

LSS Counseling

Intake information:

Last Name	First Name	
<hr/>		
Marital Status Single_____ Married_____ Other_____		
Home Address		
<hr/>		
City	State Zip	
<hr/>		
Home phone number	cell number	work number
Employer Name and Address		
<hr/>		
DOB	Social Security number	
<hr/>	<hr/>	
E-mail		

Insurance information:

Name of insured		
Last Name	First Name	Relationship
<hr/>		
Home Address		
<hr/>		
City	State	Zip
<hr/>		
DOB	Social Security number	
<hr/>	<hr/>	
Insurance ID number	Group number	
<hr/>	<hr/>	
Insured place of employment		
<hr/>		
Name and phone of insurance		
<hr/>		
Insurance Address		
<hr/>		
City	State	Zip
<hr/>		
Comments: _____		
<hr/>		
<hr/>		

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 45 – 50 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 15 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 e-faxes, 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 _____?

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 \$40.00 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 TREATMENT: *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: _____

CLINIC: _____

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* _____

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FEE SCHEDULE

EFFECTIVE October 1, 2011

CPT code	
90791 Psych Diagnostic Eval	\$135.00
90834 PsytX Pt&/Family 45 Min	\$110.00
90847 PsytX Pt&/Family 60 Min	\$130.00
Minimal phone consultation or correspondence	no charge
Extensive phone consultation or correspondence more than 15 minutes	\$32.50 per quarter hour
Missed appointment-	\$40.00

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