MILESTONE COUNSELING

ADULT INTAKE FORM

(Please Print)

Date: / /	How did you hear about us?		
❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss. ❑ Dr. ❑ Rev.	Full Name *(Last)*	(First)	(Middle)

Nick Name:	Name You Prefer:	Birth date: / /	Age:	Sex: ❑ M ❑ F
Parent/Guardian/Power of Attorney: (if applicable)	Social Security# (Insurance clients only) - -	Race: ❑ White ❑ Asian ❑ Black ❑ Other: _____ ❑ Hispanic		

CONTACT INFORMATION

Street address:		Suite/Apartment Number:	
City:	State:	ZIP Code:	May We Send Mail Here: ❑ Yes ❑ No
Mailing Address or Post Office Box:			
City:	State:	ZIP Code:	May We Send Mail Here: ❑ Yes ❑ No

Home Phone:	( )	May We Leave a Message Here: ❑ Yes ❑ No
Mobile Phone:	( )	May We Leave a Message Here: ❑ Yes ❑ No
Work Phone:	( )	May We Leave a Message Here: ❑ Yes ❑ No
Email Address:	( )	May We Send Email Here: ❑ Yes ❑ No

EMERGENCY CONTACT

Name:	Relationship:
Home Phone: ( )	Mobile Phone: ( )

EMPLOYMENT INFORMATION

Employer:	Length of Employment:
Occupation:	Average Hours Worked Per Week:

Annual Combined Household Income :

❑ Below $80,000 ❑ $80,001 to $90,000 ❑ $90,001 to $100,000
❑ $100,001 to $110,000 ❑ $110,001 to $120,000 ❑ $120,001 to $130,000
❑ $130,001 to $140,000 ❑ $140,001 to $150,000 ❑ Above $150,000

EDUCATION INFORMATION

(Circle) Last Year of School Completed: 9 10 11 12 GED	College: 1 2 3 4	Other: _____
Are You Currently in School? ❑ Yes ❑ No	If Yes, What School:	

RELATIONAL INFORMATION

Current Status: ❑ Single ❑ Dating ❑ Engaged ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Living together	Are You Content with Your Current Status? ❑ Yes ❑ No If No, Briefly Explain:

If Married, How Long: _____ Number of Previous Marriages for You: _____ For Your Partner: _____

If Separated or Divorced, How Long: _____ If Widowed, How Long: _____

MILESTONE COUNSELING

Partner's Name *(Last, First, Middle)*:	❑ Mr. ❑ Ms. ❑ Miss.	❑ Mrs. ❑ Dr. ❑ Rev.

How long Have You Known Your Partner: _____	Age: _____	Preferred Name: _____

Partner's Race: ❑ White ❑ Asian ❑ Black ❑ Other: _____ ❑ Hispanic	Partner's Sex: ❑ M ❑ F	Partner's Occupation: _____ Average Hours Worked Per Week: _____

(Circle) Last Year of School Partner Completed: 9 10 11 12 GED	College: 1 2 3 4	Other: _____

What Words Would You Use to Describe Your Partner: _____

_____

_____

Is Your Partner Supportive of You Seeking Counseling: ❑ Yes ❑ No ❑ Unsure ❑ Partner Doesn't Know	With Whom Do You Currently Live *(Check All that Apply)*: ❑ Alone ❑ Boyfriend ❑ Spouse ❑ Children ❑ Girlfriend ❑ Roommate ❑ Parent(s) ❑ Sibling(s) ❑ Other: _____

CHILDREN

List Your Children (Living or Deceased):

Name	Sex	Current Age or Year of Death	Relationship to You *Natural, Adopted, Step*	Living with You?	Describe Him/Her

Have You Ever Placed a Child for Adoption: ❑ Yes ❑ No If Yes, When: _____

Have You Ever Had a Miscarriage or Medical Abortion: ❑ Yes ❑ No If Yes, When: _____

FAMILY OF ORIGIN

List Mother, Father, Brothers, Sisters, Step Family, & Any Other Family Members who Affected You Positively or Negatively:

Name	Sex	Current Age or Year of Death	Relationship to You *(Mom, Dad, Sibling, Step)*	Occupation	Describe Him/Her

PRIMARY PHYSICIAN INFORMATION

Primary Physician: Phone: ( )

Address: City: Zip:

Specialty *(e.g. Family Practice, OB/GYN, Internal Medicine)*: Date of last physical:

Are You Currently Receiving Medical Treatment: ❑ Yes ❑ No If Yes, Please Specify: _____

List Any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas or Related Treatments You Have Had *(Use Back if Necessary)*: _____

_____

MEDICATIONS

List All Current Medications You Are Taking, Including those You Seldom Use or Take Only as Needed *(Use Back if Necessary):*

Medication: _____ Dosage: _____ ❑ Improves ❑ Prevents ❑ Controls: _____

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Are You Taking these Medication(s) According to Your Doctor's Recommendations: ❑ Yes ❑ No

If No, Briefly Explain: _____

PHYSIOLOGICAL SYMPTOMS

Please Check Any of the Following Physiological Symptoms/Sensations that Apply to You Presently, or in the Recent Past:

Headaches ❑ Past ❑ Present	Dizziness ❑ Past ❑ Present	Stomach Trouble ❑ Past ❑ Present
Visual Trouble ❑ Past ❑ Present	Sleep Trouble ❑ Past ❑ Present	Trouble Relaxing ❑ Past ❑ Present
Weakness ❑ Past ❑ Present	Tension ❑ Past ❑ Present	Rapid Heart Rate ❑ Past ❑ Present
Difficulty Breathing ❑ Past ❑ Present	Intestinal Trouble ❑ Past ❑ Present	Hearing Noises ❑ Past ❑ Present
Change in Appetite ❑ Past ❑ Present	Tiredness ❑ Past ❑ Present	Pain ❑ Past ❑ Present
Hearing Voices ❑ Past ❑ Present	Seeing Things ❑ Past ❑ Present	Other ❑ Past ❑ Present

Your Height: _____ Your Weight: _____ How has Your Weight Change in the Last 2-3 Months: _____

CURRENT STATUS

Please Check Any of the Following Problems which Pertain to You:

Stress ❑ Past ❑ Present	Nervousness ❑ Past ❑ Present	Anxiety ❑ Past ❑ Present
Panic ❑ Past ❑ Present	Unhappiness ❑ Past ❑ Present	Depression ❑ Past ❑ Present
Guilt ❑ Past ❑ Present	Apathy ❑ Past ❑ Present	Terminal Illness ❑ Past ❑ Present
Recent Death ❑ Past ❑ Present	Grief ❑ Past ❑ Present	Hopelessness ❑ Past ❑ Present
Inferiority Feelings ❑ Past ❑ Present	Defective Feelings ❑ Past ❑ Present	Loneliness ❑ Past ❑ Present
Shyness ❑ Past ❑ Present	Fears ❑ Past ❑ Present	Friends ❑ Past ❑ Present
Marriage ❑ Past ❑ Present	Communication ❑ Past ❑ Present	Physical Abuse ❑ Past ❑ Present
Emotional Abuse ❑ Past ❑ Present	Verbal Abuse ❑ Past ❑ Present	Sexual Abuse ❑ Past ❑ Present
Temper ❑ Past ❑ Present	Anger ❑ Past ❑ Present	Aggressiveness ❑ Past ❑ Present
Bad Dreams ❑ Past ❑ Present	Concentration ❑ Past ❑ Present	Racing Thoughts ❑ Past ❑ Present
Unwanted Thoughts ❑ Past ❑ Present	Memory ❑ Past ❑ Present	Loss of Control ❑ Past ❑ Present
Impulsive Behavior ❑ Past ❑ Present	Self-Control ❑ Past ❑ Present	Compulsivity ❑ Past ❑ Present
Sexual Problems ❑ Past ❑ Present	Pregnancy ❑ Past ❑ Present	Abortion ❑ Past ❑ Present
Legal Matters ❑ Past ❑ Present	Trauma ❑ Past ❑ Present	Eating Problems ❑ Past ❑ Present
Drug Use ❑ Past ❑ Present	Alcohol Use ❑ Past ❑ Present	Trouble with Job ❑ Past ❑ Present
Career Choices ❑ Past ❑ Present	Ambition ❑ Past ❑ Present	Making Decisions ❑ Past ❑ Present
Children ❑ Past ❑ Present	Being a Parent ❑ Past ❑ Present	Finances ❑ Past ❑ Present
Recent Loss ❑ Past ❑ Present	Disaster ❑ Past ❑ Present	Smoke Cigarettes ❑ Past ❑ Present
Self-Harm ❑ Past ❑ Present	Hi Risk Behavior ❑ Past ❑ Present	Zoning/blanking out ❑ Past ❑ Present

LEVEL OF DISTRESS

Indicate How Distressed You Are by Placing an "X" on the Scale Below (1 = Very' Little Distress; 10 = Extreme Distress):

1 2 3 4 5 6 7 8 9 10

Are You Currently Having Any Suicidal Thoughts? ❑ Yes ❑ No Have You Had Them in the Past? ❑ Yes ❑ No

Have You Ever Attempted Suicide: ❑ Yes ❑ No If Yes, When and How: _____

Have Any of Your Friends or Family Ever Committed or Attempted Suicide: ❑ Yes ❑ No

If Yes, When and Who: _____

PRESENTING ISSUES AND GOALS

Please Describe Why You Are Coming to Counseling (i.e. What Are Your Issues, Problems?): _____

_____

Why Have You Decided to Come for Counseling Now: _____

_____

What Do You Hope to Gain or Change by Coming for Counseling:

_____

How Long Do You Believe Counseling Should Last: _____

_____

Activities, Interests and Strengths:

1. What are your Strengths? _____
2. What are your Needs? _____
3. What are your Abilities? _____
4. What are your Preferences, if any? _____

What issues could inhibit progress towards treatment? _____

_____

During the last 12 months, any behaviors concerning to you when trying to stop/cut down on spending? Describe briefly:

_____

During the last 12 months, have you experienced challenges with avoiding family/friends from observing how much you are spending? Describe briefly: _____

_____

PREVIOUS COUNSELING

List Any Previous Counseling, Psychiatric Treatment, or Residential/In-Patient Care You Have Received *(Use Back If Necessary)*:

Therapist: _____ Location: _____ Dates: _____ Reason: _____

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RELIGIOUS BACKGROUND

Please describe your religious involvement if any. Are there any special religious, cultural or ethnic considerations we should be aware of?

_____

Church attendance? If so, what is the name? _____

Would you like spiritual principles incorporated into your counseling? ❑ Yes ❑ No

If yes, at what level? ❑ Minimally ❑Occasionally ❑ Often ❑ Very Often ❑ Intensively

TERMS OF SERVICE

I hereby give Milestone Counseling permission to provide counseling services for the patient mentioned above:

Signed: _____ Date: _____

FINANCIAL POLICY

Payment Policy:
We are committed to providing you with the best possible care. Payment for service (including co-payments) are **due at the time of service**.
It is essential that you compete these forms in their entirety and provide Milestone Counseling with all the necessary information regarding **ALL** your insurance providers.
Our fees:

- Your Sessions are _____per hour per fee schedule and policies
- Groups are $_____ per hour.
- Additional counselor Service: Treatment Summary Requests, Professional Letters, Emails or Phone/Conference calls, if requested, will be billed in 15minute increments at the your therapeutic rate listed above.
- Administrative Services by staff: Letters from the front office, insurance forms, authorization requests will be billed a $15 per 15 minutes of billable services with a $15 minimum.
- Court Appearances and Depositions are billed door to door at $300 per hour with a minimum $1000 retainer.
- Returned checks are subject to a $30 fee.
- No-show fees are charged for appointments canceled or broken without 24 hours advance notice unless there is an emergency or illness. The no-show fee is equivalent to your normal session fee.
- Insurance clients who accrue 3 no call/late call (less than 24 hours notice) or no shows for appointments may have services terminated.
- In the event there are changes to the client's insurance plan(s), co-pays, deductibles, and/or charges not paid by insurance are the responsibility of the client. A credit/debit card authorization form will be provided to pay for these charges.

Policy on Insurance Reimbursement:
If you have Insurance that provides coverage for mental health counseling, we can help you receive your maximum allowable benefits.

We will be happy to provide you with a receipt to forward to your insurance company. You are responsible for generating the claim and mailing it to the insurance company and tracking your reimbursement.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are considered to fall within the acceptable range by most companies, called "Usual, Customary and Reasonable" (UCR). Some companies pay a percentage of the UCR for a given area. However, some companies reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. If your company requests a report from us in order to process your claim, we will need to receive our normal hourly fee from you for this service.

Rate Calculation Policy:

- Mandated counseling is subject to a $20 per hour surcharge, couples & family counseling a $10 per hour surcharge, below $50,000 household income, & a $20 per hour surcharge, above $60,000 household income.
- Mediation services are billed at $140.00 per hour.
- Late evening appointments, 6 p.m. & later, will be subject to a $20 per hour surcharge
- Fees listed are for one clinical one hour. Longer sessions are calculated by .5 hour increments
- Hourly fees are calculated and based on previous year's total household income and/or support from all sources including, but not limited to, hourly wages, salaries, bonuses, investment income, Social Security, disability, retirement income, child support, alimony, welfare, unemployment compensation, food stamps, public or private childcare assistance, company vehicle, public or private housing assistance, board, etc.
- Proof of income may be required. All financial information kept confidential.
- Discounts for multiple clients or weekly sessions, from the same family, may be arranged on a case by case basis.

Signature_____ Date _____

Informed Consent & Release of Liability

This form is to document that I (please print)_____ give my consent and

permission for Milestone Counseling to provide mental health therapy services to myself and/or

(please print) _____, who is my child or for whom I am legal guardian, custodian, or legal Power of Attorney.

I have been made aware of and understand the following:

- ❑ Although I expect benefits from this treatment, such benefits or particular outcomes cannot be guaranteed.
- ❑ Due to the counseling or therapy, I may experience emotional strains, feel worse during treatment, and make life changes that could be distressing.
- ❑ This therapist is not providing an emergency service, and I have been informed of whom to call in an emergency or during weekend and evening hours.
- ❑ Regular attendance will produce maximum benefits, but I am free to discontinue treatment at any time.
- ❑ Conversations with the therapist will be almost always confidential. However, the therapist, by law, must report actual or suspected child, spouse, or elder abuse to the appropriate authorities. The therapist also has a legal responsibility to protect anyone I may threaten with violence, harmful, or dangerous actions (including those to myself) and may break the confidentiality of our communications if such a situation arises. The therapist will make reasonable efforts to resolve these situations before breaking confidentiality.
- ❑ I am financially responsible for this treatment and any portion of the fees not reimbursed or covered by insurance are payable by me.
- ❑ I have been informed that for the protection of clients and therapists, all sessions with persons under the age of 18 may be videotaped.
- ❑ I know of no reasons that I should not undertake this therapy and I agree to participate fully and voluntarily.
- ❑ I acknowledge that I have the right to request a printed copy of the Milestone Counseling Client Handbook.
- ❑ I have read and received the Office Policies & General Information Agreement for Psychotherapy Services and I agree to the policies. I have also received a copy of the HIPAA Notice of Privacy Practices. I have discussed any concerns about the policies with the therapist prior to signing this consent.

Signature: _____ Date: _____
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NOTICE OF PRIVACY PRACTICES

This Notice Describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this document carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIP AA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIP AA provides penalties for covered entities that misuse personal health information. As required by HIP AA, we have prepared this explanation of I how we are required to maintain the privacy of your health information and how we may use and disclose your health information.
Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations.

- ***Treatment*** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc.
- ***Payment*** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services.
- ***Health Care Operations*** include-the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

  In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information; to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

  Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

- You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:
  - The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
  - The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
  - The right to request an amendment to your PROTECTED HEALTH INFORMATION.
  - The right to obtain a paper copy of this notice for us upon request. We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:
The Privacy Officer of Milestone Counseling
205 Hatteras Ave.
Clermont Fl. 34711
352-348-8858

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C 20201
877.696.6775 (toll-free)

KEEP FOR YOUR RECORDS

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us.

This authorization can be used to settle any outstanding balances due, co-payments, deductibles, fees and/or charges not provided by insurance.

For your convenience, this form can be used to pay for sessions in advance, out of office appointments and/or to create a payment plan. This form will remain on file until completion of therapy and payments have been fully processed.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX □ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____ CVV:
Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize_____to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.