LSS Counseling

Intake information:

Last Name First Name

_____

Marital Status Single_____ Married_____ Other_____

Home Address

_____

City State Zip

_____

Home phone number cell number work number

Employer Name and Address_____

DOB Social Security number

_____ _____

E-mail

Insurance information:

Name of insured

Last Name First Name Relationship

_____

Home Address

_____

City State Zip

DOB Social Security number

_____ _____

Insurance ID number Group number

_____ _____

Insured place of employment

_____

Name and phone of insurance

_____

Insurance Address

_____

City State Zip

Comments:_____

_____

_____

LSS Counseling

HEALTH HISTORY

In order ensure a full understanding of your health history please complete the **following questionnaire.**

1. **Basic Information**

   Name _____ Date of Birth _____

   Marital Status Single_____ Married_____ Other _____

   Occupation _____ SS# _____

   In case of Emergency Contact _____

   Phone # _____ Relationship _____

   Children and Ages_____

   _____

2. Primary Care Physician _____ Phone Number _____

3. Serious Medical Illnesses/Accidents (Identify and give dates) _____

   _____

   _____

4. Are you on any medications? _____ Yes _____ No If yes, please provide a list _____

   _____

   Allergies? _____

5. Have you ever been treated for mental health issues? _____Yes _____No If Yes, by whom:

   Name _____ PCP/OBGYN/Psychiatrist/Therapist

   Please list any medications prescribed for mental health _____

   _____

6. Are you or have you been under the care of a psychiatrist? _____Yes _____ No If yes, by

   Whom: _____

7. Do you exercise? _____Yes ____No If yes how often _____

8. Do you drink alcohol? _____Yes _____No If yes how often_____

9. Do you use drugs? ____Yes ____No

10. Have you ever been treated for alcohol or drug abuse? _____ Yes _____No If yes, when and Where _____

11. Do you use tobacco? ____Yes _____No If yes how often_____

12. Have you ever been a victim of physical or sexual abuse? _____Yes _____No

13. Do you have suicidal thoughts? _____ Yes _____ No

14. Have you had previous suicidal attempts? _____Yes _____No

If yes, please explain_____

_____

15. Do you or have you had difficulty with an eating disorder _____ Yes _____ No

If yes, please give additional information _____

_____

16. What are your eating habits? (Typical breakfast, lunch, dinner and snacks) _____

_____

17. What are your sleeping habits? (Time, duration, dreams, etc.) _____

_____

18. Have you experienced any Anxiety or Depression lately? ____Yes ____No

If yes, please explain_____

_____

19. Please share about your support system (Family, Friends, Co-Workers, other) _____

_____

20. What is the information I need to know about your family of origin and/or your current living situation? _____

_____

21. What do you enjoy? _____

_____

22. Briefly describe your goals for therapy. _____

_____

Signature _____ Date _____

Legal Guardian _____ Date _____

INFORMED CONSENT

Thank you for choosing Luann Spencer-Steele, LPC. Today's appointment will take approximately 50 – 55 minutes. I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of my policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and I will try my best to give you all the information you need. Luann Spencer-Steele, LPC has earned a Bachelor of Arts Degree in Education from the University of Missouri, Columbia and a Master Degree in Education from the University of Missouri, St. Louis. I am licensed by the State of Missouri as a Licensed Professional Counselor. I have over Twenty years of clinical experience in treating adolescents, adults and families using individual and family therapy to treat women issues, trauma issues, sexual abuse issues and relational issues. Luann Spencer-Steele practices standard System Therapy for most conditions, although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy and plan initiations and risks will be discussed with you today.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: *All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission except where disclosure is required by law. Some of the circumstances where disclosure is required or may be required by law are: where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled; or when a client's family members communicate to Luann Spencer-Steele that the client presents a danger to others. Disclosure may also be required pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by Luann. In couple and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. Luann will use her clinical judgment when revealing such information. Luann will not release records to any outside party unless she is authorized to do so by all adult parties who were part of the family therapy, couple therapy or other treatment that involved more than one adult client. If an emergency situation for which the client or their guardian feels immediate attention is necessary, please call my cell phone/office number and leave your name and phone number only. If no call is received within 30-45 minutes, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. If there is an emergency during therapy, or in the future after termination, where Luann becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, she will do whatever she can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, she may also contact the person whose name you have provided on the intake sheet.*

Signature(s) _____Date:_____

E–MAILS, CELL PHONES, COMPUTERS, AND FAXES: *It is very important to be aware that computers and unencrypted e-mail, texts, and e-faxes communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, texts, and e-faxes, in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all e-mails, texts and e-faxes that go through them. While data on Luann Spencer-Steele's laptop is encrypted and/or password protected, e-mails and e-fax are not. It is always a possibility that efaxes, texts, and email can be sent erroneously to the wrong address and computers. Unencrypted email or text provides as much privacy as a postcard. You should not communicate any information with your health care provider that you would not want to be included on a postcard that is sent through the Post Office. Luann's laptop is equipped with a firewall, a virus protection and a password, and she backs up all confidential information from her computer on a regular basis onto an encrypted hard-drive. Please notify Luann if you decide to avoid or limit, in any way, the use of e-mail, texts, cell phones calls, phone messages, or e-faxes. If you communicate confidential or private information via unencrypted e-mail, texts or e-fax or via phone messages, will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and she will honor your desire to communicate on such matters.*

SOCIAL NETWORKING AND INTERNET SEARCHES*: At times, I may conduct a web search on my clients before the beginning of therapy or during therapy. If you have concerns or questions regarding this practice, please discuss them with me. I do not accept friend requests from current or former clients on social networking sites, such as Facebook. I believe that adding clients as friends on these sites and/or communicating via such sites is likely to compromise their privacy and confidentiality. For this same reason, I request that clients not communicate with me via any interactive or social networking web sites.*

I understand the issues regarding communication:

Signature(s) _____Date:_____

APPOINTMENT REMINDERS: *Understanding the above risks of email, would you like to receive appointment reminders by email? If so please list your email below and by so doing confirm that you accept responsibility for these risks and will not hold LSS Counseling or Luann Spencer-Steele responsible for any event that occurs after we send the message.*

E-Mail_____

RECORDS AND YOUR RIGHT TO REVIEW THEM*: Both the law and the standards of Luann Spencer-Steele's profession require that she keep treatment records for at least seven years. Unless otherwise agreed to be necessary, Luann retains clinical records only as long as is mandated by Missouri law. If you have concerns regarding the treatment records, please discuss them with Luann. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when Luann assesses that releasing such information might be harmful in any way. In such a case, Luann will provide the records to an appropriate and legitimate mental health professional of your choice.*

Considering all of the above exclusions, if it is still appropriate, and upon your request, Luann will release information to any agency/person you specify unless Luann assesses that releasing such information might be harmful in any way. When more than one client is involved in treatment, such as in cases of couple and family therapy, Luann will release records only with signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment.

Signature(s) _____Date:_____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: *I/We are aware that LSS Counseling, LLC Privacy Practices and Clients Rights are available on the website www.luannspencersteele.com on the contact page titled 2013 HIPAA.pdf, and have had the opportunity to read them, or have had an opportunity to read the copy in the office. I am aware that I may ask for an electronic or paper copy.*

Signature(s) _____Date_____

*May we contact you at home (circle one) yes **no**? May we contact you at work **yes no?** May we contact you by cell phone yes **no?** Where may we contact you _____?*

GOOD FAITH ESTIMATE NOTICE: *Notice to clients and prospective clients:*
Under the law, health care providers need to give clients who don't have insurance or who are not using insurance an estimate of the expected charges for medical services, including psychotherapy services.
You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency healthcare services, including psychotherapy services.
You can ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule a service, or at any time during treatment.
If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate.
For questions or more information about your right to a Good Faith Estimate, or how to dispute a bill, see your Estimate, or visit www.cms.gov/nosurprises.

Will you be using insurance? Yes/no

If you will be private-pay please note that you have received your Good Faith Estimate
Initials _____

Signature_____Date_____

FINANCIAL/INSURANCE ISSUES: *As a courtesy we will bill your insurance company, HMO, responsible party or third-party payer for you if you wish. We ask that you be fully aware of how your insurance coverage works, such as, if a referral is needed it is the patient's responsibility to obtain it. We ask that at each session you pay your co-pay or 50% of the fee. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your balance exceeds $300.00 we will need to ask that you pay for services when rendered. After 60 days any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to a collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to LSS Counseling.*

Signature(s) _____Date_____
I have received a copy of my fee schedule _____

Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be billed $60.00 for a missed or late cancelled appointment. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask. ***You may have a copy of this form if requested***
Signature(s)_____Date_____

ADVANCE DIRECTIVE: *An Advance Directive is a written document describing what a person desires to happen should a time occur in the future they are judged to be unable to decide for themselves or are not able to effectively communicate. It often names a person they have designated/ given authority to make decisions on their behalf. It can also inform providers what treatments they do or do not want. Please inform Luann Spencer-Steele if you have an advance directive you would like to include in you file or if you would like information about an advance directive.*

Signature(s)_____Date_____

COORDINATION OF TREAMENT: *It is important that all health care providers work together. As such, I would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year.* ***Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization****. If you prefer to decline consent no information will be shared.*
____You may inform my physician(s) ____I decline to inform my physician
PHYSICIAN NAME: _____
ADDRESS: _____
PHONE: _____

Signature(s) _____Date_____

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS: *I/We consent that _____ may be treated as a client by Luann Spencer-Steele. It is understood that children over the age of 12 have confidentiality protected by law. At times it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide treatment for you and your children. This consent to treat expires at the end of treatment or if revoked in writing.*

Signature(s) _____Date_____

LSS Counseling

FEE SCHEDULE FOR PRIVATE PAY

EFFECTIVE January 15, 2022

CPT code	
90791 Psych Diagnostic Eval	$145.00
90834 Psych Pt&/Family 45 Min	$120.00
90847 Psych Pt&/Family 60 Min	$140.00
Minimal phone consultation or correspondence	no charge
Extensive phone consultation or correspondence more than 15 minutes	$35.00 per quarter hour
Missed appointment-	$60.00

Based on information provided by you and your insurance company, your portion of the fee at the time of service is estimated to be deductible met/not met/unknown

Initial consultation $_____
Follow up sessions $_____

Insurance will not reimburse for extensive phone consultation or missed appointments.

This is merely an estimate and we cannot guarantee this is the final amount due.

Thank you