Karen Spruill, M.A.,LMHC #10479
Florida Hospital SDA Church
2800 N. Orange Ave.
Orlando, Florida 32804
407-760-9027

Confidential Client Intake Form

GENERAL INFORMATION

Date: ______________________ Referred by: ____

Full name: ____ Name you prefer: _________________________

Sex: ❑ Male ❑ Female Date of birth:__________________________ Age:__________

Street address: ____ Suite/Apartment #: _____________

City: ____ State: ___________ Zip code: ________________
May we send mail here: ❑ Yes ❑ No

Home Phone:________________________________ Call you here? ❑ Yes ❑ No Message here? ❑ Yes ❑ No

Work phone:________________________________ Call you here? ❑ Yes ❑ No Message here? ❑ Yes ❑ No

Cell phone:__________________________________ Call you here? ❑ Yes ❑ No Message here? ❑ Yes ❑ No

Email:____ Contact you here? ❑ Yes ❑ No

Employer:____ How long have you been there:________________

Occupation:____ Average hours worked per week:_______________

Highest level of education completed: ______________________ Are you currently in school? ❑ Yes ❑ No

If Yes, what level? ______________________________ Degree pursuing: __________________________________

Do you regularly attend a place of worship? ❑ Yes ❑No. If Yes, where? __________________________________

In case of emergency, contact:

Name:________________________________ ___________________ Relationship: _________________________

Home phone: ___________________________________ Cell phone: ____________________________________

RELATIONAL INFORMATION

Current marital status: ❑ Single ❑ Dating ❑ Engaged ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

If dating, engaged, married, separated, divorced, or widowed, for how long?_________________________________

Number of previous marriages for you? __________________ For your partner/spouse? __________________

Partner's/Spouse's name:_________________________ Partner's/Spouse's age:__________

With whom do you currently live? (*Check all that apply*)
❑ Alone ❑ Spouse ❑ Children ❑Parent(s) ❑ Sibling(s) ❑ Boyfriend ❑ Girlfriend ❑ Roommate
❑ Other:_________________________

List your children (including step, adopted, foster) below:

Name	Sex	Age or year of death	Relationship to you	Living with whom?

Have you ever placed a child for adoption? ❑ Yes ❑ No. If Yes, when? _________________________

Have you ever had a miscarriage or medical abortion? ❑ Yes ❑ No. If Yes, when? _________________________

Please list your parents, brothers, sisters, step-family relations, grandparents, aunts/uncles, nieces/nephews and any other family member who had a significant effect (positive or negative) upon your life. Use back of sheet if needed.
Circle those names who you know experienced struggles with addictions or "bad habits".
Put a star (*) by the names of those with mental health issues such as depression, anxiety, suicide, "nervous breakdown," incest, etc.
Check (√) those with physical health issues such as heart attacks, asthma, emphysema, cancer, etc.

Name	Age or year of death	Relationship to you (e.g., mother, father, sibling, step-relation)	Give 2-3 words to describe this person

COUNSELING HISTORY

If you have had any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care, please list the names of the therapists or programs: *(Use the back, if necessary*)

Therapist's name or program	Major issue	Approximate Dates

MEDICAL HISTORY

List any medical conditions, illnesses, car accidents, head injuries, treatments, or surgeries:

____

____

Your current family/personal physician____

Your height: ____________________ Your weight: ____________________

How has your weight changed in the last 2-3 months: ❑ little or no change ❑ up _________lbs. ❑ down __________ lbs.

List all current medications you are taking, including those you seldom use or take only as needed: *(Use back if necessary)*

Name of medication	Dose	Reason for taking medication

PRESENT ISSUES

Please describe what brings you to counseling now:

____

____

Check any of the following symptoms or problems that you are presently experiencing or have experienced in the past.

Present	Past		Present	Past		Present	Past	
☐	☐	Stress	☐	☐	Anxiety/Worry	☐	☐	Panic
☐	☐	Depression	☐	☐	Crying a lot	☐	☐	Lack of motivation
☐	☐	Fatigue/lack of energy	☐	☐	Poor appetite or overeating	☐	☐	Trouble sleeping
☐	☐	Poor concentration	☐	☐	Feeling worthless or inferior	☐	☐	Feeling hopeless
☐	☐	Guilt	☐	☐	Death of friend/loved one	☐	☐	Grief
☐	☐	Chronic Pain	☐	☐	Physical Disability	☐	☐	Terminal Illness
☐	☐	Health Concerns	☐	☐	Loneliness	☐	☐	Fears
☐	☐	Shyness	☐	☐	Low self-esteem	☐	☐	Don't like myself
☐	☐	Marital problems	☐	☐	Other relational problems	☐	☐	Parenting problems
☐	☐	Physical abuse	☐	☐	Emotional abuse	☐	☐	Sexual abuse
☐	☐	Sexual problems	☐	☐	Gender identity	☐	☐	Anger
☐	☐	Aggressive behavior	☐	☐	Bad dreams	☐	☐	Bad memories
☐	☐	Loss of control	☐	☐	Impulsive behavior	☐	☐	Controlling
☐	☐	Controlled by others	☐	☐	Obsessive thoughts	☐	☐	Compulsive acts
☐	☐	Seeing things others don't see	☐	☐	Hearing voices	☐	☐	Racing thoughts
☐	☐	Eating problems	☐	☐	Drug use	☐	☐	Alcohol use
☐	☐	Cutting/burning self	☐	☐	Gambling	☐	☐	Pregnancy
☐	☐	Abortion	☐	☐	Legal matters	☐	☐	Lack of discipline
☐	☐	Financial problems	☐	☐	Spiritual apathy	☐	☐	OTHER________

Please use an "X" on the scale below to indicate how distressing your problem(s) are to you.

Little Distress Moderate Distress Extreme Distress

____

Are you presently experiencing any suicidal thoughts? ❑ Yes ❑ No
Have you experienced them in the past? ❑ Yes ❑ No
Have you ever attempted suicide? ❑ Yes ❑ No
If Yes, when and how: ____
Have any of your friends or family ever committed or attempted suicide? ❑ Yes ❑ No
If Yes, when and who: ____
Are you presently experiencing any thoughts of harming another person? ❑Yes ❑No

Policies and Informed Consent

Thank you for trusting me with the privilege of providing your counseling service. This information will help you understand the policies, and practical and legal aspects of the counseling process. Please do not hesitate to ask questions regarding any of these matters.

Attached to this form is the newly required Notification of Patient Rights document now required with the passage of the federal "medical records privacy law" known as HIPAA (Health Insurance Portability and Accountability Act). See pages 7 & 8. 44I am required by law to give you a copy of this document and to secure your signature indicating you have received a copy of it. Laws such as these are important but also complex and in the Notification of Patient Rights document I have tried to inform you about your rights in plain, simple language.

APPOINTMENTS

Appointments are scheduled with the counselor. If you wish to terminate sessions, please schedule and allow for a final appointment so we may review your progress and make any necessary referrals.

CANCELLATIONS

If you must cancel an appointment, please do so at least 24-hours in advance of the session. Missed or cancelled appointments with less than 24 hours notice will be charged at your usual fee (with exceptions for family deaths or hospitalizations). After two such missed appointments our agreement may need to be terminated with referral to other services. If I miss a scheduled appointment without 24-hour prior notice, you will be provided with one free session.

EMERGENCIES

I have limited my practice to clients who are not in need of 24-hour care. If you believe that you have need for 24-hour care, please inform me so that I can refer you to another professional colleague or treatment center.
If you have an emergency situation, either call 911or go to a local hospital emergency room.

PHONE CALLS

If you need to speak to me between your regularly scheduled sessions, please leave a message on my phone and I will return your call as promptly as possible. You may also use the e-mail address for short messages. All phone consultations lasting 10 minutes or more will be charged to you on a prorated basis.

FEE INFORMATION

All payment is in cash or check payable to Karen Spruill. I do not accept insurance, Medicare or Medicaid. If you wish to file for reimbursement with your insurance provider, I will be glad to furnish you with a diagnosis and a receipt. You may wish to first discuss the possible ramifications of doing so with me.

The basic fees are charged per 50 minute individual, couple, and family therapy session. Clients are offered a sliding fee scale of $45-$75, depending upon ability to pay. Couples reviewing Prepare/Enrich results are scheduled for 90 minute sessions with an adjusted fee. Group therapy or support group fees to be established as needed.

Payment is expected at the time of service and further appointments cannot be schedules without payment. If you should encounter financial difficulties at any time during counseling, please discuss this with me.

CONFIDENTIALITY

Your case records will be kept confidential and private. Because I do not accept insurance, your records remain with me and we make the decisions for your therapy. In matters where disclosure is not authorized or required by law, confidential information will not be released without your written authorization.
By law I am required to notify authorities if:

1.) You are likely to do harm to yourself
2.) You are likely to harm others, or
3.) You report suspected abuse or neglect of a child, elderly person, resident of an institution, or a disabled person.
4.) If I am court-ordered to release information

YOUR INFORMED CONSENT TO CARE AND TERMS OF SERVICE

Counseling offers no absolute guarantee of success and there are limitations to any form of care offered to a person. You are invited to discuss your treatment plan with me. You need to be aware that as you work on life issues in counseling you may at times feel more distress or unhappiness. Change sometimes provokes resistance among coworkers and family members. Significant others may not appreciate the changes that you make during counseling or provide the support that you request. I want you to be aware that I am committed to providing care from sound counseling principles, research-based information and my personal foundation of a Christian worldview. I am not promising a cure or offering a guarantee of symptom relief.

I, the client, voluntarily consent to take part in counseling treatment services provided by Karen Spruill, M.A. I understand that this consent to services will be valid and remain in effect as long as I attend counseling sessions with Karen Spruill, unless revoked by me in writing, with written notice provided to her.
I certify that this form, including the statements on the limits of confidentiality and risks of treatment have been fully explained to me, that I have read it or had it read to me, and that I understand its contents.

I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of intention to cancel, I will be charged the full fee for service.

If I have any questions or concerns, now or in the future, I understand that I should consult with my counselor. My signature below acknowledges acceptance of the terms of service and my informed consent for care.

____ __________________
Signature of client or other legally authorized person Date

____
If signing for a minor, print name and relationship to the minor

Acknowledgement of Receipt of Privacy Practices Notice

I, ____________________________________ have received a copy of
Karen Spruill, M.A.'s Notice of Privacy Practices.

Name ____

Address ____

____

Signature of Client __________________________________ Date _____________

Signature of Guardian ________________________________ Date _____________
(If client is a minor)

Witnessed by ______________________________________ Date _____________

Signature of Witness ________________________________

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, I have prepared this explanation of how I am required to maintain the privacy of your health information and how I may use and disclose your health information.

Without specific written authorization, I am permitted to use and disclose your health care records for the purposes of *treatment, payment, and health care operations*.

- *Treatment* means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc.

- *Payment* means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services.

- *Health Care Operations* include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services. I will use and disclose your PROTECTED HEALTH INFORMATION when I am required to do so by federal, state or local law. I may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information; to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if I have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. I may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. I may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, I will only make disclosures to a person or organization able to help prevent the threat.

Your written authorization will be required for any other uses or disclosures. Should you choose to revoke your authorization, you may do so only in writing. I will abide by your
written request with the exception of information I released upon obtaining the written authorization and releasing information as required by law.

You may contact Karen Spruill in writing to invoke your following rights:

- You may request in writing that I restrict using and disclosing your Protected Health Information to family members and relatives, friends, or others you identify. I reserve the right to deny this request.

- You may request an amendment to your Protected Health Information.

- You may request alternative means or locations in which you receive confidential communications.

- You may request an accounting of disclosures of Protected Health Information beyond treatment, payment, and health care operations.

I am required by law to protect the privacy of your Protected Health Information and to abide by the terms of the Notice of Privacy Practices. I will make and post revisions to the Notice of Privacy Practices in accordance with the law. You may obtain a written copy of these changes by written request.

You may file a formal, written complaint with me at the address below or with the Department of Health & Human Services, Office of Civil Rights, if you feel your privacy rights have been violated.

For more information regarding my Privacy Practices, please contact:

- The Privacy Officer
  Karen Spruill, M.A.
  Florida Hospital SDA Church
  2800 N. Orange Ave.,
  Orlando, FL 32804
  (407) 760-9027

For more information about HIPAA or to file a complaint, please contact:

- The U.S. Department of Health & Human Services
  Office of Civil Rights
  200 Independence Avenue, S.W.
  Washington, D.C. 20201
  877 – 696 – 6775 (Toll free)