COLLEGE SKYLINE CENTER LLC INTAKE QUESTIONNAIRE

1230 North Duquesne Joplin MO 64801 (417) 782-1443

PATIENT	Name			
	Address			
	Contact #			
	Email			
	DOB			
	SSN			
	Employer			
	Please Circle: ☐ Male ☐ Female ☐ Other _____ ☐ Married ☐ Single ☐ Other _____ Are you disabled? ☐ Yes ☐ No		Spouse Name	
			Spouse Contact #	
			Spouse DOB	
			Spouse SSN	
PARENTS/ GUARDIANS OR RESPONSIBLE PARTY	Name		DOB	
	Relationship to Patient		SSN	
	Address			
	Name		DOB	
	Relationship to patient		SSN	
	Address			
PERSON TO CONTACT IN EMERGENCY	Name		Contact #	
	Relationship			

OTHER PEOPLE WHO LIVE IN PATIENT'S HOME	**Name/s**	**Relationship to Patient**	**Age**

PATIENT'S HEALTH	Health Problems		
	Physician		
	Medications		
	Previous Counseling	Where:	
		When:	
REASON FOR APPOINTMENT			
HOW DID YOU HEAR ABOUT CSC?			
PAYMENT INFORMATION	Insurance Name		Please Circle: ☐ EAP ☐ Insurance ☐ Self Pay
	Insured's Name		
	Insured's Employer		
	Insured's SSN		
	Insured's DOB		

Therapist_____ Today's Date_____ Appt Time_____ **CSC 07/25**

INDIVIDUAL HISTORY INTAKE FORM

Name:		DOB:	
PSYCHOSOCIAL HISTORY	Birthplace (City, State)		
	Was your birth mother's pregnancy/delivery considered dangerous or complicated?	☐ YES	☐ NO
	Did you experience developmental delays or learning disorders growing up?	☐ YES	☐ NO
	Is the patient sexually active?	☐ YES	☐ NO
	Are you or have you ever been suicidal?	☐ YES	☐ NO
	Is there any known drug or food allergies?	☐ YES	☐ NO
	If yes, describe:		
	Are there any religious, social, or cultural variables that could affect treatment?	☐ YES	☐ NO
	If yes, describe:		
FAMILY BACKGROUND	Do you have siblings?	☐ YES	☐ NO
	If yes, describe (gender & age):		
	Do you have step-parents?	☐ YES	☐ NO
	Have you ever been abused?	☐ YES	☐ NO
	If yes, circle one: ☐ Physically ☐ Emotionally ☐ Sexually		
	Where did you grow up primarily?		
	Maternal Medical History (Mom's side)		
	Paternal Medical History (Dad's side)		
EDUCATIONS HISTORY	Highest education attained (Circle one) ☐ GED ☐ HS Diploma ☐ College Degree		
	Highest grade completed? (Completion year)		
	Have you ever attended special education or behavior disorder classes (EMR or BD) classes in elementary or secondary schools?	☐ YES	☐ NO
	Are you employed?	☐ YES	☐ NO
SUBSTANCE USE	Do you use tobacco products?	☐ YES	☐ NO
	Does anyone in the household use nicotine past or present?	☐ YES	☐ NO
	If yes, describe age started and how much used daily:		
	Approximately how many caffeinated beverages do you consume daily?		
	Have you ever used alcohol?	☐ YES	☐ NO
	If yes, age started and how much used daily:		
	Have you ever used illegal drugs?	☐ YES	☐ NO
	If yes, age started and how much used daily:		
	Do you currently use drugs and/or alcohol?		
	Have you ever received any kind of treatment for alcohol or drug use?	☐ YES	☐ NO
ARRESTS/CONVICTIONS	List all arrests, charges, or convictions you have been named in.		
	Are you a registered Felon?	☐ YES	☐ NO
	Are you on parole or probation?	☐ YES	☐ NO

COLLEGE SKYLINE CENTER LLC

Confidential Communications

In order to protect your privacy, we ask that you complete this form so we know if and in what ways we may communicate with others regarding your health information. Please mark as many of the communication options below you feel comfortable with regarding your private health care information.

This is not an authorization to release your complete private healthcare information to others. This is authorization is only for the information listed below.

Patient Name _____ **DOB** _____

I authorize College Skyline Center to discuss my healthcare as indicated with the following individuals:

Name:	Name:	Name:
Relationship:	Relationship:	Relationship:
Phone:	Phone:	Phone:

Yes	No		Yes	No		Yes	No	
☐	☐	Appointment Reminders	☐	☐	Appointment Reminders	☐	☐	Appointment Reminders
☐	☐	Billing Information	☐	☐	Billing Information	☐	☐	Billing Information

I understand that I have the right to change or cancel this request at any time by notifying the Privacy Officer, in writing, at College Skyline Center Attention: Privacy Officer, 1230 North Duquesne Road, Joplin, Mo 64801. I also understand that the changes or cancellation will not affect action taken based on this request prior to the change or cancellation

Signature of Patient/Representative and Date	Printed Name of Patient/Representative

Relationship to Patient	Witness Signature and Date(if needed)

Informed Consent for Telehealth Services and Text Messaging Communication

Definition of Telehealth

Telehealth involves the use of electronic communications to enable College Skyline Center mental health professionals to connect with individuals using interactive video and audio communications.

Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that I have the rights with respect to telehealth:

- The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.
- I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
- I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. CSC utilizes secure, encrypted audio/video transmission software to deliver telehealth.
- I understand that if my counselor believes I would be better served by another form of intervention (e.g., face-to-face services), I will be referred to a mental health professional associated with any form of psychotherapy, and that despite my efforts and the efforts of my counselor, my condition may not improve, and in some cases may even get worse.
- I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my counselor, I may be directed to “face-toface” psychotherapy.
- I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.
- I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my counselor in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history that are personally sensitive to me, (2) ask non-clinical personnel to leave the telehealth room, and/or (3) terminate the consultation at any time.
- I understand that my express consent is required to forward my personally identifiable information to a third party.
- I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.

- By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.
- I understand that different states have different regulations for the use of telehealth. In Wisconsin, telehealth may only be conducted between certified office locations. I understand that, in Wisconsin, I am not able to connect from an alternative location for the provision of audio-/video-/computer based psychotherapy services.

Payment for Telehealth Services

College Skyline Center will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. We will provide you with a statement of service to submit to your insurance company if you wish.

Patient Consent to the Use of Telehealth

I have read and understand the information provided above regarding telehealth, have discussed it with my counselor, and all of my questions have been answered to my satisfaction.

I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein.

Text Message Consent Option

Please indicate consent to communication via text messages by circling: ☐ **Yes** ☐ **No**

By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

_____

Print Name

_____ _____

Client's Signature Date

_____ _____

Parent or Guardian Signature Date

UNDERSTANDING YOUR INSURANCE BENEFITS IS YOUR RESPONSIBILITY.

You are responsible to contact your insurance company to obtain an ***estimate*** of ***potential reimbursement*** from your insurance companies for your/your child's services.

Your insurance company may determine that some, but not all, of the appointments are covered services, and your insurance companies may not pay in full for covered services.

Even if your insurance company informs you that a particular service is "covered at 100%" this does NOT necessarily mean that you will have no out of pocket expenses. You may have additional insurance plan circumstances that affect your actual out of pocket costs, such as:

> ***Deductibles:*** In an insurance policy, the deductible is the amount of expenses that must be paid out of pocket *by you* for medical or dental services *before* your insurer will pay any expenses. If you have not reached your deductible already, then you will have out of pocket expenses. *We have no means of obtaining your personal information regarding how much deductible you have paid. You should check this before treatment is rendered.*
>
> ***Co-pays:*** A Copayment or copay is a fixed payment for a covered service. The amount of your copay is defined by your insurance company, and must be paid by you each time you receive a service. ***College Skyline Center, LLC*** *does not waive copays.*
>
> ***Denial after the fact:*** In rare cases, even after we have obtained an estimate of potential reimbursement from your insurance company, your insurance company can deny payment for services after the treatment occurs and when the claim is submitted. *Every effort will be made to assist you in appealing this unfortunate insurance decision and to obtain reimbursement for any covered services.*

As a courtesy to you, we will submit your insurance claims for you, and we will accept payment directly from the insurance company for any covered services, and outstanding balances will be billed to you and overpayment's will be reimbursed. *Your other option is to pay in full for services and submit an insurance claim for reimbursement yourself. If you would like to submit claims yourself, please let us know.*

Remember, your insurance company exists to help *reimburse* for your medical expenses. Your insurance company is not responsible to pay your bills. YOU are ultimately responsible to pay for services rendered to you or your dependent(s) in this office.

I have read and understand this statement:

Name (print)_____

Signature_____

Date_____

Therapist-Patient Services Agreement

Welcome to College Skyline Center. This agreement contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purposes of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice explains HIPAA and its application to your personal health information in greater detail. We can discuss any questions you have about the procedures. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it. If there are obligations imposed on me by your health insurer in order to process or substantiate claims
made under your policy, or if you have not satisfied any financial obligations you have incurred.

Behavioral Health

Psychotherapy or counseling (therapy) is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the particular problem. There are many different methods I may use to deal with the problems that you have to address. Therapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Therapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guild, anger, frustration, loneliness, and helplessness. On the other hand, therapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. Our first session or more, if needed, will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another behavioral health professional for a second opinion.

Meetings

I normally conduct an evaluation that will last from 1 to 4 sessions. During this time, we can both decide if I'm the best person to provide the services you need in order to meet your treatment goals. If therapy is begun, I will usually schedule one 50-minute session (one appointment hour of 50 minutes per week or every other week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide at least 24 hours advance notice of cancellation unless we both agree that you were unable to attend due to circumstances beyond your control. It is important to note that insurance companies do not provide reimbursements for cancelled sessions.

Contacting Me

CSC is open 8:00 am to 7:00 pm weekdays (5:00pm on Fridays). I am in at various times during the week. If I am gone, office staff typically know, and I usually have a voice mail message about my absence. Due to my work schedule, I am often not immediately available by telephone. I am usually in my office daily, but I probably will not be able to answer the phone when I am with a patient. When I am unavailable my telephone is answered by voice mail or clerical staff. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are unable to reach me and believe that you cannot wait for me to return your call, contact your family physician or the nearest hospital emergency room and ask for the behavioral health professional on call. If I will be unavailable for an extended time, I will provide you with the name of a College Skyline Center colleague to contact, if necessary.

Limits on Confidentiality

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities as follows:

- Professional staff at CSC have current or future access to your records to aid in your treatment or evaluation at CSC. The other professionals are also legally bound to keep the information confidential. If you do not object, we will not tell you about these consultations unless we believe that it is important to our work together. I will note all consultations in your Clinical Record.
- You would be aware that I practice with other behavioral health professionals and that I utilize administrative staff help.

In most cases, I need to share protected health information with these individuals for both clinical and administrative purposes, such as scheduling, billing, and quality assurance. All of the behavioral health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

- I have contracts with a collection agency and sometime as required by HIPAA, I have a formal business associate
contact with such business in which they promise to maintain the confidentiality of these data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of these organizations and/or a blank copy of their contract.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this agreement.

There are some situations where I am permitted or required to disclose information without either your consent or
Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the therapist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, I must, upon appropriate request, provide a copy of the patient's record to the Labor and Industrial Commission or the Workers' Compensation Division of the Missouri Department of Labor and Industrial Relations, or the patient's employer.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have reasonable cause to suspect that a child has been or may be subjected to abuse or neglect or observe a child being subjected to conditions or circumstances that would reasonably result in abuse or neglect, the law requires that I file a report with the Missouri Division of Family Services. Once such a report is filed, I may be required to provide additional information.
- If I have reasonable cause to suspect that an elderly or disabled adult presents a likelihood of suffering serious physical harm and is in need of protective services, the law requires that I file a report with the Department of Social Services. Once such a report is filed, I may be required to provide additional information.
- If I believe that it is necessary to disclose information to protect against a clear and substantial risk of imminent serious harm being inflicted by the patient on him/herself or another person, I may be required to take protective action. These actions may include initiating a hospitalization and/or contacting the potential victim, and/or the police and/or the patient's family. If such a situation arises, I will make every effort to fully discuss this with you before taking any action and I will limit my disclosure to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

You should be aware that pursuant to HIPAA, I keep Protected Health Information about you in a patient chart, which contributes to your Clinical and Accounting records. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in the unusual circumstance where disclosure is reasonably likely to endanger you and/or others or when another individual (other than another health care provider) is referenced and I believe disclosing that information puts the other person at risk of substantial harm, you may examine and/or receive a copy of your clinical and accounting record if you request in writing. Because these are professional records, they can misinterpret and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence or have them forwarded to another mental health professional so you can discuss the contents. I am sometimes willing to conduct this review meeting without charge. In most circumstances, I am allowed to charge a copying fee and for certain other expenses. The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your Clinical and Accounting Records, you have a right of review, which I will discuss with you upon request.

Patient Rights

HIPAA provides you with several rights with regard to your Clinical and Accounting Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical and Accounting Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the previously mentioned notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

Minors and Parents

Patients under 18 years of age, who are not emancipated, and their parents should be aware that the law may allow parents to examine their child's treatment records. Parents have equal access to the records. Because privacy in therapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. Any other communication will require the child's Authorization unless I believe that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have. If either parent wishes the child to not be seen, I will terminate counseling.

Billing and Payments

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. If your account is not paid, I may hire a collection agency or go through small claims court, which will require me to disclose otherwise confidential information. In most collection situations, I release identifying information (name, address, phone, social security #, place of work etc.) the dates of services, the nature of services provided, and the amount due. If such action is necessary, its costs may be included in the claim and/or a 1.5% month carrying charge on all delinquent accounts may be charged.

Insurance Reimbursements

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for behavioral health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out what behavioral health services your insurance policy covers. Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much behavioral health coverage is available. "Managed Health Care" places such as HMO's and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in a short-term therapy, some patients feel that they need more services after insurance benefits end. Some

managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will my best to find another provider.

You should also be aware that you contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do once it is in their hands. In some cases, they may share the information with a national medical information data bank. I will provide you with a copy of any report I submit, if your request it. By signing this agreement, you agree that I can provide requested information to your carrier.

Assignment of Benefits

Your signature below is your authorization for your insurance/managed care to send payment for services to me. Once we have all the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above (unless prohibited by contract).

Professional Fees

All fees related to patient care are the responsibility of the patient or responsible party. Services include report writing, telephone conversations, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time. Initial Diagnostic and evaluative sessions are charged at $180 per hour and $165 per hour for subsequent therapeutic and administrative service including but not limited to report and transportation costs, even if I am called to testify by another party.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE

Agreed to by _____ **Patient Signature**_____ **Date**_____

Patient Name Printed

_____ _____ **Date**_____

Patient's legally authorized representative name **Patient's legally authorized representative signature**

_____ **Date**_____

Therapist Signature

SUBMIT