

## Image Bearers Ministries 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
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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**

<u>Relationship</u>	<u>Name</u>	<u>Age</u>	<u>Grade in School Last Completed</u>	<u>Occupation</u>
Spouse	_____	_____	_____	_____
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brother (s)	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Sister (s)	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Children	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

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? \_\_\_\_\_

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					_____ Religious/Spiritual Concern					
_____ Depression					_____ Sexual Concerns					
_____ Education					_____ Thoughts of Suicide					
_____ Eating Difficulties					_____ Trouble Making Decisions					
_____ Fearfulness					_____ Unhappy most of the time					
_____ Nervousness					_____ Use of alcohol					
_____ Financial Problems					_____ Use of alcohol by family member					
_____ Marital Problems					_____ Use of other drugs					
_____ Physical problems					_____ Work					
_____ Problems with social relationships					_____ Worry					
_____ Problems with children					_____ Other (specify) _____					
_____ Problems with parents										

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

I have read the Image Bearers Ministries Informed Consent Statement and voluntarily request counseling services at Image Bearers Ministries 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 Ministries is required to secure your signature indicating you have received a copy of the Patient Notification of Privacy Rights document.

Image Bearers Ministries  
HIPAA Compliance Officer

**Patient Name (print):** \_\_\_\_\_

I have received a copy of the Image Bearers Ministries 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 Ministries

### 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 Ministries 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 \$75.00. We will collect the fee for each session prior to the session. If you are unable to afford the standard fee you may apply for a reduced fee by completing the Application for Reduced Fee Form. The reduced fee must be approved before it is applied to a session. As Image Bearers Ministries is a non-profit Christian ministry, amounts contributed above the \$75.00 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 Ministries 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 Ministries. 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, pastoral counseling. We operate on a fee base of \$75 per 50 minute visit. However, if you are financially unable to pay this amount you may submit a Reduced Fee Application. Annual adjusted gross income verification is necessary when the Reduced Fee Application is submitted. Adjusted gross income verification should be in the form of a copy of your most recent IRS Form 1040.

Image Bearers Ministries utilizes the Taylor-Johnson Temperament Analysis to assist in assessing our clients. There is a separate fee charged for the initial administration, scoring and evaluation of this assessment. The fee is \$10 per individual. Couples may also be asked to complete the Taylor-Johnson Temperament Analysis assessments for one another. If so, that cost is \$30 per couple.

Appointment scheduling is conducted during business hours, Monday – Thursday from 10 am to 5 pm. Image Bearers Ministries 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 Ministries.

I accept the session fee of \$\_\_\_\_\_ per 50 minute visit. This amount is based upon the \$75 standard visit fee or the approved reduced fee.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date