billing Services, LP on behalf of Life Practice as the contracted medical biller for the following (Please initial each one):

_____ Regular session fees and/or Co-Pay amounts (As discussed at intake or at your request)
Initials

_____ Fees for same-day cancellation or No shows (missed appointments)
Initials

_____ Fees for cancellation without _____ hours notice (according to your counselor's policy)
Initials

_____ Delinquent session fees (fees more than 30 days overdue)
Initials

_____I understand there are no refunds given and that the balance due will remain
Initials

"I _____ (print name) have read and understand the terms of providing my credit card to Life Practice Counseling Group. I understand that my credit card may be charged for the reasons indicated above. I also understand there are No refunds given. Any questions I have about this practice have been answered and I give my full consent to charge my credit card under the circumstances checked above."

_____ _____
Your Signature Consenting to Charges Today's Date

1/17/2024