CLIENTS LEGAL NAME _____ _____ _____
First MI Last Date of Birth Age

SPOUSE/PARTNER _____ _____ _____
First MI Last Date of Birth Age

PRESENT ADDRESS _____
Street City State Zip

HOME PHONE NUMBER: ( ) _____ CLIENT'S SOCIAL SECURITY # _____

CLIENT'S PLACE OF WORK _____ Phone ( ) _____
Name

CELL PHONE NUMBER ( ) _____

Check contact number where we may leave a voice message? Home __yes __no Cell __yes __no Work __yes __no

To receive information and personal helps from our office, clearly print your e-mail address: _____

How did you hear about our clinic? __Friend/Relative __ Phone Book __ Internet (Which web site?)_____ __ Our Web Site

__ Church/Pastor __ Insurance Co. __ Doctor's.(Name)_____ _____ Other_____

IF WE ARE FILING FOR INSURANCE, THIS SECTION MUST BE COMPLETED EVEN IF WE HAVE YOUR INSURANCE CARD!

INSURANCE COMPANY _____

EMPLOYER ISSUING INSURANCE _____

EMPLOYEE HOLDING INSURANCE _____ Date of Birth _____

SOCIAL SECURITY OR I.D. NUMBER _____ GROUP NUMBER _____

RELATIONSHIP TO CLIENT _____

HAVE YOU BEEN IN THERAPY THIS CALENDAR YEAR? YES _____ NO _____ NUMBER OF VISITS _____

IF YOU ARE COVERED UNDER 2 POLICES WE MUST HAVE THE FOLLOWING INFORMATION

INSURANCE COMPANY _____

NAME OF POLICY HOLDER _____ ID# _____ GROUP# _____

Medical Information: I would like information about my counseling disclosed to my doctor. ____ Yes ____No

Name of Doctor _____ Name of Clinic _____

Address of Clinic _____ Clinic Phone ( ) _____

Are you taking medication? YES _____ NO _____ Clinic Fax ( ) _____

List Medications **Dosage**

_____ _____

_____ _____

_____ _____

An Authorization form must be completed and signed in order for Merrilie Rackham, LMFT to disclose information.

Have you ever been in counseling before? NO _____ YES _____ Dates _____

Reason _____

Have you ever been hospitalized for mental health reasons? _____ Yes _____ No Dates _____

Reason _____

Family of Origin Information Please provide names and ages of your parents and siblings. Indicate biological with *.

Parents	Age	Siblings	Age

Family Relationships

In your opinion, did your parents have a good relationship with each other? Yes _____ No _____Somewhat _____

Did you have a good relationship with your parents or guardians? Yes _____ No _____Somewhat _____

Were you punished as a child? Yes _____ No _____ If so, how? _____

Did anyone in your family lose control when they were angry? Yes _____ No _____

If yes, who? _____ How? _____

Did you have any other significant adult in your life during childhood? (Grandparents, aunts, uncles, etc.)

Name_____ Relationship _____

Current Family

Are you currently: _____single _____widowed _____in a significant relationship

_____married _____divorced

Date of Marriage or Start of Significant Relationship	Name of Spouse or Partner	Date o f Divorce or Ending of Relationship

Names of Children	Ages	Names of Children	Ages

Have you ever been restrained, pushed, hit, slapped or kicked while in a relationship? Yes _____ No _____

If yes, in which relationship/s _____

DRUG AND ALCOHOL USE

Place a check mark by any substances that you currently use. Place an "X" by any you have used in the past:.

__ Alcohol	__ Prescription Med. Abuse	__ Narcotics
__ LSD	__ Speed/Stimulants	__ Ecstasy
__ Ephedrine	__ Appetite Suppressants	__ Cigarettes
__ Chewing Tobacco	__ Marijuana	__ Acid
__ Inhalants	__ Cocaine	__ Methamphetamine (crank)

IN THE PAST YEAR:

Have you ever felt the need to cut down? Yes _____ No _____

Have you ever felt annoyed by criticism of your usage? Yes _____No _____

Have you ever felt bad or guilty about your drinking or drug use? Yes _____ No _____

Have you ever had a drink or used drugs as an eye opener first thing in the morning to steady your nerves or get rid of a hangover, or to get the day started. Yes _____No _____

How much beer, wine, liquor, marijuana, or other substances do you consume each week, on an average?

_____

_____

ADULT SYMPTOM/PROBLEM ASSESSMENT

Client Name _____

Please indicate the PRIMARY cause for your visit today.

___Depressed feelings ___Grief or Loss ___Relationship/family Problems ___Occupational Problems

___Anxiety or worry ___Abuse Issues ___General Stress ___Physical Health Issues

___Other emotional concerns ___Substance Use Concerns ___Self-Esteem Issues ___Eating Problems

How much have you been bothered by the following symptoms over the last 7 days. (Circle ***only*** the ratings that apply to you)
Rating: 0 = not bothered at all 1 = mildly bothered 2 = moderately bothered 3 = severely bothered

Feeling sad or down	0	1	2	3	Mood Swings	0	1	2	3
Loneliness	0	1	2	3	Perfectionism	0	1	2	3
Worthlessness	0	1	2	3	Emptiness	0	1	2	3
Low Self-esteem	0	1	2	3	Anger/Temper Problems	0	1	2	3
Nervousness/Worry	0	1	2	3	Irritability	0	1	2	3
Panic Feelings	0	1	2	3	Poor Concentration	0	1	2	3
Restlessness	0	1	2	3	Cutting/Self Mutilating	0	1	2	3
Lack of Energy	0	1	2	3	Feeling Overwhelmed	0	1	2	3
Low Motivation	0	1	2	3	Nightmares/flashbacks	0	1	2	3
Fears or phobias	0	1	2	3	Guilt	0	1	2	3
Suicidal thoughts	0	1	2	3	Withdrawn/avoidant	0	1	2	3

How has your life been affected by the symptoms or problem that brought you here?

Circle your current level of impairment for ***only*** those issues that apply to you. 0 = none 1 = slight 2 = moderate 3 = severe

ACTIVITIES OF DAILY LIVING

Getting out of bed	0	1	2	3
Sleeping	0	1	2	3
Person hygiene	0	1	2	3
Household chores	0	1	2	3
Paying bills	0	1	2	3
Opening mail	0	1	2	3
Making/eating meals	0	1	2	3
_____	0	1	2	3

RELATIONAL/MARITAL

Fights/arguments	0	1	2	3
Withdrawal	0	1	2	3
Aggressiveness	0	1	2	3
Violence	0	1	2	3
Lying	0	1	2	3
Sexual problems	0	1	2	3
_____	0	1	2	3

OCCUPATIONAL

Arriving late/leaving early	0	1	2	3
Quality of work	0	1	2	3
Not attending work	0	1	2	3
Non-compliance with rules	0	1	2	3
Excessive errors	0	1	2	3
Impaired creativity	0	1	2	3
Poor judgment	0	1	2	3
Dishonest behavior	0	1	2	3
Co-worker fights/arguments	0	1	2	3
_____	0	1	2	3

SOCIAL RELATIONSHIPS

Isolation/withdrawal	0	1	2	3
Loss of relationships	0	1	2	3
Discord with friends/family	0	1	2	3
_____	0	1	2	3

BEHAVIORAL

Normal Exercise up/down	0	1	2	3
Self injurious behavior	0	1	2	3
Appetite loss/overeating	0	1	2	3
Weight gain/loss	0	1	2	3
Alcohol/drug use increased	0	1	2	3
Increased smoking	0	1	2	3
Reckless driving	0	1	2	3
Increased spending	0	1	2	3
Loss of enjoyment in fun activities	0	1	2	3
Poor or non compliance with medications	0	1	2	3

SPIRITUAL

Inability to pray/meditate	0	1	2	3
Inability to participate in Spiritual community	0	1	2	3

PHYSICAL PROBLEMS (Circle the level of problem you experience currently) 0 = none 1 = slight 2 = moderate 3 = severe

Dizziness	0	1	2	3	Heart racing/pounding	0	1	2	3	Stomach trouble	0	1	2	3
Headaches	0	1	2	3	Swallowing	0	1	2	3	Ulcer	0	1	2	3
Blackouts	0	1	2	3	Indigestion/heartburn	0	1	2	3	Thyroid	0	1	2	3
Allergies	0	1	2	3	Frequent colds	0	1	2	3	Feeling cold	0	1	2	3
Back pain	0	1	2	3	Asthma	0	1	2	3	Chest pain/pressure	0	1	2	3

Other _____

What would you like to achieve as a result of therapy? _____

_____

_____

Creating Connections
Merrilie Rackham, LMFT, Registered Play Therapist

Private insurance companies and governmental insurance programs such as Medicare and Medicaid, require you to sign an assignment of benefits in order for us to bill your insurance company directly. Missouri Law requires a signed patient consent to release medical information to your insurance company and any other parties cooperating in the delivery of your care.

ASSIGNMENT OF INSURANCE INFORMATION:

I hereby authorize assignment of benefits and payment of medical/mental health benefits to Creating Connections, Merrilie Rackham, LMFT for services rendered to myself and/or other dependents. I agree to be responsible for payment of any co-pay charges and any balance due for charges not covered by my insurance policy. I understand that co-pays are due at the time of service and any additional charges are due in full upon receipt of my first statement. I authorize refunds to my insurance company for any overpaid benefits.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

AUTHORIZATION FOR RELEASE OF INSURANCE INFORMATION:

I hereby authorize Creating Connections, Merrilie Rackham, LMFT to contact my insurance company directly to obtain coverage and payment information regarding my policy.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.

Name (printed) _____

Signature _____ Date _____

Creating Connections
Merrilie Rackham, LMFT
Registered Play Therapist

Welcome to my office. I want to help make your experience with me pleasant and comfortable. Please feel free to ask questions about anything you do not understand.

Client Name _____

Business and Billing Policies

- **I agree to pay my co-pays at the time of service.**
- Personal accounts must be up to date for appointments to be scheduled.
- **I agree to pay all bills within 30 days after receiving a statement or as otherwise expressly agreed.**
- Phone consultations with the therapist that exceed 10 minutes in length will be billed as a session and charged based on the time spent. You will be responsible for the co-pay or cash payment for that time.
- **I agree to give a 24 hour notice for cancellation or change of appointments. Insurance companies do not pay for appointments that are cancelled or missed. A $25 charge will be added to your balance for late cancelled or missed appointments.**
- Clients who do not show for appointments or make late cancels may lose their right to continue therapy.
- I understand that a $25 fee will be assessed for checks returned to us by the bank.
- If it is necessary for me to use collection services to receive payment from you, you will be assessed the amount owed to Creating Connections, Merrilie Rackham, LMFT plus the amount charged by the collection service.

Psychological Service Policies

- Counseling sessions are 50 minutes in length unless otherwise specified.
- The information we gather about you will be kept private. Please review the Privacy Policy you receive at the time of your intake.
- I will take from 1 to 3 sessions to evaluate your needs, set goals with you and determine a treatment plan.
- **If for any reason you are not comfortable with me, I will be happy to place you with someone else or refer you as necessary.**
- Therapists will return calls within 24 hours with the exception of weekends. When leaving messages please indicate times and numbers where you are most easily reached.
- All intake forms must be completed on your initial visit.
- Children under the age of 10 are not allowed to wait in the lobby while you attend a session.

Signature of Client/Guardian_____ Date _____

Creating Connections
Merrilie Rackham, LMFT
Registered Play Therapist

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 IT CAREFULLY.

Protecting your privacy
Protecting your privacy and your medical information is at the core of my business. I recognize my obligation to keep your information secure and confidential whether on paper or the Internet. At Creating Connections, Merrilie Rackham, LMFT, privacy is one of my highest priorities.

Keeping your information
Keeping the medical and health information I have about you secure is one of my most important responsibilities. I value your trust and will handle your information with care and respect. I access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. I may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you.

I safeguard information during all business practices according to established security standards and procedures, I continually assess new technology for protecting information. I am trained to understand and comply with these information principles.

Working to meet your needs through information
In the course of doing business, I collect and use various types of information, like name and address and claims information. I use this information to provide service to you, to process your claims and to bring you health information that might be of interest to you.

Keeping information accurate
Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please call or write me at the telephone number and address listed below. I take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

How and why information is shared
I limit who receives information and what type of information is shared.

- *Sharing information with supervisors.* I share information with my supervisors to deliver you the health care services and the related information specified in your plan.

- *Other.* Patient-specific personally identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further, unless you give permission.

If I receive a subpoena or similar legal process demanding release of any information about you I will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, I do not share information with other parties, including government agencies.

Creating Connections, Merrilie Rackham, LMFT does not share any customer information with third party marketers who offer their products and services to my patients.

Email Reminders:
I now have an email reminder system available for your convenience. At your request, I can send you a reminder via email to let you know of an upcoming appointment, however, it is important that you understand that the internet is not a secure delivery system.

_____Yes, please send me email reminders. _____No, thank you.
Initial Initial

Email address is: _____

- Any communication done with email and text is not HIPPA compliant.

I am committed to your privacy
You can count on me to keep you informed about how I protect your privacy and limit the sharing of information you provide to me – whether it is at my office, over the phone or through the Internet.

Signed _____Date _____

Creating Connections
Merrilie Rackham, LMFT
Registered Play Therapist

Merrilie Rackham, LMFT
Registered Play Therapist

Creating Connections

I understand that my records are protected under federal and state regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. I also understand that permission to release records must come from all members of the family participating in treatment. This authorization expires 6 months following termination of treatment with_____.

I/We authorize therapist _____ TO OBTAIN INFORMATION FROM:

Name:_____ Phone:_____ Fax:_____

Address:_____

Check all which apply:

Purpose:
____Treatment Planning
____Monitoring of treatment progress
____Other (must specify):_____

Content:
____Information regarding attendance at scheduled appointments
____Status with program: admitted, discharged, etc.
____Assessment of treatment needs
____Treatment progress
____Other (must specify):_____

I/We authorize therapist _____ TO REALEASE OMFORMATION TO:

Name:_____ Phone:_____ Fax:_____

Address:_____

Check all that apply:

Purpose:
____Treatment Planning
____Monitoring of treatment progress
____Other (must specify):_____

Content:
____Information regarding attendance at scheduled appointments
____Status with program: admitted, discharged, etc.
____Assessment of treatment needs
____Treatment progress
____Other (must specify):_____

Client Name:_____Signature:_____Date:_____

Guardian Name:_____Signature:_____Date:_____

Therapist Name:_____Signature:_____Date_____

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