Adult Intake Form **CONFIDENTIAL**

The following form will become a part of your confidential record and will enable us to gain a quicker understanding of you and your concerns. Please answer each question as completely and carefully as you can. You may use the back of any page for additional comments.

Name: ____ Date of Birth___________ Age _____ Sex _____

Present Address: ____
Street Address

____
City County State Zip Code

Preferred Phone: (_____) _________________ Email address_______________________________________

Ethnicity: ______________ Years of Education _____ Referred by: _______________________________

Marital Status: Single ____ Married ____ (How long ____) Divorced ____ Separated ______

Presently living with: Parents ____ Spouse ____ Roommate ____ Alone ____ Other __________________

Occupation ____ Total Hours Per Week ________________

Employed by ____ Phone Number ______________________

Religious Affiliation __________________________________ Church ____________________________

Are you a member? Yes ___ No ___ Active ___ Inactive ____

Family member to notify in case of emergency: Name ____

Address ____ Phone ___________________

FAMILY MEMBERS

Relationship	**Name**	**Age**	**Grade in School Last Completed**	**Occupation**
Spouse				
Father				
Mother				
Brother (s)				
Sister (s)				
Children				

Revised 5/21/2018

Describe any physical problems you have that require medication or physical care ________________________

____

Are you currently receiving medical treatment? Yes _____ No _____

When did you last consult your primary care physician? ______________________________________

Are you currently taking any prescription medications? Yes _____ No _____ If yes, please list by name and dosage. ____

____

Previous Counseling/Therapy? Yes _____ No _____ If yes, when? ______________________________

With whom? Name ___________________________ Address __________________________

____

Briefly describe the problems which prompted you to seek counseling at this time. ________________

____

____

____

____

Have there been times when the problem improved or disappeared? Yes _____ No _____

If yes, when? ____

What do you think helped? ____

____

____

Were there times when the problems were especially bad? Yes _____ No _____

If yes, when? ____

What do you think made it bad?

____

____

____

Are there other people who play a major role in causing your problems or in helping you cope with your problems? Yes _____ No _____ Explain briefly____

____

Is there anything else that you believe might be important for your counselor to know at this time? __________

____

____

____

Revised 5/21/2018

Using the scale below, please choose a number that reflects the extent of your concern about each of the issues listed below. Please rate every item.

0	1	2	3	4	5	6	7	8	9	10
No Concern					Moderate Concern					Extreme Concern

_____ Anger
_____ Depression
_____ Education
_____ Eating Difficulties
_____ Fearfulness
_____ Nervousness
_____ Financial Problems
_____ Marital Problems
_____ Physical problems
_____ Problems with social relationships
_____ Problems with children
_____ Problems with parents

_____ Religious/Spiritual Concern
_____ Sexual Concerns
_____ Thoughts of Suicide
_____ Trouble Making Decisions
_____ Unhappy most of the time
_____ Use of alcohol
_____ Use of alcohol by family member
_____ Use of other drugs
_____ Work
_____ Worry
_____ Other (specify) ________________

A survey may be mailed to you, with your permission, upon completion of your counseling experience at Image Bearers Counseling. Would you like to receive a survey? Yes _____ No _____

I have read the Image Bearers Counseling Informed Consent Statement and voluntarily request counseling services at Image Bearers Counseling in accordance with the terms described on the information sheet.

Signature ____ Date ___________________________

For clients age 18 and under, the signature of his or her guardian or custodial parent is required.

Parent/Guardian ____ Date ___________________________

PLEASE SUBMIT PAYMENT WITH THIS FORM PRIOR TO YOUR FIRST SESSION

IMAGE BEARERS MINISTRIES
CLIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("security rules"). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. The Patient Notification of Privacy Rights is our attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important that you know what patient protections HIPAA affords to all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship, and as such, you will find we make every effort to do all we can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask for further clarification.

By law, Image Bearers Counseling is required to secure your signature indicating you have received a copy of the Patient Notification of Privacy Rights document.

Image Bearers Counseling
HIPAA Compliance Officer

Patient Name (print):____

I have received a copy of the Image Bearers Counseling Patient Notification of Privacy Rights document, which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand that I have the right to review this document and that I may at any time, now or later, ask any questions about or seek clarification of the matters discussed in this document. Signing below indicates only that I have received a copy.

____________________________ ________________
Patient Signature Date

____________________________ ________________
Patient Signature if patient is a Minor Date

____________________________ ________________
Guardian Signature if patient is Legal Charge Date

Image Bearers Counseling

Informed Consent

Counseling is a cooperative venture with responsibility resting on both the counselor and the client. In order to enable you and your counselor to work most effectively together, we ask that you carefully read the information below. If you have any questions, your counselors will be happy to discuss them with you.

Image Bearers Counseling exists to provide counseling, spiritual direction and training from a Biblical perspective for individuals, couples, families and groups. Our services are available to members of the community regardless of religious affiliation. **Your counselor has biblical training in pastoral counseling and several of our counselors have additional training in spiritual psychotherapy and spiritual direction, to include state licensing.** If your situation is deemed inappropriate for a counselor with these credentials you will be provided with a referral.

Confidentiality: The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides patient protections related to the electronic transmission of data, the keeping and use of patient records, and storage and access to health care records. HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. An explanation of those rights is attached to this document. Communication between client and counselor are confidential and will not be revealed unless required by law such as situations of child abuse or threats of physical harm to self or others or subpoena of a court. We may discuss the circumstances of your case with other staff counselors during our treatment team sessions to insure the best care for you but will always insure your total anonymity when doing so. Your counselor will be discreet if it is necessary to contact you at work or home.

Counseling Fees: The normal fee for a 50-minute session is $85.00. We will collect the fee for each session prior to the session. If you are unable to afford the standard fee you may be considered for a reduced fee. As Image Bearers Counseling is a non-profit Christian ministry, amounts paid above the $85.00 fee are tax deductible and will be used to help operate our ministry. Please make checks payable to Image Bearers Ministries.

Insurance: We regret that we are unable to accept insurance at this time.

Cancellation of Appointments: If you must cancel your appointment please phone our office (770.461.2910) and speak to our receptionist or leave a message on our voicemail. When cancellations are received less than 24 hours in advance, a charge of the full fee will be made for the time reserved, except in the case of illness or other emergency. Your cooperation in this matter will be greatly appreciated.

Telephone Calls: Should you need to contact your counselor please leave a message on our voice mail. Our answering system will receive your call 7 days a week, 24 hours a day. Your call will be returned as soon as possible.

Emergency Procedures: The counselors are not available to handle emergencies. If you have an emergency you will need to call 911 or contact the nearest hospital emergency room or police department depending on the situation.

Child Care: Child care is not provided by Image Bearers Counseling and parents should not plan to leave children unattended in the waiting room.

I have read the above information and voluntarily request counseling services as Image Bearers Counseling. I also agree with these terms and conditions*.

Signature ____ Date: ______________________

*__The signature of the custodial parent or guardian is required for clients under 18 years of age.__

FINANCIAL COMMITMENT

Image Bearers Ministries is a 501(c)3 non-profit, non-denominational ministry which focuses on Christ-centered counseling. We operate on a fee base of $85.00 per 50 minute visit. However, for those financially unable to pay this amount you may receive consideration for a reduced fee at .15% of your net family income. In cases in which there is no income or a family is under financial duress, lower payments will be considered.

Appointments are conducted during business hours, Monday – Friday from 9 am to 5 pm. Image Bearers Counseling asks that you call 24 hours prior to a scheduled appointment should you need to cancel or change your appointment date or time. If you fail to give us notice and miss your scheduled time you are required to pay the session fee for the missed appointment.

By my signature I affirm that I have read and understand the above statements. I agree to this financial commitment to Image Bearers Counseling.

I accept the session fee of $__________________ per 50 minute visit. This amount is based upon the $85.00 standard visit fee or the approved reduced fee.

______________________	______________________	______________
Printed Name	**Signature**	**Date**