Lifesong Client Intake Form

Client Intake

* Indicates required question

1. Email *

2. Today's Date *

Example: January 7, 2019

3. Select Staff Member *

Check all that apply.

- [ ] Shelly Foster
- [ ] Stephen Hansen
- [ ] Adina Loomis
- [ ] Joe Madrid
- [ ] Sheri Miller
- [ ] Veronica Pedersen
- [ ] Bob Reece
- [ ] Susan Bolint
- [ ] Alyse McShane
- [ ] Brandon Sego

4. May I contact you by email *

Mark only one oval.

- ◯ Yes
- ◯ No

5. Name *

6. If minor, what is parent's name?

7. DOB *

8. Age *

9. Gender *

Mark only one oval.

- ◯ Female
- ◯ Male
- ◯ Other: _____

10. Marital Status *

11. Race *

12. Address *

13. City *

14. State *

15. Zip *

16. Home Phone *

17. Work Phone

18. Cell Phone

19. May I call you at work, home, or cell? *

Mark only one oval.

- Home
- Work
- Cell

20. Children & Ages *

_____

21. Referred By *

_____

22. Why have you come to see me today? *

_____

_____

_____

_____

_____

23. How long have you been experiencing this? *

_____

24. Any prior counseling experience? *

_____

25. When? *

_____

26. Length of counseling? *

27. For what reason? *

28. Status of your Health: *

Mark only one oval.

- Excellent
- Very good
- Good
- Fair
- Poor

29. Physical Condition: *

Mark only one oval.

- Excellent
- Very good
- Good
- Fair
- Poor

30. Health or physical issues I should know about: *

31. Physician's Name: *

32. Physician Address and Phone: *

33. Are you currently taking any medications? Please list: *

34. Employment: *

Mark only one oval.

- Full Time
- Part Time
- Unemployed
- Student
- Retired

35. Employer

36. Employer Address

37. Signature: *

38. Date: *

Example: January 7, 2019

Health Insurance

Please provide a copy of your card.

Lifesong IS NOT an EAP provider

39. Insurance Company Names - Primary and Secondary *

40. Policy #/Member # for each insurance *

41. Group # for each insurance:

42. Policyholder's Name for each insurance:

43. Policy holder's date of birth for each insurance:

44. TriCare and TriWest SPONSER'S SS#:

45. Contact in case of emergency(name and phone #): *

46. INSURED OR AUTHORIZED PERSON'S SIGNATURE: I authorize the payment of medical benefits to the signing provider or supplier for services described on the submitted HCFA 1500 forms. Sign: *

Consent to Treatment

47. I give consent for Lifesong Counseling to treat me and agree that I am financially responsible for my sessions at the hourly rate discussed. *

Mark only one oval.

- Yes
- No

48. Sign: *

49. Date: *

Example: January 7, 2019

Email/Text/Phone Consent Form

Patient HIPAA Acknowledgement and Consent Form January 1, 2016. Consent to Email, Text or Cell Phone Usage for Appointment Reminders and Other Healthcare Communications: Patients may be contacted via email, cell phone or text messaging to remind you of an appointment, to obtain feedback on your experience, and to provide general health reminder/information.

50. If I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at this email or text address from the Practice. Please initial: *

51. I consent to receive text message from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below). The cell phone number that I authorize to receive text messages for appointment reminders, feedback and general health reminders/information is: *

52. The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is: *

I do not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

53. I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages: *

Mark only one oval.

- Yes
- No

54. I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email: *

Mark only one oval.

- Yes
- No

Note: This revocation only applies to communications from this practice.

55. Sign: *

56. Date: *

Example: January 7, 2019

Disclosure & Informed Consent

1520 Logan Avenue, Cheyenne, WY 970-817-3426

Shelly Foster, LPC; Stephen Hansen, LCSW; Adina Loomis, LPC; Joe Madrid, LCSW; Alyse McShane, LPC: Sheri Miller, LPC; Veronica Pedersen, LCSW; Sue Bolint, MFT; Brandon Sego, PPC

Pychotherapist-Client Service Agreement:

Welcome to our practice. This document contains summary information about confidentiality including, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA). Confidentiality is required by a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment and healthcare operations. This Disclosure Statement is required by the Mental Health Professions Licensing Act and the Board of Psychology.

Disclosure Statement:

Shelly Foster, MA, LPC; Master of Arts Degree in Counseling from the University of Northern Colorado, obtained in 1988. Shelly will adhere to the American Counseling Association Code of Ethics.

Susan Bolint, MA, MFT; Master of Arts in Marriage and Family Therapy from St. Mary's University, San Antonio, TX obtained in 2010. Sue will adhere to the American Counseling Association Code of Ethics.

Stephen Hansen, MSW, LCSW; Master of Social Work from the University of Wyoming in 2019. Stephen will adhere to the National Association of Social Workers Code of Ethics.

Adina Loomis, MA, LPC; Master of Arts in Clinical Psychology from Wheaton College obtained in 2010. Adina will adhere to the American Counseling Association Code of Ethics.

Joe Madrid, MSW, LCSW; Master of Social Work from University of Denver, obtained in 1990.
Joe will adhere to the National Association of Social Workers Code of Ethics.

Alyse McShane. LPC: Master of Arts in Counseling from Ottawa University, obtained in 2021. Whitney will adhere to the American Counseling Association Code of Ethics.

Sheryl Miller, MS, LPC; Master of Science in Counselor Education from the University of Wyoming, obtained in 1997. Sheri will adhere to the American Counseling Association Code of Ethics.

Veronica Pedersen, MSW, LCSW; Master of Social Work from Indiana University, obtained in 1992.
Veronica will adhere to the National Association of Social Workers Code of Ethics.

Bob Reece, MA: Masters Degree in Clinical Mental Heath from Adams State University in 2024. Bob will

adhere to the American Counseling Association Code of Ethics and is practicing under the supervision on Veronica Pederesn (above) who can be reached at 307-274-2428 or vpedersen1@yahoo.com.

Brandon Sego, PPC; Master of Social Work from University of Northern Colorado in 2023. Brandon will adhere to the

National Association of Social Workers Code of Ethics and is practicing under the supervision of Shelly Foster (below), who can be contacted at 970-817-3426 or shelly.foster@lifesong-counseling.com

This disclosure statement is required by the Mental Health Professions Licensing Act.
The maintenance of confidentiality of all written or verbal communications between client and therapist. As of March 1, 1999 Wyoming has implemented a privileged communication statute. This law states that, when involved in legal proceedings (civil, criminal or juvenile) clients retain the right to privacy, unless these specific circumstances exist:

a) abuse or harmful neglect of children, the elderly or disabled or incompetent individuals is known or reasonably suspected
b) the validity of a will of a former client is contested
c) information related to counseling is necessary to defend against a malpractice action brought by a client
d) an immediate threat of physical violence against a readily identifiable victim is disclosed to the counselor
e) in the context of civil commitment proceedings, where an immediate threat of self-inflicted harm is disclosed to the counselor
f) the client alleges mental or emotional damages in civil litigation or his/her mental or emotional state becomes an issue in any court proceeding concerning child custody or visitation

g) the patient or client is examined pursuant to a court order
h) in the context of investigations and hearings brought by the client and conducted by the board, where violations of this act are at issue.

Please note, in these professional relationships, sexual intimacy between a therapist and client is never appropriate. If sexual intimacy occurs it should be reported to the Wyoming Mental Health Professions Licensing Board, 2001 Capital Avenue, Room 104, Cheyenne, WY, 307-777-3628 or to the Wyoming Board of Psychology, 2001 Capital Avenue, Room 103, Cheyenne, WY 307-777-5403. These Boards have the general responsibility of regulating the practice of licensed professional counselors, social workers and psychologists, respectively.

Psychological Services:

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy you have certain privileges, rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. Your therapist has corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy is a unique process that varies depending on a numerous of factors, including, but not limited to, the personalities of the therapist and you, and client and/or the particular issues being presented. There are many different methods we may implement to help you deal with the problems you present. Unlike a visit to your medical doctor, your role in therapy is not a passive one. The process calls for a very active effort and involvement on your part and you may be asked to work on things we discuss both during our sessions and at home.

While the goal of treatment is to benefit you the client, it may also involve risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness, helplessness, and or hopelessness. Making changes in your beliefs or behaviors may be scary, and sometimes disruptive to the relationships you already have. You may find your relationship with one of us to be a source of strong feelings. On the other hand, psychotherapy has been shown to have benefits for those who are committed to the process. Therapy often leads to better relationships, solutions to specific problems, or significant reductions in feelings of distress. However, there is no guarantee of what you might experience; therefore, it is important that you consider whether the potential risks are worth the benefits. The majority of people who do take these risks find that therapy is helpful.

The first few sessions of your therapy will involve an evaluation of your needs, as well as an opportunity to gather information about you. By the conclusion of the evaluation, we will be able to offer you some initial impressions of what our work together will include and a more detailed treatment plan (verbal and/or in writing if requested) will be developed should you wish to continue. You should evaluate this information along with your own opinions as to whether you feel comfortable working with your clinician. Therapy involves a large commitment of time, energy and finances; therefore, you should be selective when choosing a therapist.

The first 2 - 4 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, your therapist will be able to offer you some initial impressions of what the work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with your therapist. If you have questions about procedures please discuss them whenever they arise. If your doubts persist your therapist will be happy to help you set up a meeting with another mental health professional for a second opinion.

Appointments:

Appointment times will ordinarily be 50 minutes in duration, once per week at a time we agree on. The rate for a fifty (50) minute sessions is $200.00. Please note that you may have more or less frequency in sessions dependent upon your individual needs. The time scheduled for your appointment is reserved for you and you alone. If you need to cancel or reschedule an appointment we expect at least a a twenty-four (24) hour notice. If you miss a session without canceling, or give less than a 24 hour notice you will be charged a $50.00 No-Show fee (unless we both agree you were unable to attend or give notice due to circumstances beyond your control).

Confidentiality:

The maintenance of confidentiality of all written or verbal communications between you and your therapist is a privileged communication as defined by W.S. 33-38-113 in Wyoming. This law states that, when involved in legal proceedings (civil, criminal of juvenile) you retain the right to privacy, unless these specific circumstances exist: a) abuse or harmful neglect of children, the elderly or disabled or incompetent individuals is known or reasonably suspected, b) the validity of a will of a former client is contested, c) information related to counseling is necessary to defend against a malpractice action brought by a client, d) an immediate threat of physical violence against a readily identifiable victim is disclosed to the therapist, e) in the context of civil commitment proceedings, where an immediate threat of self-inflicted harm is disclosed to the therapist, f) the client alleges mental or emotional damages in civil litigation or his/her mental or emotional state becomes an issue in any court proceeding concerning child custody or visitation, g) the patient or client is examined pursuant to a court order, or court ordered therapy, h) in the context of investigations and hearings brought by the client and conducted by the board, where violations of this act are an issue.

Contacting Us:

We are not always immediately available by telephone. We do not answer phones when we are with other clients or otherwise unavailable. If you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) go to your Local Hospital Emergency Room, or 2) call 911. We will make every attempt to inform you in advance of planned absences and to provide you with the name and phone number of the mental health professional covering for us in our absence.

Other Rights:

If you are unhappy with what is happening in therapy we hope you will talk with us so we can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that we refer you to another therapist and you are free to end therapy at any time. In most cases the client is the one who decides when therapy will end. However, should you pose a threat or blatantly threaten to commit violence, either verbal or physical, to anyone working at Lifesong, or any family member of those who work here, we reserve the right to immediately terminate your therapy. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin or source of payment. You have the right to ask questions about any aspect of therapy and about your clinician's specific training and experience. You have the right to expect that we will not have social or sexual relationships with clients or former clients.

Client Consent to Psychotherapy:

I have fully read this statement, had time to be sure that I considered carefully, asked any questions that were necessary and obtained needed clarification, and understand its terms completely. I consent to the use of a diagnosis for billing purposes, and to the release of that information and other information necessary to complete the billing process. I agree to pay the fee of $200.00 per 50-minute sessions should insurance not cover the services provided. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree to undertake therapy with the Lifesong clinician listed below. I am aware that I may terminate therapy at any time I wish and for any reason I feel necessary and that I may also refuse any requests or suggestions made to me by my therapist. I attest that I am at least 18 years of age.

57. Your signature below indicates that you have read the information contained in this document and agree to abide by its terms during our professional relationship. Sign: *

_____

Telehealth

Telehealth Informed Consent

58. I hereby consent to engaging in telehealth counseling with a Lifesong Counseling practitioner as part of my psychotherapy. I understand 'telehealth' includes the practice of healthcare delivery, diagnosis, consultation, treatment, transfer of mental health data and education using interactive audio, visual or data communications. *

Mark only one oval.

- ◯ Yes
- ◯ No

59. I understand that I have the following rights with respect to telehealth: I have the right to withhold or withdraw my consent at any time without affecting my right to future care of treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled. *

Mark only one oval.

- ◯ Yes
- ◯ No

60. I understand that I have the following rights with respect to telehealth: The laws that protect the confidentiality of my medical and mental health information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder and dependent adult abuse; expressed threats of violence toward self and/or an ascertainable victim; and when I make my mental or emotional state an issue in a legal proceeding. *

Mark only one oval.

- ◯ Yes
- ◯ No

61. In case of emergency my location is: *

_____

62. My contact information for local emergency service is: *

_____

63. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction will not occur without my written consent. *

Mark only one oval.

- ◯ Yes
- ◯ No

64. I understand there are risks and consequences from telehealth therapy including, but not limited to, the possibility that the transmission of my medical or mental health information could be disrupted or distorted by technical failures; the transmission of my medical or mental health could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and that there may be limitations in the ability to respond to emergencies. *

Mark only one oval.

- ◯ Yes
- ◯ No

65. Also, I understand that telehealth-based service may not be as complete as face-to-face services. I understand that if my practitioner believes I would be better served by another form or psychotherapeutic services I may be referred to a practitioner who can provide such services in my area. Finally, I understand there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my therapist, my condition may not improve and in some case may even get worse. *

Mark only one oval.

- ◯ Yes
- ◯ No

66. I understand I may benefit from telehealth services, but results cannot be guaranteed or assured. *

Mark only one oval.

- ◯ Yes
- ◯ No

67. I have read and understand the information provided above. Your signature below indicates that you have read the information contained in this document and agree to abide by its terms during our professional relationship I have discussed it with my psychotherapist and all of my questions have been answered to my satisfaction. Signature of patient/parent/guardian: *

_____

68. Relationship to patient: *

69. Date: *

Example: January 7, 2019

Late Cancellation Policy

At Lifesong Counseling, we are committed to providing quality mental health care and support to our clients. In order to maintain the continuity and quality of our therapeutic services, and to allow the practitioners to manage their schedules most effectively, we have established a cancellation policy regarding therapy sessions scheduled with our licensed therapists and mental health professionals.

Cancellation of Therapy Appointments

We understand that unforeseen circumstances may arise, requiring the need to cancel a scheduled therapy session. Clients are encouraged to provide at least 48 hours' notice if they need to cancel or reschedule an appointment.

If a client cancels a therapy session with less than 48 hours' notice, this will be considered a "Late Cancellation."

The client will be responsible for payment of a $50 Late Cancelation fee each time an appointment is canceled with less than 48 hours' notice.

If a client accumulates two Late Cancellations within a three-month period for their scheduled therapy sessions, we may require a consultation between the client and their therapist to ensure that the treatment plan and care provided are still appropriate for the client's needs. This consultation is designed to maintain the quality and continuity of care.

The consultation may include a discussion between the client and their therapist to understand the reasons for the Late Cancellations and evaluate whether the current treatment approach remains suitable. The goal is to address any potential barriers to attendance and work collaboratively to find solutions.

We acknowledge that emergencies and unforeseeable situations may occur. In cases of emergencies or extenuating circumstances, clients are encouraged to contact their therapist as soon as possible, and we will work together to find a suitable solution.

Clients are welcome to reschedule their therapy sessions
within the 48-hour notice period, subject to their therapist's availability.

Our cancellation policy is designed to maintain the quality
and consistency of care provided to our clients while respecting the challenges
life may present. We encourage open communication and collaboration between
clients and therapists to ensure that the treatment plan and therapeutic
relationship remain effective. It is our sincere hope that this policy supports
our clients in their journey toward improved mental health and well-being.

70. I have read and understood the Lifesong Counseling "No-Show" Policy as described above. *

_____

71. Relationship to patient: *

_____

72. Date: *

_____
Example: January 7, 2019

Release of Information

Authorization for Use or Disclosure of Protected Health Information

73. Is there anyone we need to release or receive records from? *

Mark only one oval.

- ◯ Yes
- ◯ No

74. I authorize Lifesong Counseling to release my information to (Name):

_____

75. Address of recipient:

_____

_____

_____

_____

_____

76. Phone of recipient:

_____

Lifesong Counseling will only release documents originated by Lifesong Counseling.

77. Client Initial for verbal and/or written information to be released and/or received (Check all that apply):

Check all that apply.

- [ ] Clinical Assessment
- [ ] Diagnostic Impressions
- [ ] Treatment Plan
- [ ] Discharge Summary
- [ ] Progress Notes
- [ ] Other: _____

78. Purpose or need for disclosure:

Mark only one oval.

- ◯ Treatment planning
- ◯ Billing Purposes
- ◯ Relay of information to guardians

79. I understand that my records are protected under the Federal and Specific State confidentiality laws and regulations and cannot be disclosed without my written consent, unless otherwise provided for in the regulations. I also understand that I may, in writing, revoke this consent at any time, except to the extent that action has been taken in reliance on it (such as the provision of treatment upon consent to disclose to third-party payers) or after the occurrence of a specified ascertainable event (such as release from probation or parole). In any event, this consent expires automatically as described below. I acknowledge that the information released was fully explained to me and this consent is given of my own free will. The information I authorize for release may include records which may indicate the presence of substance abuse or communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, or the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome.

Mark only one oval.

- ◯ Yes
- ◯ No

80. This consent expires on (or no later than termination of treatment):

_____

Example: January 7, 2019

81. Today's Date:

_____

Example: January 7, 2019

82. Signature:

_____

83. Witness Signature:

_____

TO RECIPIENT:

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal and State regulations prohibit you from making any further disclosure of it without the express written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Financial Agreement

This office will provide insurance billing services as a courtesy to you. Remember that you are ultimately responsible for any charges incurred in this office. It is your legal responsibility to pay any deductible amount, co-insurance and/or other balances not paid by your insurance carrier. Your signature on this form indicates that you agree to pay for any outstanding charges incurred in this office.

Clients who do not have health insurance:

You are responsible for the full cost of services. Payment is due at the time of service. You may negotiate with your therapist for a reduced fee if necessary.

Clients with insurance may incur three types of balances after insurance has paid:

1. Dedutible: The amount you must pay before your insurance starts covering any services.

2. Co-pay: The insurance has a stated amount that you pay for each visit. You pay your co-pay at the time of service. We will bill your insurance for the remaining balance. You may have to meet a deductible before your insurance starts charging only co-pays.

3. Co-insurance: The insurance has stated your cost of service based on a percentage of the covered charges (for example, insurance pays 80% and you pay 20%). You may have to meet a deductible before your insurance starts charging only co-insurance. Payment of deductible and co-insurance is due at the time of service.

We will strive to work out feasible payment arrangements.

Unless other prior arrangements have been made, any outstanding balance over 60 days old will be considered delinquent. A re-billing fee of 1% (based on the outstanding balance) may be added to accounts that fit these criteria. Office policy dictates that delinquent accounts may be referred for collection which may include possible blemishes on your credit record.

If your insurance denies payment for any reason, charges for services become your responsibility, and you agree to pay for any outstanding charges incurred.

"No Shows"

If you do not show up for your appointment and have not cancelled or rescheduled without at least 24 hours' notice, you will be charged a fee of $50.00.

84. I authorize payment of insurance benefits directly to Lifesong Counseling AND I authorize the clinician to release any treatment information necessary to process Medicaid/Insurance claims. By signing below, I indicate that I have read, understand and agree with the terms on this page. Sign: *

85. Date: *

Example: January 7, 2019

Payments

Lifesong prefers that you keep a credit card on file. That card will be charged for any balances on Sunday mornings. We will call you before the first charge is taken. If you will not be paying by credit card you will need to pay at time of service by cash or check. If you will be using a credit or debit card for payment to Lifesong please provide the following information: Card should be charged.

86. Cardholder Name *

87. Client Name *

88. Credit/Debt Card Type (Visa, Mastercard, Discover, etc): *

89. Credit Card Number *

90. Expiration Date (mm/yy): *

91. CVV Code: *

92. Cardholder Zip Code from card billing address: *

Health Insurance Claim Form

Lifesong submits claims electronically and/or on paper using a HCFA 1500 form. You may ask to review this form at any time.

93. AGREEMENT TO BILL CLAIMS. Patient's or authorized person's signature: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government or commercial benefits to the party who accepts assignment below. Sign: *

94. Date: *

Example: January 7, 2019

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