



ANDOVER < DERBY < GODDARD < NEWTON < WICHITA <
WINNETKA

TODAY'S DATE _____

IDENTIFICATION

Client's Name: _____ DOB: _____ Age: _____

Client's Nicknames or Aliases: _____ Social Security# _____

Home Street Address: _____ Apt.#: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ I give my permission to be called at this number: Yes No

Work Phone: _____ I give my permission to be called at this number: Yes No

I give my permission to receive the FirstStep newsletter, *Thriving*, by email: _____
Email Address

CURRENT EMPLOYER

If child, school attended _____

Name _____ Address: _____

SPOUSE / SIGNIFICANT OTHER or PARENT

Name: _____ DOB: _____ Age: _____

Employer _____ Address: _____

EMERGENCY CONTACT PERSON

Name: _____ Phone _____

Address _____

REFERRED BY:

Name _____ Address _____

I give my permission for my therapist to thank this person, Yes No

FINANCIALLY RESPONSIBLE PERSON (if other than client)

Name: _____ DOB: _____ S.S.# _____

Address _____ Phone _____

Employer _____ Phone _____

Relationship to Client _____

PRIMARY INSURANCE *Need copy of card!*

Policy Holder _____ DOB _____ SS# _____

Insurance Company _____ I.D. # _____ Group # _____

OTHER INSURANCE *Need copy of card!*

I/We have no other insurance

Policy Holder _____ DOB _____ SS# _____

Insurance Company _____ I.D. # _____ Group # _____

FAMILY PHYSICIAN or PRIMARY CARE PHYSICIAN (PCP) Phone _____

Name: _____ City _____

The above information is true and accurate. If any of the information changes, I will immediately notify my therapist

Signature _____



COORDINATION OF BENEFITS.

DO YOU OR YOUR FAMILY MEMBERS HAVE OTHER INSURANCE? **YES NO** (circle one)
IF "NO": COMPLETE SECTION "A" AND SIGN AT THE BOTTOM OF THIS FORM.
YOU DO NOT NEED TO PROVIDE OTHER INFORMATION

A. EMPLOYEE INFORMATION

Employee's Name

Last	First	MI	Soc.Sec. #	Date of Birth mm/dd/yyyy	Gender
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Mailing Address

Street	City	State	Zip
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B. DEPENDENT INFORMATION

Spouse's Name

Last	First	MI	Soc. Sec. #	Date of Birth mm/dd/yyyy	Gender
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Dependent Children or Sponsored Dependents

Gender

Date of Birth mm/dd/yyyy

1		
2		
3		
4		

C. OTHER INSURANCE POLICIES

Name of Insurance Company	Identification Number	Group Number
Name of Policy Holder	Date of Birth	Soc. Sec. #
Coverage Effective Date	Insurance Telephone Number	Claims Address

Name of Insurance Company	Identification Number	Group Number
Name of Policy Holder	Date of Birth	Soc. Sec. #
Coverage Effective Date	Insurance Telephone Number	Claims Address

Do any dependent children have other medical coverage according to a divorce decree? If YES, complete section E.
Does Medicare cover your spouse or any children/sponsored dependent(s)? If YES, complete Section D.

D. MEDICARE INFORMATION

Name	Policy Number	Part A	Part B	Age 65?	Disability ?
Name	Policy Number	Part A	Part B	Age 65?	Disability ?

E. DEPENDENT CHILDREN COVERED UNDER DIVORCE DECREE OR COURT ORDER

Name	Gender	Relationship	Parent with Primary Responsibility for Medical Expenses	Date decree was effective
Insurance Company	Policy Number	Group Number		Parent w/whom child lives

Name	Gender	Relationship	Parent with Primary Responsibility for Medical Expenses	Date decree was effective
Insurance Company	Policy Number	Group Number		Parent w/whom child lives

I certify that the above information is true and correct to the best of my knowledge and belief

Date	Participant Signature	Provider Signature (optional)
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Client: _____ SS# _____ Date _____

CHECKLIST OF CONCERNS

Please mark all the items that apply to you or someone in your life:

- | | | |
|--|--|--|
| <input type="checkbox"/> No problems or concerns | <input type="checkbox"/> Grieving | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Abuse | <input type="checkbox"/> Guilt | <input type="checkbox"/> Panic |
| <input type="checkbox"/> Affairs | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Parenting |
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Hallucinogens (LSD, PCP) | <input type="checkbox"/> Perfectionism |
| <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pessimism |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Ambivalent feelings | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Physical abuse |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Homicidal thoughts | <input type="checkbox"/> Physical health |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hormones | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Attention | <input type="checkbox"/> Hostility | <input type="checkbox"/> Poor concentration |
| <input type="checkbox"/> Backaches | <input type="checkbox"/> Impulsiveness | <input type="checkbox"/> Prescription drug use |
| <input type="checkbox"/> Birth control pills | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Procrastination |
| <input type="checkbox"/> Bruise or bleed easily | <input type="checkbox"/> Inferiority feelings | <input type="checkbox"/> Rage |
| <input type="checkbox"/> Can't have fun | <input type="checkbox"/> Infidelity | <input type="checkbox"/> Relationship problems |
| <input type="checkbox"/> Career concerns/goals/choices | <input type="checkbox"/> Insecurity | <input type="checkbox"/> Remarriage |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Responsibility |
| <input type="checkbox"/> Childhood issues | <input type="checkbox"/> Interpersonal conflicts | <input type="checkbox"/> Risk taking |
| <input type="checkbox"/> Children | <input type="checkbox"/> Illness | <input type="checkbox"/> Sadness |
| <input type="checkbox"/> Childcare | <input type="checkbox"/> Irritability | <input type="checkbox"/> School problems |
| <input type="checkbox"/> Cocaine/crack use | <input type="checkbox"/> Irresponsibility | <input type="checkbox"/> Self-centeredness |
| <input type="checkbox"/> Co-dependence | <input type="checkbox"/> Isolation | <input type="checkbox"/> Separation |
| <input type="checkbox"/> Coffee | <input type="checkbox"/> Job losses | <input type="checkbox"/> Self-esteem |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Judgment problems | <input type="checkbox"/> Self-neglect |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Lack of enjoyment | <input type="checkbox"/> Sexual abuse |
| <input type="checkbox"/> Compulsions | <input type="checkbox"/> Lack of motivation | <input type="checkbox"/> Sexual issues |
| <input type="checkbox"/> Cruelty to animals | <input type="checkbox"/> Lawsuits | <input type="checkbox"/> Shakiness |
| <input type="checkbox"/> Custody of children | <input type="checkbox"/> Laxative use | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Crying | <input type="checkbox"/> Legal matters | <input type="checkbox"/> Shyness |
| <input type="checkbox"/> Debt | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Sleep too much |
| <input type="checkbox"/> Decision-making | <input type="checkbox"/> Losses | <input type="checkbox"/> Smoking/tobacco use |
| <input type="checkbox"/> Delusions (false ideas) | <input type="checkbox"/> Loss of control | <input type="checkbox"/> Social isolation |
| <input type="checkbox"/> Dependence | <input type="checkbox"/> Low energy | <input type="checkbox"/> Spending |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Low income | <input type="checkbox"/> Stimulants |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Management of children | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Marital conflict | <input type="checkbox"/> Street drug use |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Marijuana use | <input type="checkbox"/> Suspiciousness |
| <input type="checkbox"/> Diet issues | <input type="checkbox"/> Medical problems | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Diuretic use | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Suicidal actions |
| <input type="checkbox"/> Diet pills | <input type="checkbox"/> Menopause | <input type="checkbox"/> Temper problems |
| <input type="checkbox"/> Earaches | <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Thought disorganization |
| <input type="checkbox"/> Early morning awakening | <input type="checkbox"/> Mourning | <input type="checkbox"/> Threats |
| <input type="checkbox"/> Eat junk food | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Tiredness |
| <input type="checkbox"/> Eating problems | <input type="checkbox"/> Narcotics | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Employment | <input type="checkbox"/> Nausea | <input type="checkbox"/> Undereating |
| <input type="checkbox"/> Emotional abuse | <input type="checkbox"/> Negative thinking | <input type="checkbox"/> Violence |
| <input type="checkbox"/> Emptiness | <input type="checkbox"/> Neglect (children or elderly) | <input type="checkbox"/> Vitamins |
| <input type="checkbox"/> Ex-spouse | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Failure | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Weight problems |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Obsessions | <input type="checkbox"/> Work problems |
| <input type="checkbox"/> Fears | <input type="checkbox"/> Outbursts | <input type="checkbox"/> Workaholism |
| <input type="checkbox"/> Financial problems | <input type="checkbox"/> Overeating | |
| <input type="checkbox"/> Fitful sleep | <input type="checkbox"/> Oversensitivity | |
| <input type="checkbox"/> Friendships | <input type="checkbox"/> Over-the-counter drug use | |
| <input type="checkbox"/> Gambling | <input type="checkbox"/> Physical pain | |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Painkillers | |



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AGREEMENT FOR THERAPEUTIC SERVICES

As a client of FirstStep Counseling, Inc., you have certain rights and responsibilities. Those rights and responsibilities are outlined below. Each family member, 13 years of age and older in the client family, should read and check each box on this form. Signing the form indicates acceptance of these terms for services.

- I have the right to ask questions about my therapy. If I request, my therapist will explain his/her therapy approach and methods used, as well as the Code of Ethics under which he/she practices.
- I have the right to end therapy at any time without moral, legal or financial obligations, other than those already incurred. If I make a decision to stop therapy, I will schedule a final session to explore my decision, as this can be a helpful process for me. If a referral to another therapist is desired, it will be made for me at this time.
- I have the right to specify and negotiate therapeutic goals, and to renegotiate when necessary.
- I have the right to be fully informed about fees for therapy and the methods of payment available.
- In working to achieve the potential benefits of therapy, it may require that I make firm efforts to change and may involve experiencing significant discomfort. Remembering and therapeutically resolving unpleasant events can arouse many intense feelings, such as fear, anger, depression, frustration, and hurt. Seeking to resolve issues between family members, marital partners, and in other relationships, can also lead to discomfort, as well as changes that may not have originally been intended. I understand that the results of therapy vary and no promises have been made to me regarding the results of treatment provided.
- Appointments are scheduled for 45 to 50 minutes, known as a “clinical hour.” The remaining 10 minutes of the “clock” hour are used by my therapist to maintain my file and other activities related to my therapy process. Because the appointment time is reserved for me, it is necessary for my therapist to charge for appointments that are cancelled less than 24 hours in advance, unless there are circumstances that both my therapist and I define as an emergency. If I must reschedule, I will notify FirstStep Counseling, Inc. as far in advance as possible.
- I have the responsibility to provide my therapist with accurate information as to how he/she might best help me, and to keep my therapist advised of my needs throughout the therapeutic process.
- By signing this form, I am authorizing my therapist to discuss case information, as needed, with FirstStep Counseling colleagues, and my therapist’s Clinical Supervisor/Consultant, if applicable. Specific identifying details will not be included.
- Under Kansas law, my therapist is required to consult my primary care physician or psychiatrist to determine if there is any medical condition or medication that is contributing to my presenting symptoms, and to coordinate delivery of healthcare services. You may waive this consultation by signing this blank. If I do not sign this blank, I am granting permission for my therapist to both secure information from my physician and/or psychiatrist and release pertinent therapy information to them.

I have read this Agreement for Therapeutic Services and will receive a copy per my request. I understand the services and practice policies of FirstStep Counseling, Inc. and by signing this form, I accept these terms.

Client _____ Date _____

Client _____ Date _____

I have presented the issues above to my client(s). My observations of his/her behavior(s) and responses give me no reason to believe that he/she is not fully competent to give informed and willing consent.

Therapist _____ Date _____



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CONSENT TO USE OR DISCLOSE HEALTH INFORMATION

I authorize FirstStep Counseling, Inc., to use and disclose my mental health information for the purposes of treatment, payment, and health care operations.*

* Treatment includes:

1. Activities performed by a mental health provider and his/her staff in providing care for you
2. Coordinating or managing your care with third parties
3. Consultations with and between other care providers

This consent includes treatment provided by any provider covering FirstStep Counseling's practice by telephone as the on-call therapist.

* Payment includes:

1. Activities involved in determining your eligibility for health plan coverage
2. Billing and receiving payment for your health benefit claims
3. Utilization management activities which may include review of care services
4. Justification of charges
5. Pre-certification and pre-authorization.

* Health Care Operations includes:

1. Necessary administrative and business functions of our office, which may include providing information to governmental agencies to maintain compliance with existing laws
2. Reviewing charts to assure quality assurance and proper staff supervision.

You may review FirstStep Counseling's "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent. Please verify that you have received a copy of our Notice by placing your initials here: _____

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other therapists who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

I understand that I have the right to revoke this Consent provided that I do so in writing, except to the extent that the therapist has already used or disclosed the information in reliance on this Consent.

Signature of Client or Client Representative

Signature of Client or Client Representative

Date

Date



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MINISTERS

Effective Date: April 14, 2003
NOTICE OF PRIVACY PRACTICES

This notice describes how mental health information about you may be used and disclosed, and how you can gain access to this information.

If you have any questions about this notice, please contact the Privacy Officer of FirstStep Counseling at 262-5253.

WHO WILL FOLLOW THIS NOTICE

This notice describes the practices followed by FirstStep Counseling therapists and office staff regarding information gathered about you through the course of assessment and treatment.

YOUR MENTAL HEALTH INFORMATION

This notice applies to the information and records we have about your mental health treatment and services you receive at this office. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose mental health information about you and describe your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE & DISCLOSE MENTAL HEALTH INFORMATION ABOUT YOU

We must have your written, signed consent to use and disclose mental health information for the purposes listed below. The policy at FirstStep Counseling, Inc., is to ask your permission before releasing information to anyone outside of our agency (except when services are provided in response to a court order), and to release the minimum amount of information to achieve the intended purpose.

For Treatment: We may use mental health information about you to provide you with treatment or services. We may disclose information about you to office staff or other personnel who are involved in taking care of you. Personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as assisting you to schedule an appointment with a psychiatrist.

For Payment: We may use and disclose mental health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about a service you received so that your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Operations: We may use and disclose mental health information about you in order to run the office and make sure that you and our other clients receive quality care. For example, we may use your mental health information to evaluate the performance of our staff in caring for you. We may also use mental health information about all or many of our clients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders: We may contact you as a reminder that you have an appointment for treatment at the office. Please notify us if you do not wish to be contacted for appointment reminders.

You may revoke your consent at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures that occurred before that time.

If you revoke your consent, we will not be permitted to use or disclose information for purposes of treatment, payment or operations, and we may, therefore, choose to discontinue providing you with treatment and services.

SPECIAL SITUATIONS

We may use or disclose information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety: We may use and disclose information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required by Law: We will disclose mental health information about you when required to do so by federal, state or local law.

Workers' Compensation: We may release mental health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness. When you request such benefits, access to related information is assumed.

Oversight Activities: We may disclose mental health information to a mental health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliances with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose information about you in response to a subpoena.

Information Not Personally Identifiable: We may use or disclose information about you in a way that does not personally identify you or reveal who you are.

OTHER USES AND DISCLOSURES OF MENTAL HEALTH INFORMATION

We will not use or disclose your mental health information for any purpose other than those identified in the previous sections without your specific, written Authorization. We must obtain your Authorization separate from any Consent we have obtained from you. If you give us Authorization to use or disclose information about you, you may revoke the Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a written and signed Authorization from you. In order to disclose these types of records for purposes of treatment, payment or operations, we will have to have both your signed Consent and a special written Authorization that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING MENTAL HEALTH INFORMATION ABOUT YOU

Right to Inspect and/or Copy: You have the right to inspect and/or copy your mental health information that we use to make decisions about your care. There are limitations to this right. For example, you do not have the right to view therapy notes made by your therapist or material that is being accumulated in anticipation of a legal or court action.

You must submit a written request to your therapist in order to inspect and/or copy your mental health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy, in certain limited circumstances.

If you are denied access to your mental health information, you may ask that the denial be reviewed. If law requires such a review, the Privacy Officer will review your request and the therapist's denial.

Right to Amend: If you believe information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as this office keeps the information.

To request an amendment, complete and submit a Record Amendment/Correction Form to the Privacy Officer. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- We did not create, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the information that we keep
- You should not be permitted to inspect and copy
- Is accurate and complete

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of information about you for purposes other than treatment, payment and operations. Information disclosed pursuant to a written Authorization from you, will not be logged. To obtain this list, you must submit your request in writing to the Privacy Officer. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. There is no charge for providing the list.

Right to Request Restrictions: You have the right to request a restriction or limitation on the information we use or disclose about you for treatment, payment or operations. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may complete and submit the Request for Restriction On Use/Disclosure of Protected Health Information to the Privacy Officer.

Right to Request Confidential Communications: You have the right to request that we communicate to you about mental health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you may complete and submit the Request for Restriction On Use/Disclosure of Protected Health Information and/or Confidential Communication to the Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for information we already have about you, as well as, any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Privacy Officer at 262-5253. You will not be penalized for filing a complaint.