**Cord of Three Counseling Services**
**Individual Adult Intake Form**

| Client Home Phone | Client Cell Phone |
|---|---|
| _____ | _____ |

**Date of Intake:**
**BACKGROUND INFORMATION**

Client Name: _____ SSN: _____ DOB: _____

Address: _____ City: _____ State: GA Zip: _____

Employer: _____ Occupation: _____

Email: _____ Home Phone: _____

Emergency Contact Person: _____ Emer. Contact #: _____

Client Age: _____ Client Gender: _____ Client Ethnicity: _____

Church of Attendance: _____ Active Member: Yes No

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Presently living with:
- Parents ☐
- Spouse ☐
- Roommate ☐
- Alone ☐
- Other _____

Marital Status:
- Single ☐
- Married ☐
- Separated ☐
- Divorced ☐
- Widowed ☐
- Other _____

Highest Education Completed:
- Elementary School ☐
- High School ☐
- College ☐
- Graduate School ☐
- Professional School ☐
- Other _____

If you are or have been divorced or are separated, please explain the situation.

Please write in black ink.

| **Chief Complaint** (What are the primary problems that have caused you to seek out counseling at this time?) |
|---|
| |

**Have you ever received any previous counseling/psychiatric or substance abuse treatment?**

| TX PROVIDER/ FACILITY NAME | DATE | REASON FOR TREATMENT | LEVEL (check one) Inpatient, | Partial, | Residential, | Out Pt |
|---|---|---|---|---|---|---|
| | | | ☐ | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ | ☐ |

**MEDICAL HISTORY:** (Please check any of the following medical problems you have experienced)

| | | | | |
|---|---|---|---|---|
| ☐ Asthma | ☐ Bowels | ☐ Respiratory | ☐ Encephalitis | ☐ Herpes |
| ☐ Cardiac | ☐ Emphysema | ☐ Ulcers | ☐ Chlamydia | ☐ Meningitis |
| ☐ Diabetes | ☐ Hypertension | ☐ Cancer | ☐ Gonorrhea | ☐ Sickle Cell |
| ☐ Cirrhosis | ☐ Liver | ☐ Glaucoma | ☐ Syphilis | ☐ Toxoplasmosis |
| ☐ Thyroid | ☐ Kidney | ☐ Gynecological | ☐ Arthritis | ☐ Tuberculosis |
| ☐ Rheumatic Fever | ☐ Scarlet Fever | ☐ Neurological exam | | |
| ☐ Hemophilia | ☐ Seizures, type: _____ | | | |
| ☐ Chicken Pox | ☐ Hepatitis, type: _____ | | | |
| ☐ Other : _____ | | | | |

**MEDICATIONS: (All Current Medications You Are Taking)**

| Current Medications | Dosage/Frequency | Prescribed by | Last use | Is medication being taken as prescribed? |
|---|---|---|---|---|
| | | | | ☐ YES ☐ NO |
| | | | | ☐ YES ☐ NO |
| | | | | ☐ YES ☐ NO |
| | | | | ☐ YES ☐ NO |

List all allergies (include medications, foods, insects, substances, & any others):

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Please list all health care providers treating you at this time: _____

**Physical Pain Screening:**
Please circle the face that corresponds to your level of physical pain today.


If you have physical pain today, describe what is causing your pain:

Have you talked with your medical doctor about your pain?

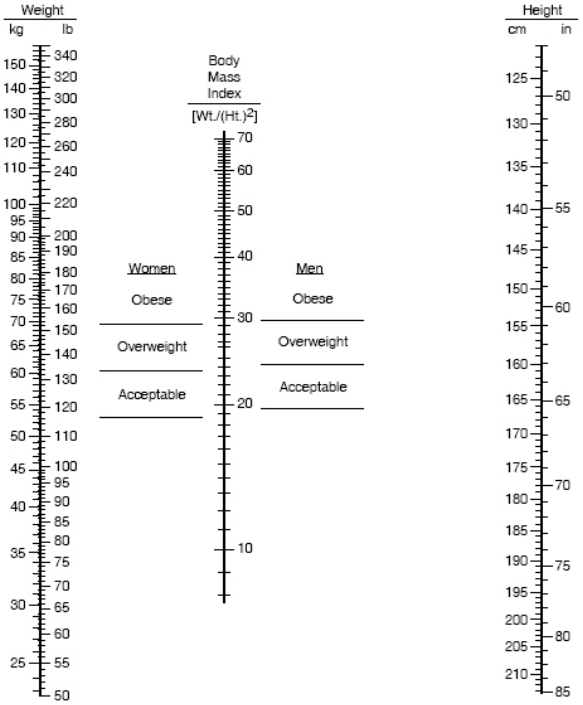
**LEGAL STATUS ASSESSMENT:**
Please provide an explanation of any legal involvement:
Are there any current/pending legal problems? ☐ YES ☐ NO
Are you on probation/parole? ☐ YES ☐ NO (If yes, P.O.'s name & phone)
_____

Do you have previous legal history?
☐ YES ☐ NO

Will legal situation impact treatment?
☐ YES ☐ NO

## Nutrition Screening:

Please mark you height in inches and your weight in lbs.




| Please Circle each number if you answer yes to any of the questions below: | Yes |
|---|---|
| I have lost or gained 10 lbs. in past 6 months | 2 |
| I do not have enough food to eat each day | 1 |
| I do not eat 1 or more days each month | 2 |
| I have an illness that has made me change the kind and/or amount of food I eat | 1 |
| I eat fewer than 2 meals per day | 1 |
| I eat few fruits or vegetables or milk products | 1 |
| I have 3 or more drinks of beer, liquor or wine each day | 2 |
| I have tooth or mouth problems that makes it hard to eat | 1 |
| I don't always have enough money to buy the food I need | 1 |
| I eat alone most of the time | 1 |
| I have a history of binging and/or purging | 2 |
| I exercise excessively to maintain weight | 2 |
| I am anorexic | 2 |
| **0 – 2 Good!**<br>**3 – 7 You are at moderate nutritional risk:** See what can be done to improve your eating habits and lifestyle.<br>**8 or more You are at high nutritional risk:** You may need to be under the help of a qualified medical doctor or counselor. | |

## ALCOHOL/DRUG HISTORY:

Any History of drug/alcohol use? ☐ YES ☐ NO If NO, go to Psychosocial History.

☐ Alcohol ☐ Marijuana ☐ Stimulants ☐ Barbiturates
☐ Cocaine ☐ Hallucinogens (Acid/LSD) ☐ Methadone ☐ Pain Medications
☐ Crack ☐ Opiates ☐ Tranquilizers ☐ Over-the-counter Medications
☐ Tobacco ☐ Heroin ☐ Sedatives ☐ Crank
☐ Caffeine ☐ Inhalants ☐ Methamphetamine (Ecstasy, crystal meth)

☐ Other: _____

COMPLETE THE FOLLOWING FOR THE ITEMS CHECKED ABOVE:

| Substance Checked | Amt/Frequency | Duration of Use | First Use | Last Use | Amt. used in last 24 hours |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Withdrawal Symptoms/behaviors from alcohol/drug use: (Check all that apply)

☐ Aggression/assaultive ☐ Cramps ☐ Agitation ☐ Weakness
☐ Profuse sweating ☐ Change in blood pressure ☐ Tingling ☐ Rapid heart beat
☐ Diarrhea ☐ Fever/chills ☐ Nausea/vomiting ☐ Tremors
☐ Irritability ☐ Delirium ☐ Anorexia ☐ None

**PSYCHOSOCIAL HISTORY:**
Describe your leisure and recreational activities:

What type of social activities do you participate in?

Have you ever been a victim of physical/sexual abuse? ☐YES ☐NO
Are you sexually active? ☐YES ☐NO
Have you ever physically or sexually abused another person? ☐YES ☐NO

**SUPPORT SYSTEMS**
(availability of family/friends to participate in treatment, special family concerns)

**LIST OF PEOPLE LIVING IN THE HOME, NOT INCLUDING YOURSELF:**

| NAME | RELATION TO CLIENT | AGE | GENDER | OCCUPATION |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Do you want your significant other or anyone in your family to participate in your treatment? If so, who? | | | | |

**REVIEW OF COMMUNITY RESOURCES**
(check all that apply now or that you have used in the past):

☐ Church ☐ Health Dept ☐ Medical Clinics ☐ Voc. Rehab ☐ Adult Ed.
☐ Housing ☐ Schools ☐ SSI/Medicaid ☐ SSA/Medicare ☐ Food Stamps/WIC
☐ Child ☐ Insurance ☐ Family/Friends ☐ Financial Aid
☐ DFCS: Name of current case worker
☐ Other community resources (please specify):

**Safety Risk Screening:**

| **Please Circle the number to the left if any of the following are true:** | |
|---|---|
| | **Risk Factors** |
| 1 | Current/past psychiatric diagnosis: I have been diagnosed with a mood disorder, psychotic disorder, alcohol/substance abuse addiction. |
| 1 | Key Symptoms: I experience any of the following symptoms: depression, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations |
| 2 | Suicidal Behavior: I have a history of past attempts of suicide or self-injurious behaviors |
| 1 | Family: I have a family history of suicide or suicide attempts and/or a family history of mental health problems |
| 1 | Precipitating Factors: I have experienced public humiliation, shame or despair (i.e. loss of relationship, financial problems, health status changed) or I have been diagnosed with an ongoing medical illness |
| 1 | I have access to firearms |
| | **Protective Factors** |
| -1 | I have the ability to cope with stress and I have religious beliefs against self-harm |
| -1 | I have a responsibility to my children or loved ones and I have positive outlets for expressing myself and being understood |
| | **Suicide Inquiry** |
| 2 | I have a been thinking about suicide during the past<br>☐ 48 hours ☐ month ☐ Year |
| 2 | I know when, how and where I would commit suicide |

| | |
|---|---|
| 2 | I have attempted suicide in the past and I have rehearsed (literally or in my mind) how I would commit suicide or hurt myself |
| 2 | I have a desire to physically hurt someone else |

Risk Level Score: _____

Please check any of the symptoms listed below which apply to you:

| | Current | History | N/A |
|---|---|---|---|
| Depressed mood | ☐ | ☐ | ☐ |
| Feelings of worthlessness | ☐ | ☐ | ☐ |
| Manic thought/behavior | ☐ | ☐ | ☐ |
| Crying spells | ☐ | ☐ | ☐ |
| Phobias | ☐ | ☐ | ☐ |
| Angry | ☐ | ☐ | ☐ |
| Anxious | ☐ | ☐ | ☐ |
| Obsessive/compulsive | ☐ | ☐ | ☐ |
| Changes in Appetite | ☐ | ☐ | ☐ |
| Change in Energy Level | ☐ | ☐ | ☐ |
| Sleep Disturbance | ☐ | ☐ | ☐ |
| Decreased Concentration | ☐ | ☐ | ☐ |
| Disorganized/Disoriented | ☐ | ☐ | ☐ |
| Learning Problem | ☐ | ☐ | ☐ |
| Social Withdrawal | ☐ | ☐ | ☐ |
| Binging/Purging | ☐ | ☐ | ☐ |
| Sexual Acting Out | ☐ | ☐ | ☐ |
| Sexual Promiscuity | ☐ | ☐ | ☐ |
| Distractibility/Impulsivity | ☐ | ☐ | ☐ |
| Hyperactive | ☐ | ☐ | ☐ |
| Lying/Manipulative | ☐ | ☐ | ☐ |
| Running Away | ☐ | ☐ | ☐ |
| Truancy/Absenteeism | ☐ | ☐ | ☐ |
| Property Destruction | ☐ | ☐ | ☐ |
| Fire Setting | ☐ | ☐ | ☐ |
| Cruelty to Animals | ☐ | ☐ | ☐ |
| Stealing | ☐ | ☐ | ☐ |
| Other legal Issues | ☐ | ☐ | ☐ |
| Oppositional Behaviors | ☐ | ☐ | ☐ |
| Family Problems | ☐ | ☐ | ☐ |
| Religious/Spiritual Concerns | ☐ | ☐ | ☐ |
| Talk of Suicide | ☐ | ☐ | ☐ |
| Hallucinations | ☐ | ☐ | ☐ |
| Bedwetting | ☐ | ☐ | ☐ |

What do you hope is changed as a result of coming to counseling?

Any other information you would like for your counselor to know?

# Cord of Three Counseling Services
# Information and Office Policy Statement
# Informed Consent

## I. New Client: Welcome!

Cord of Three Counseling Services is a private Christian Counseling Service offered to families of Southeast Georgia. Thank you for considering the use of our counseling services. The information below is to help you understand the nature of counseling with our agency and to understand the necessary procedures that are required by law to provide for your safety and confidentiality as well as the agency's.

## II. Aims and Goals:

The major goal is to help you identify and cope more effectively with problems in daily living and to deal
with inner conflicts which may disrupt your ability to function effectively. This purpose is accomplished
by:

1. Increasing personal awareness.
2. Increasing personal responsibility and acceptance to make changes necessary to attain your goals.
3. Identifying personal treatment goals.
4. Promoting wholeness through Christian clinical counseling.

You are responsible for providing necessary information to facilitate effective treatment. You are expected to play an active role in your treatment, including working with your therapist to outline your treatment goals and assess your progress. There may also be negative consequences if you do not follow through with recommended treatment(s). You may be asked to complete questionnaires or to do homework assignments. Your progress in therapy often depends much more on what you do between sessions than on what happens in the session. You may be contacted by a Cord of Three Life Coach. The role of the Life Coach is to contact you via the phone and encourage you through prayer and biblical discipleship.

## I. Appointments:

Appointments are usually scheduled for 50 minutes. Sessions are by appointments only. Patients are generally seen weekly or more/less frequently as acuity dictates and you and your therapist agree. You may discontinue treatment at any time, but please discuss any decisions with your therapist. Cord of Three is not an emergency facility, therefore, in the event of an emergency; please call 911, your primary care physician or the Focus on the Family crisis hotline: 1-800-232-6459

## II. Confidentiality:

Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." However, there are limits to the privilege of confidentiality. Those situations include: 1. Suspected abuse or neglect of a person, 2. When your psychiatrist or therapist believes you are in danger of harming yourself or are unable to care for self, 3. If you report that you intend to physically harm someone the law requires the agency to inform that person and the legal authorities, 4. If your therapist is ordered by a court to release information as part of a legal involvement in company litigation, 5. When your insurance company is involved (i.e. filing of claims, etc…), 6. In natural disasters whereby protected records may become exposed, or 7. When otherwise required by law. You may be asked to sign a release of information so that your therapist may speak with other mental health professionals or to family members. If you are deemed a threat to yourself or to someone else, Cord of Three will make a referral for you to the appropriate facility.

## Client Information and Office Policy Statement – continued

## III. Record Keeping:

A clinical chart is maintained describing your condition and your treatment and progress in treatment, dates of and fees for sessions, and notes describing each therapy session. Your records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section above. Medical records are kept under the care of your therapist.

## IV. Fees:

Fee for the initial visit is $120.00 and each 45-50 minute session thereafter is $95.00.
Other fees may apply when assessment instruments are used. Cord of Three does provide services on a Sliding Fee Schedule, if you do not have insurance and cannot afford to pay for the cost of your sessions, please indicate your needs to your therapist or contact our program office at 912-282-0992 and speak to the Administrative Assistant about your payments.

## V. Payments:

Payment is due at the time of the session unless other arrangements have been made. Your therapist will file you insurance claim, but you are responsible for deductibles, co-insurance, and co-payments. It is your responsibility to familiarize yourself with your insurance benefit.

## VI. Cancellations and Missed Appointments:

You will be billed for any sessions that you cancel with less than 24 hours notice. You may leave messages 24 hours per day at 912-282-0992. You will be billed $50 --not just a co-payment. Insurance companies generally do not reimburse for missed appointments. After two consecutive no-show's, your may not be able to schedule another appointment with Cord of Three.

## VII. Complaints:

You have a right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, your physician, therapist, or any office policy please inform us immediately and discuss the situation. If you do not feel the complaint has been resolved, you may also inform our accrediting agency (The Joint Commission) at www.jointcommission.org .

## VIII. Consent for Treatment

By signing below, you are stating that you have read and understood this 2-page policy statement and you have had your questions answered to your satisfaction. You also understand that you may be contact by one of the Cord of Three Life Coaches and are giving your consent to their calls. You are also acknowledging that as a Christian counseling agency, we recognize the Holy Bible as the authority on moral/emotional/social issues and you agree to the counselors use of the bible as the standard for counseling services. **Therefore, I accept, understand and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time.**

*I understand that I am financially responsible for payment of services received by me or my dependent(s). I authorize the release of clinical or medical information to my insurance company, primary care physician and referral source or agency when needed for insurance coverage and/or payment. I understand that insurance claims will be electronically filed to my insurance carrier on my behalf. I am responsible for payment(s) not received from the insurance company within 90 days of treatment and will make payment to Cord of Three Counseling Services. I assign insurance benefits payable to me to Cord of Three Counseling Services Inc.*

Name of patient (please print): _____

Signature: _____ Date: _____

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I understand that, under the Health Insurance Portability Act of 1996 (HIPPA), I have certain rights to privacy regarding my PHI. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Insurance companies require that you are given a diagnosis
- Conduct normal healthcare operations such as a quality assessment and physical certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it Notice of Privacy Practices from time to time and that I may contact this organization at any time at 204 S. Crawford Street Waycross, GA 31503 to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

| | |
|---|---|
| Printed Name | Date |
| Signature Of Responsible Party | Cord of Three Witness |

**NOTICE OF PRIVACY PRACTICES**
**(KEEP THIS COPY FOR YOUR OWN PERSONAL RECORDS)**

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.

The Health Insurance Portability and Accountability Act of 1996 (HIPA) is a federal program that requires that all medical records and other individually identifiable health information use or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use ad disclose your health information. We may use and disclose our medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordination, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** includes the business aspects of running our practices, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis and customer service. An example would be an internal quality assessment review.

We may also create and duplicate de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternative or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization in writing and we are required to honor and abide by that written request, except in the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your Protected Health Information (PHI), which you can exercise by presenting a written request to the Privacy Officer at Cord of Three: Clay Gill or Tracy Crews at 912-282-0992.

- The right to request restriction on certain uses and disclosures of PHI, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by your signature. We are, however not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable request to receive confidential communications of PHI from us by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of PHI.
- The right to obtain a paper copy of this notice upon request.

| | |
|---|---|
| We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. This notice is effective as of January 1, 2015 and we are required to abide by the terms of this Notice of PrivacyPractices an dmake the new notice providions effective for allPHI that we maintain. You may request a written copy of a revisited Notice of Privacy Practices. You have recourse if you feel that your privacy protections have been violated. You have the right to fil ea w2ritten complaint to our office at<br>204 S. Crawford Street<br>Waycross, GA 31503<br>912-282-0992/Phone<br>912-285-8817/Fax | For Information about HIPPA or to file a complaint:<br><br>The U.S. Department of Health & Human Services<br>Office of Civil Rights<br>200 Independence Avenue S. W.<br>Washington, DC 20201<br>Toll Free: 877-696-6775 |

Our Mission

It is the mission of Cord of Three to provide **Christ-Centered Services** that will impact, protect, and preserve the emotional and spiritual health of the God ordained institution of the Family.

Cord of 3
Counseling Services, Inc.

PO Box 1984
Waycross, GA 31502
912-282-0992/Phone
912-285-8817/Fax

**AUTHORIZATION to use and Disclose**
**Protected Health Information (PHI)**

**I am completing this form to allow the use and sharing of Protected Health Information about:**

Client's Name: _____

Address: _____

Social Security # and/or DOB: _____

**I hereby authorize:**

Cord of Three Counseling Services
PO Box 1984
Waycross, Georgia 31503 912-282-0992/phone 912-285-8817/fax

**To:** ☐ OBTAIN Protected health Information (PHI) from: -and/or-
☐ RELEASE/Disclose PHI to:

Name/Agency _____

Address: _____

_____

Phone: _____

- **Expiration:** I understand and agree that this authorization will be valid and in effect until _____ unless I choose to revoke it. I understand that after that date or event, no more of this information can be obtained by/released to the person or organization unless I sign a new authorization like this one.
- **Revocation:** I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer, Cord of Three Counseling Services at the address listed above. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information was sent or shared before that date.
- I understand that I do no have to sign this authorization and that my refusal to sign will not be cause to discharge my minor child from obtaining services at Cord of Three Counseling Services.
- I understand that I may inspect and have a copy of the health information described in this authorization.
- I understand that if the person/entity that receives the information is not a healthcare provider or health plan covered by federal regulations, the information described above may be re-disclosed and no longer protected by those regulations.
- I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

_____ _____
Authorized Representatives Printed Name Date

_____ _____
Authorized Representatives Signature Cord of Three Staff Signature