Hello,

Enclosed is the initial intake document for you to fill out completely.

Please note on the last two pages I need the name of spouse, family member or significant other as well as the name of any doctors you are seeing…this page is the two-way release of information. The Privacy page is one of the last pages I need to have you check all forms of communication that is ok for us to reach you. Please make sure you have signed all required forms. You will not be able to submit unless you do so.

We will meet on the website below for the TeleHealth session.

Please sign in before the first appointment and set up your patient portal. I will sign in and then we can start…please wait if I am a few minutes late for the appointment.

The site is: **doxy.me/kathygreen**

We will also need a copy of the front and back of your insurance card. You can email this to Kathy@KathyGreen.org or we can send you a Dropbox link. This is in addition to filling out the insurance information section on the intake form.

If you have EAP Sessions from your insurance; you will not be billed for those sessions. The Credit Card page that needs to be filled out will be used when we bill your regular insurance after the EAP sessions if there are any. Please be aware of any copays are deductibles you may have. This information is kept private and under lock as all documents will be. If you have any questions please call the office at 208.342.8347

Thank you,

Kathy Green, MA LCPC
Phone: (208) 342-8347
Fax: (866) 639-2595
www.kathygreen.org

PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- **I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.**
- **Co-payments are due at time of service.**
- **If my plan requires a referral/authorization, I must obtain it prior to my visit.**
- **If I have any EAP's, I am responsible for bringing in the necessary paperwork to bill authorization. My health insurance will be billed if no paperwork is presented.**
- **In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.**
- **If I am uninsured, I agree to pay for the medical services rendered to me at time of service.**
- **I understand that I will be charged for missed appointments unless I give 24-hour notice.**

_______(Initials)

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

- **I hereby authorize and direct payment of my medical benefits to Kathy Green on my behalf for any services furnished to me by the providers. _______(Initials)**

3. AUTHORIZATION TO RELEASE RECORDS

- **I hereby authorize Kathy Green to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider._______(Initials)**

4. TELEHEALTH CONSENT

- **I authorize consent to engaging in telehealth sessions with Kathy Green, LCPC whenever she deems necessary or there is an agreement between both parties. My telehealth sessions will occur through interactive audio and video and I have the right to withdraw consent at any time._______(Initials)**

Signature of Patient, Authorized Representative or Responsible Party:

____

Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient:

____

Date:_________________

INFORMED CONSENT FOR TELEHEALTH SERVICES

I, ____(Name of Client) hereby consent to engaging in telehealth sessions with Kathy Green, LCPC.

I understand the following with respect to telehealth.

My telehealth sessions will occur through interactive audio and video.

The conditions in this Informed Consent for telehealth are in addition to the conditions in the general Informed Consent for treatment.

I have the right to withdraw consent at any time.

The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed to my therapist during the course of my sessions is confidential. However, all the mandatory reporting exceptions outlined in the general Informed Consent at Kathy Green, LCPC also apply to telehealth.

There are potential risks and consequences with telehealth, including but not limited to the possibility that the transmission of my personal information could be disrupted or distorted by technical failures or be interrupted by unauthorized persona.

My clinician will conduct my telehealth sessions in a private room. In order to protect my privacy, I should find a quiet and private place for my session.

No permanent voice or video recording is kept of my telehealth sessions.

Telehealth services and care may not be as complete or as effective as face to face services, especially if there is a poor audio or video connection.

If my Clinician believes that I would be better served by another form of intervention (face to face services). I will be referred to a mental health professional who can provide such services in my area.

Authorization for Credit Card Use

PRINT AND COMPLETE THIS AUTHORIZATION AND RETURN.
All information will remain confidential

Name on Card: ____

Billing Address: ____

____

Phone Number: ____

Credit Card Type: _____ Visa _____ Mastercard ____ Discover _____ AmEx

Credit Card Number: ____

Expiration Date: ____

Card Identification Number: ______ (usually last 3 digits located on the back of the credit card)

Amount to Charge will vary depending on patient's coinsurance or copay agreement with their insurance.

_____ ok to email statements

Email Address: ____

I authorize **Kathy Green** to charge the amount listed above to the credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder – Please Sign and Date

Signature: ____

Date: ____

Print Name: ____

INFORMED CONSENT FOR TELEHEALTH SERVICE

Name of client's emergency contact:

____

Telephone number of client's emergency contact:

____

Local area crisis services name(s) and number(s):

____

Telephone number my clinician should call to talk to me in the case of a disrupted telehealth session:

____

Client Signature____

Client name (printed)____

Date_________________

Clinician Signature_________Kathy Green_________________________________

Clinician name (Printed)_____Kathy Green______________________________

Date__________________

Kathy Green, MA LCPC
Phone: (208) 342-8347
Fax: (866) 639-2595
www.kathygreen.org

PERSONAL INFORMATION

PATIENT INFORMATION		FINANCIALLY RESPONSIBLE PERSON
Name:		Name:
Address:		Address:
City/State/Zip:		City/State/Zip:
Marital Status:	DOB:	Relation to Patient:
Gender:	SSN:	Home Phone:
Name of Spouse:	Yrs Together:	Referred By:
Home Phone:		SSN:
Employer:		Employer:
Address:		Address:
Occupation:		Occupation:
Business Phone:		Business Phone:
Cell Phone:		Cell Phone:
Email:		Email:

INSURANCE

This care will be paid for by: Blue Cross_____ Blue Shield_____ HP_____ Self Paid_____ Other_____

Name of Insurance Company:____________________________ **Address:**____________________________

City/State/Zip:____________________________ **Phone:**____________________________

Group Number:____________________________ **Subscriber's Name:**____________________________

Insurance ID Number ____________________________ **Date of Birth**____________________________

PAYMENT AND PROMISORY INFORMATION

All charges for professional services rendered by Kathy Green, MA LCPC, are the responsibility of the patient or financially responsible person listed on page one of this document. The patient or financially responsible person listed above is fully responsible for all fees. Payment for our services is due and payable at the time they are rendered.

The patient or financially responsible person understands that he or she is personally financially responsible for payment for services rendered to the above named patient and that a service charge of $15 per month will be added to the unpaid balance (excluding amount billed to insurance.)

COLLECTION NOTE: **I also understand that if the account becomes delinquent, efforts to collect may include assignment to collection agencies and/or Small Claims Court, making my name public record.**

MISSED APPOINTMENT NOTE: ***I understand that I will be charged for missed appointments unless I give 24-hour notice.***

Signature of Patient or Financially Responsible Person **Date Signed:**

____ ____________________________

Name:______________________________

REASON FOR SEEKING ASSISTANCE

YOUR FAMILY'S MEDICAL/PYSCHOLOGICAL HISTORY

☐ Abuse	☐ Hepatitis	☐ Sexually Transmitted Diseases
☐ AIDS	☐ Hernia	☐ Any and all other conditions:
☐ Alcoholism	☐ Kidney Disease	☐ Alzheimer's
☐ Arthritis	☐ High Blood Pressure	☐ ________________________
☐ Allergies	☐ Pneumonia	☐ ________________________
☐ Asthma	☐ Rheumatic Fever	☐ ________________________
☐ Bronchitis	☐ Seizures/Epilepsy	☐ ________________________
☐ Cancer	☐ Stroke	☐ ________________________
☐ Chronic Fatigue Syndrome	☐ Thyroid Disease	☐ ________________________
☐ Chronic Lung Disease	☐ Tuberculosis	☐ ________________________
☐ Diabetes	☐ Ulcers	☐ ________________________
☐ Drugs	☐ Vaccine Reaction	☐ ______________________
☐ Heart Disease	☐ Whooping Cough	☐

Other Medical Conditions in Your Family's Past
____

YOUR CURRENT MEDICAL CONDITIONS

Are you pregnant? ______ **Birth Control Methods__________________** **Do you have a pacemaker?______________**

Do you have AIDS?______ **Do you have hepatitis in any of its forms?__________________**

Do you have any other current medical condition?____

YOUR PAST MEDICAL CONDITIONS

☐ Abuse	☐ Hepatitis	☐ Sexually Transmitted Diseases
☐ AIDS	☐ Hernia	☐ Any and all other conditions:
☐ Alcoholism	☐ Kidney Disease	☐ Alzheimer's
☐ Allergies	☐ High Blood Pressure	☐ ________________________
☐ Arthritis	☐ Pneumonia	☐ ________________________
☐ Asthma	☐ Rheumatic Fever	☐ ________________________
☐ Bronchitis	☐ Seizures/Epilepsy	☐ ________________________
☐ Cancer	☐ Stroke	☐ ________________________
☐ Chronic Fatigue Syndrome	☐ Thyroid Disease	☐ ________________________
☐ Chronic Lung Disease	☐ Tuberculosis	☐ ________________________
☐ Diabetes	☐ Ulcers	☐ ________________________
☐ Drugs	☐ Vaccine Reaction	☐ ________________________
☐ Heart Disease	☐ Whooping Cough	☐ ________________________

Other Medical Conditions in Past
____

For children clients: mom, how was the pregnancy and delivery? Stress, strep, throat, gestational diabetes, etc.

____
____
____

Name:______________________________

GENERAL MEDICAL INFORMATION

- ☐ Poor Appetite
- ☐ Change In Appetite
- ☐ Large Appetite
- ☐ Cravings
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Fevers
- ☐ Chills
- ☐ Sweating
- ☐ Night Sweats

- ☐ Sweat Easily
- ☐ Insomnia
- ☐ Hours of Sleep ________
- ☐ Fall Asleep Easily
- ☐ Heavy Sleeper
- ☐ Light Sleeper
- ☐ Dream Disturbances
- ☐ Hard To Fall Back To Sleep
- ☐ Tremors/Shaking
- ☐ Dizziness

- ☐ Poor Coordination
- ☐ Headache
- ☐ Vertigo
- ☐ Edema
- ☐ Bleeds Easily
- ☐ Bruises Easily
- ☐ Fatigue/Tired
- ☐ Sudden Drop In Energy
- ☐ When?________________________
  ____

GENERAL MEDICAL INFORMATION

Energy Level: 0____10
Low High

Sexual Desire Level: 0____10
Never Think About Always Think About

Thirsty: 0________________10 Desires: Hot______Cold______Room Temperature______No Desire______
(water temperature)

Appetite: 0____________________________10 *Desires:* ______________ *Aversions:*________________________
Never Hungry Always Hungry (Food) (food)

Coldness Hands______ Feet______ Back______

Heat: Hand______ Feet______ Solar Plexus______ Abdomen______ Whole Body______

Stiffness: Joints______ Back______ Limbs_______

Intolerance To: Heat______ Cold______ Wind______ Fan______ Air Conditioning______

Pain: Upper Back______ Lower Back______ Upper Limbs______ Lower Limbs______
Entire Body______

Please Rate Your Pain On A Scale From 1 to 10, 10 Being the Worst. ______

SKIN AND HAIR

- ☐ Rashes
- ☐ Eczema
- ☐ Dry Skin
- ☐ Moist Skin
- ☐ Sores
- ☐ Ulcers
- ☐ Herpes
- ☐ Psoriasis
- ☐ Eruptions
- ☐ Discharge

- ☐ Acne/Pimples
- ☐ Bruises
- ☐ Hives
- ☐ Itching
- ☐ Sweating
- ☐ Change in Skin Texture
- ☐ Dandruff
- ☐ Loss of Hair
- ☐ Balding
- ☐ Thinning of Hair

- ☐ Change in Hair
- ☐ Other Hair Problems
- ☐ Birth Marks
- ☐ Other Skin Problems

RESPIRATORY

- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Asthma
- ☐ Coughing Blood
- ☐ Wheezing
- ☐ Tightness in Chest

- ☐ Shortness of Breath
- ☐ Fullness in Chest
- ☐ Difficulty Breathing When Sitting Down
- ☐ Difficulty Breathing When Lying Down
- ☐ Other Chest Discomfort

Cough:
Dry______ Croup_____
Other:____________________
Phlegm:
Thin______ Thick______
White_____ Yellow_____
Green_____
How Long Coughing? _________

Name:______________________________

HEAD/EYES/EAR/NOSE/MOUTH/THROAT

Head	Eyes	Ears	Nose
☐ Dizziness	☐ Cataract/Glaucoma	☐ Loss of Hearing	☐ Loss of Smell
☐ Migraine	☐ Eye Pain	☐ Discharge	☐ Increased Sense of Smell
☐ Frontal Headaches	☐ Twitching	☐ Earaches	☐ Nose Bleeds
☐ Temporal Headaches	☐ Floaters/Spots	☐ Poor Hearing	☐ Allergies
☐ Vertex Headaches	☐ Poor Vision	☐ Itchiness	☐ Nasal Discharge
☐ Occipital Headaches	☐ Blurry Vision	☐ Loud Ringing In Ears	☐ Color of Discharge
☐ Head Injury	☐ Night Blindness	☐ Soft Ringing in Ears	☐ Amount of Discharge
☐ Facial Pain	☐ Itchiness	☐ High Pitched Ringing	☐ Other______________
☐ Facial Paralysis	☐ Glasses/Contacts	☐ Low Pitched Ringing	
☐ Sinus Problems	☐ Red Eyes	☐ Inflammation/Tenderness	
☐ Other______________	☐ Dry eyes	☐ Other______________	
	☐ Thick matter in corner		
	☐ other______________		

Mouth	Mouth	Throat	Throat
☐ Grinding Teeth	☐ Taste In Mouth	☐ Dry Throat	☐ Frequent Tonsilitis
☐ Drooling	☐ Ulcers	☐ Hoarseness	☐ Other______________
☐ Excess Saliva	☐ Sores	☐ Recurrent Sore Throat	
☐ Dry Mouth	☐ Silver fillings	☐ Loss of Voice	
☐ Pyorrhea	☐ Fever blisters	☐ Difficulty in Swallowing	
☐ Bad Breath	☐ Coating on tongue	☐ Lump in throat	
☐ Gum Bleeding	☐ Other___________		
☐ Gum Swelling			

CARDIOVASCULAR

☐ High Blood Pressure	☐ Chest Pain	☐ Difficulty In Breathing	☐ Coma
☐ Low Blood Pressure	☐ Cold Hands/Feet	☐ Shortness of Breath	☐ Loss of Consciousness
☐ Dizziness	☐ Swelling Hands/Feet	☐ Dream Disturbance	☐ Other______________
☐ Fainting	☐ Irregular Heart Beat	☐ Poor Memory	
☐ Palpitations	☐ Insomnia	☐ Mania/Delirium	

MENTAL EMOTIONAL TRAUMAS

☐ Physical Abuse	☐ Parents Divorced (Your Age At Divorce)______________
☐ Sexual Abuse	☐ Ages In Your Life For Which You Don't Have Memories: ______________
☐ Emotional Abuse	☐ Mental Hospitalization (Reason):______________
☐ Depression Self	☐ Death of Friend or Relative (Date): ______________
☐ Depression Family	☐ Other______________

SURGERIES

Type of Surgery	Date of Surgery	Doctor Performing Surgery

Name:______________________________

TRAUMATIC INJURIES

Car Accident	**Date**
Car Accident	**Date**
Falls	**Date(s)**
Head Trauma(s)/Concussion(s)	**Date**

ALLERGIES

Foods______________________________

Drugs/Chemicals______________________________

Other______________________________

CURRENT MEDICATIONS

1)______________________ **2)**______________________

3)______________________ **4)**______________________

OCCUPATIONAL/ENVIROMENTAL EXPOSURES OR HAZARDS

Chemical______________ **Acid/Alkaloids**______________

Heavy Metals______________ **Physical Labor**______________

Electrical______________ **Psychological**______________

HABITS/EXESSIVE USAGE

☐ **Alcohol**	☐ **Drugs**	☐ **Sugar**
☐ **Chocolate**	☐ **Exercise**	☐ **Tea**
☐ **Cigarettes**	☐ **Food**	☐ **Other**
☐ **Coffee**	☐ **Salt**	______________
☐ **Cola/Diet Cola**	☐ **Sex**	

PROFESSIONAL HISTORY

Have you had any psychological treatment/therapy in the past?________ **Name of Therapist**______________

In the past 5 years, have you seen any physicians?______________ **Name of Physician(s)**______________

Chiropractors:______________ **Attorneys:**______________

Other Health or Legal Practitioners: ______________________________

____

Name:______________________________

EMERGENCY CONTACT INFORMATION

Name:____________________ **Address:**____________________ **City/State/Zip:**____________________
Relationship:____________________ **Phone:** ____________________
Name:____________________ **Address:**____________________ **City/State/Zip:**____________________
Relationship:____________________ **Phone:** ____________________

FAMILY HISTORY

Your Parents

Patient's Mother:____________**Alive Age:**________**Died of:** ____________**Age at Death:**________
State of Health:____
Patient's Father:____________**Alive Age:**________**Died of:** ____________**Age at Death:**________
State of Health:____
Your Age at the Time of Your Mother's Death:____________**Father's Death:**____________

Your Children **Please include names, ages, if from present or prior marriage and the name and age of former spouse.**

Name:________________ **Age:**________ **Present/Prior Name of Former Spouse:** ________________
Name:________________ **Age:**________ **Present/Prior Name of Former Spouse:** ________________
Name:________________ **Age:**________ **Present/Prior Name of Former Spouse:** ________________
Name:________________ **Age:**________ **Present/Prior Name of Former Spouse:** ________________
Name:________________ **Age:**________ **Present/Prior Name of Former Spouse:** ________________

Your Siblings **Please include ages, from oldest to youngest and health problems past and present.**

Brother/Sister: **Alive Age:**________ **Age at Death:**________**Cause:**____________________
Health Problems:____
Brother/Sister: **Alive Age:**________ **Age at Death:**________**Cause:**____________________
Health Problems:____
Brother/Sister: **Alive Age:**________ **Age at Death:**________**Cause:**____________________
Health Problems:____
Brother/Sister: **Alive Age:**________ **Age at Death:**________**Cause:**____________________
Health Problems:____
Brother/Sister: **Alive Age:**________ **Age at Death:**________**Cause:**____________________
Health Problems:____
Brother/Sister: **Alive Age:**________ **Age at Death:**________**Cause:**____________________
Health Problems:____

Have you had miscarriages?_____**Abortions?**_____**Stillborn Babies?**______**# of Children Who Have Died**____________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACE PRACTICES

***THIS PAGE MUST BE COMPLETELY FILLED OUT**

By my signature below I,____________________________, acknowledge that I received a copy of the Notice of Privacy Practices for Kathy Green LCPC.

_____________________________________ _______________________________

Signature of Client (or personal representative) Date

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: ____

Relationship to Client: ____

The HIPPA Privacy rule gives individuals the right to request confidential communications or that a communication of the private health information is made by alternative means such as sending correspondence to the individual's office instead of the individual's home.

Preferred Method of Communication-Select all that apply

Home Phone

- ☐ Okay to leave a message with detailed information
- ☐ Leave a message with a call-back number only

Work Phone (check one):

- ☐ Okay to lave a message with detailed information
- ☐ Leave a message with a call-back number only

Cell Phone (check one if applicable):

- ☐ Leave a message with a call-back number only
- ☐ Leave a message with a call-back number only
- ☐ Okay to send a text message

Written Communication (check all that apply):

- ☐ Okay to mail to my home address
- ☐ Okay to mail to my work/office address
- ☐ Okay to fax to this number _____________________

E-Mail Communication:

- ☐ Okay to email to the listed email address

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the acknowledgement**
- ☐ **Other (Please Specify)**

____

____

Kathy Green, MA LCPC
Phone: (208) 342-8347
Fax: (866) 639-2595
www.kathygreen.org

Name: ______________________________ Date of Birth: ______________________________

SSN: ______________________________ Previous Name: ______________________________

Two-Way Health Care Information Release:

Name and Organization: ____

Insurance Company: ____

Address: ____

State: ________ Zip Code: _________ Phone Number: ___________________________

Fax Number: _______________________________

Release the following information:

X___ Health care information relating to the following treatment condition:
MENTAL HEALTH____

_____ Health care information for the date(s) below:
____

_____ All health care information:
____

_____ Other:
____

This authorization ends: ______ in 90 Days; or end of therapy/billing process:
______ When the following occurs (but no longer than 90 days:)

I may cancel this authorization in writing as allowed by law. This would not affect any actions already taken based upon my original request. There are three ways to cancel this authorization:

1) Sign and date a revocation form. This form is available from Kathy Green, MA LCPC; or
2) Write, sign and date a letter to Kathy Green, MA LCPC to cancel the authorization; or
3) Sign, date and write “CANCEL” on this original form.

Once Kathy Green, MA LCPC gives out the information, then she no longer has control over it. The recipient might re-disclose it. Privacy laws may no longer protect it. I also agree to the release of health care information regarding testing, diagnosis, and/or treatment for: HIV (AIDS virus), Sexually transmitted diseases, Psychiatric disorders/mental health, or Drug and/or alcohol use.

____ ____________________ ____________________
Patient or legally authorized individual signature Date Time

____
Relationship to patient if signed on behalf of the patient by parent, legal guardian, personal representative, etc.