W.F. PRECOURT COUNSELING SERVICES

William F. Precourt LPCMH CADC
1326 S Governors Ave
Ste A
Dover DE 19904
(P) 302.736.1232
(F) 302.736.1280
PrecourtCounseling.com

Client Intake Form

Client Contact Information
First & Last Name _____ MI _____

Gender ☐ M / F ☐

SSN _____-_____-_____ Date of Birth _____/_____/_____

Address Line 1 _____

Address Line 2 _____

City _____ State _____ Zip Code _____

Home phone (_____) _____-_____

Cell phone (_____) _____-_____

If minor, parent / guardian name _____

Emergency Contact Information
First & Last Name _____

Phone Number (_____) _____-_____

Relationship to Client _____

Billing Insurance Information (person or insurance company responsible for payment)
Primary Insurance Company _____

Member ID _____ Group# _____

Policy Holder Name _____

Policy Holder Date of Birth _____/_____/_____

Secondary Insurance Company_____

Member ID _____ Group# _____

Policy Holder Name _____

Policy Holder Date of Birth _____/_____/_____

Insurance Authorization and Assignment
I attest that I have provided complete and accurate information regarding insurance coverage for myself (and / or minor child client). I understand that I am financially responsible for any sessions not authorized or rejected by my insurance carrier. I authorize the release of medical, mental health, or substance abuse information necessary to process insurance claims for the duration of my treatment. I also request payment of benefits directly to William F. Precourt LPCMH CADC for the services described and submitted on the claim form[s]. This authorization is for the duration of my treatment and until all claims are submitted and processed. I understand that I am responsible for any deductible, co-insurance, and / or co-pay amounts. I am responsible to provide any changes in insurance within twenty (20) days of the new effective date to William F. Precourt LPCMH CADC.

Signature _____ Date _____/_____/_____

Authorization to Disclose Information to Primary Care Physician

Report to Primary Care Physician from William F. Precourt LPCMH CADC

The patient named below has consented to allow me to communicate with you about their treatment.

I understand that my records are protected under the applicable state laws[s] governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 24 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve months following the termination of treatment services at William F. Precourt LPCMH CADC.

I, _____ (Printed Name of Client or Parent / Guardian) hereby authorize the staff of William F. Precourt LPCMH CADC to (check all that apply):

☐ release any applicable information to my Primary Care Physician

☐ obtain any applicable information from my Primary Care Physician

Signature _____

Printed Name of Signer _____

Date _____/_____/_____

Primary Care Physician Information

Physician's Name _____

Address Line 1 _____

Address Line 2 _____

Address Line 3 _____

City _____ State _____ Zip Code _____

Office phone (_____) _____-_____

Fax (_____) _____-_____

Private Health Information

HIPAA Review

Health Information which we receive and / or create about you, personally in this program, relating to your past, present or future health treatment or payment for health care services, is "protected health information" under the federal law known as the Health Insurance Portability and Accountability Act (HIPPA), 45 C.F.R. Parts 160 and 164.

The confidentiality of alcohol and drug abuse patient records maintained by this agency is protected by another federal law as well, commonly referred to as the Alcohol and Other Drug (AOD) Confidentiality Law, 42 C.F.R. Part 2. Generally the program may not say to a person outside the program that you attend the program or disclose any information identifying you as an alcohol or drug abuser, or use or disclose any other protected health information except in limited circumstances a permitted by federal law. Your health information is further protected by any pertinent state law that is more protective or stringent then either of these two federal laws.

All new clients receive the "Notice of Privacy Practices" which describes how we protect personal health information we have about you, and how we may use and disclose this information. The notice also describes your rights with respect to protected health information and how you can exercise those rights.

HIPAA Consent Form

By signing below, I hereby acknowledge that I have been provided a copy of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities, and healthcare operations of the office as described in the Notice.

Signature (patient or personal representative) _____

Printed (patient or personal representative) _____

Description of Legal Authority to patient _____

Date _____/_____/_____

Outpatient Services Admission and Discharge Criteria

Admission Criteria

1. Client has an identifiable behavioral health problem with an Axis I Diagnosis.
2. Client does not meet criteria for a more or less restrictive Level of Care.
3. Face-to-face participation is necessary and sessions last at least 45 minutes.
4. Program Staff is qualified / able to adequately treat the client's unique presenting problems.

Continued Treatment

1. Client continues to meet admission criteria.
2. A problem-focused goal-oriented treatment plan is formulated.
3. The involvement of family in child / adolescent treatment is required unless precluded by legal restrictions.
4. Evidence of compliance with treatment program and motivation for treatment is indicated.

Discharge Criteria

1. The client/family has met the goals identified at intake and developed during the course of treatment.
2. Client/family terminates treatment on their own.
3. A higher or lower level of care is needed therefore requiring a referral to internal or external programming.

Medication Treatment

When your Psychiatrist or Nurse Practitioner prescribes you or your family members a new medication or new dosage of an existing medication he / she will review the possible adverse side effects, the benefit of the medication, possible interactions, and possible consequences of not taking the medication or not taking the medication as prescribed. It is expected that all clients will read all information that comes with their medication, and request from their pharmacists any literature available regarding the medications they are taking and possible interactions with other medications. Clients should also alert their primary care physician of all medication changes. It is the patient / guardian's responsibility to report any medication that is being taken by the client at his / her time prior to treatment. Clients and guardians do reserve the right to refuse medication management and continue with outpatient behavioral health treatment.

Confidentiality

I understand that information between me and my therapist is held strictly confidential, and my therapist will not release any information about my therapy unless permitted by law or

1. I agree in writing to permit such a release
2. My therapist believes I pose a physical danger to myself
3. My therapist believes I pose a danger to others
4. Child / elder abuse / neglect is suspected

I understand that in the latter 2 cases (3 and / or 4), the therapist is required by law to inform potential victims and legal authorities so that protective measures can be taken. If I participate in group counseling, I agree to not discuss any details of the group outside of the counseling sessions.

Release of Information

In addition to releases of information permitted above, I authorize discussion of my case with the referral source and other William F. Precourt LPCMH CADC providers and facilities for purposes of diagnosis and treatment. I further authorize the release of information for claims, certification / case management / quality improvement and other purposes related to the benefits of my health plan (releases of information to providers, family, etc. require separate form[s])

Appointment Reminder Calls

William F. Precourt LPCMH CADC typically makes courtesy calls to a client's home or designated primary number, one day prior to the scheduled appointment. Reminder information typically includes the time and date of the appointment and the name of the clinician. The information is also left on the home answering machine or voice mail if no one picks up the call. Clients who do not want these calls or have a specific request regarding how these calls are made should note special instructions below. We will do our best to accommodate any request but do not guarantee all requests can be accommodated.

Special Requests

_____

_____

_____

_____

_____

Canceled/Missed Appointments

When possible, please call 24 hours in advance if unable to keep your scheduled appointment. Clients missing two appointments in a row or repeated no shows in the course of treatment, as subject by the clinician, will be terminated from services at William F. Precourt LPCMH CADC.

Financial Terms

Payment is to be made in full with cash, personal check, ~~or credit card~~ at the time of the session. For those plans which William F. Precourt LPCMH CADC accepts assignment upon verification of health plan / insurance coverage and policy limits, my insurance carrier will be billed for you and the company and / or Provider will be paid directly by the carrier. I will be responsible for any applicable deductibles, co-payments, and co-insurance payments. I agree to make these payments at each appointment. I understand that if I am not eligible at the time services are rendered, I am responsible for payment, even if the determination is made after services are rendered. All fees are due within forty-five (45) days of the date of service. The client or guardian is responsible to notify the billing department of any / all insurance changes. You must report insurance changes within twenty (20) days of the effective changes. Any changes not reported in a timely manner will render the client and / or guardian responsible for services.

Client Information Packet

William F. Precourt CADC provides all new clients with an information packet, which includes information regarding hours of operation, emergency on-call procedures, financial and insurance arrangements as well as other agency specific information. You may request for a client information packet at any time.

Complaints / Feedback

Feedback, either positive or negative, regarding our services and staff is always appreciated. You have the right to file a complaint about any and all services provided and to receive feedback in a reasonable amount of time. We encourage you to discuss any complaints with your provider[s]. You may however contact the office manager, Cheryl Precourt to file a complaint or give feedback. If you provide a written complaint an outcome of an investigation will be mailed to the return address indicated in that notice.

Consent for Treatment

I further authorize and request that my therapist carry out psychological or psychiatric examinations, treatments, and / or diagnostics procedures, which now or during the course of my care as a patient are advisable. **I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement.** I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable. If you consent for treatment, please initial below.

Client or Patient / Guardian Initial _____

Patients Rights And Responsibilities

The Rights of the Patient

1. You have the right to be treated with respect and dignity and receive quality services.
2. You have the right to have your clinical information kept confidential within the constraints of the law.
3. You have the right to an explanation of your conditions of treatment.
4. You have the right to participate in decisions involving your treatment. You may refuse treatment at any time.
5. You have the right to refuse to participate in scientific research. This type of refusal will not omit you from your regular course of treatment in any way.
6. You have the right to have your complaints heard.
7. You have the right to request a male or female therapist, as well as a therapist who understands and speaks your language. We will try to honor these requests so long as we have available staff.
8. You have the right to request a change in therapist. We will try to accommodate such requests. Such a request will be void if you have been terminated from the practice or are pending possible termination.
9. You have the right to receive assistance with respect to knowing and understanding your mental health and substance abuse benefits.

The Responsibilities of the Patient

1. You are expected to support the patient therapist relationship. For example, you should exercise courtesy and make every effort to keep scheduled appoints. A "no show" payment will be applied if you miss an appointment without notifying the office. Notification must be made at least 24 hours in advance of your scheduled appointment.
2. You are expected to present true and accurate information when it is requested and participate actively in planning of your treatment.
3. You are expected to follow the recommendations of the clinical treatment program and address any problems about your treatment with your provider.
4. You may not use profane language, threaten or endanger the life, health, or social well being of any staff members or another individual in / on our premises.
5. You may not engage in any illegal acts, such as altering for forging a staff member's name (to include prescriptions, work / school excusals, disability forms, housing forms, etc).
6. You are expected to pay any necessary fees at the time of your appointment.
7. You are expected to notify your therapist or the office manager if you are terminating treatment.
8. You are expected to respect the confidentiality of other patients or visitors you may encounter on our premises.

Acknowledgements and Contract

Final Instructions

William F. Precourt LPCMH CADC wishes to ensure that all clients have enough information regarding the agency and the treatment in which they are participating to make informed decisions. Please read the following page carefully as your signature verifies that you have received various documents, that you have an understanding of expectations regarding your participation, and that you have knowledge of agency policies. If you have not received the information listed, please request it or ask for any needed clarification prior to signing.

Final Authorization

I, the patient or guardian for the patient, have read the materials presented in this disclosure statement. My signature indicates that I understand the information present in this packet and all my questions have been answered to my satisfaction. I agree with the conditions of therapy that are either stated or implied here and commit myself to compliance with them. I also agree that my provider[s] may discuss information regarding my case with another covering provider in my provider[s] absence. I also understand that I have the right to NOT sign this form until I discuss my concerns with my provider before treatment begins. I understand that once mental health treatment begins I have the right to withdraw my consent to participate in treatment at any time that seems appropriate. I will make every effort to discuss my concerns about progress of my treatment with my provider[s]. My rights as a patient or guardian of a patient, which includes my right to review records, have been explained to me. Additionally, I have received a copy of the agency's privacy practices and copies of any signed releases I have requested.

Signature of Patient _____

Date _____/_____/_____

Signature of Parent / Guardian _____

(if patient is minor)

Date _____/_____/_____

Signature of Staff _____

(as witness)

Date _____/_____/_____