

TINA FLAHERTY, MSW LISW FLAHERTY COUNSELING & CONSULTING, INC

2435 KIMBERLY ROAD, 165-S
BETTENDORF, IA 52722
563.232.1878 563.232.1879 (FAX)

www.flahertycounseling.com tina@flahertycounseling.com

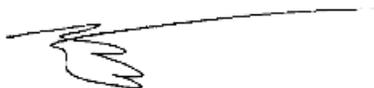
Hello and welcome! I look forward to meeting you at your first appointment! Below is the basic housekeeping in order to make this a smooth process.

- Paperwork: Please find paperwork attached that you can fill out in advance and bring with you. If you don't have it with you, please arrive about 15-30 minutes early to complete paperwork.
- Insurance/Payment: Please bring a copy of your insurance card if we will be billing insurance. Also come prepared to make payment at the time of service. I accept checks and most major credit cards.
- Address/Directions: 2435 Kimberly Rd, Suite 165 South, Bettendorf, IA 52722 - located in the Alpine Business Centre. (Google Maps Link: <https://goo.gl/maps/v3NXWqjnWU72> *** BEWARE other electronic searches lead people to Paul Revere Square. **ONLY USE GOOGLE MAPS.**) We are across from Duck Creek Golf Course, and BETWEEN Tree House Pub & Eatery and Red Lobster. When you pull in the parking lot, you will be entering the building on the south, nearest Duck Creek and the bike path, and toward Hobby Lobby.
- Entrance: Come to the north entrance of the SOUTH building. You will see a blue sign that reads "Alpine Centre South" over the door you will enter. My office is on the main level. Go to the end of the hall and turn left, my office is the first on the right. The suite (165 S) number and my name will be on the door.

Come on in and wait while I finish up with the client before you. I will do my best to be with you at the start time of your session. Have a seat, grab a drink from the beverage refrigerator and relax!

Thank you for choosing me to serve you, and again I look forward to meeting you.

Regards,



Tina Flaherty, LISW

TINA FLAHERTY, MSW LISW

FLAHERTY COUNSELING & CONSULTING, INC

2435 KIMBERLY ROAD, 165-S
BETTENDORF, IA 52722
563.232.1878 563.232.1879 (FAX)

www.flahertycounseling.com tina@flahertycounseling.com

Adult Intake Form

Name & Identifying Information:

Name (First, MI, Last): _____

Sex: Male _____ Female _____ TG _____ Date of Birth: _____

Employment Status: Employed _____ Full-Time Student _____ Part-Time Student _____ Retired _____

Employer: _____ Occupation: _____

Marital Status: Single ___ Married ___ Widow ___ In a Relationship ___ If so, for how long? _____

Whom may we thank for referring you? _____

Address & Contact Information:

Street Address: _____

City: _____ State: _____ Zip Code: _____

How may we best contact you in respect to your privacy? Please provide two phone numbers, or a phone number and an email address you are authorizing us to use as your contact information:

Home Number: _____ Mobile Number: _____ Work Number: _____

Email Address: _____

Initial _____ *I agree that Flaherty Counseling & Consulting may communicate with me electronically (via Email) unless and until I revoke this authorization by submitting notice to us in writing. This authorization does not allow for electronic transmission of my protected health information to third parties and I understand I must execute a separate authorization for it to be disclosed to third parties.*

In case of emergency, who should we notify? _____ Phone: _____

Appointment Reminders, Online Scheduling & Electronic Communication:

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a voice message) before your scheduled appointments. Where would you like to receive appointment reminders? (Missed appointment fees will still apply if you chose not to receive one)

Text message _____ Email message _____ Phone message _____ No message _____

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

★ **Signature:** _____ **Date:** _____

Insurance Information: (Please present your insurance card at the time of intake.)

Initial _____ I understand that by using my insurance, the insurance company has the right to audit my file to ensure services are proper and necessary.

Primary Health Insurance Company: _____

Policy Holder's Name: _____ Date of Birth: _____

May we submit information to your insurance company that is necessary to receive payment? _____

Presenting Problems and Concerns

What brought you here today? _____

Please mark all of the behaviors and symptoms that you consider problematic:

- Parenting/Relationship
- Withdrawal from people
- Increased risky behavior
- Wide Mood Swings
- Concentration/Forgetful
- Self-harming
- Pornography
- Decrease/Increase Libido
- Impulsive/Compulsive
- Unmotivated
- Sleeping/Nightmares
- Sadness/Depressed
- Social discomfort
- Thoughts of death
- Computer addiction
- Anxiety/Worry
- Panic Attacks
- Low self-worth
- Avoidance
- Suspicion/Paranoia
- Flashbacks
- Obsessive thoughts
- Hyperactivity
- Seeing/Hearing things
- Guilt/Shame
- Alcohol/Drug use
- Racing thoughts
- Hopelessness
- Fatigue
- Change in appetite
- Gambling problems
- Other: _____

Are your problems affecting any of the following?

- Handling everyday tasks
- Self-esteem
- Relationship/Sexual Activity
- Health/Hygiene
- Work/School
- Housing/Finances
- Legal Matters
- Recreational activities
- Other: _____

Any additional concerns that are not on the list: _____

Have you ever had feelings or thoughts that you didn't want to live? _____

Have you ever tried to kill or harm yourself before? _____

Have you recently been physically hurt or threatened by someone else? If yes, please explain.

Have you ever had thoughts, made statements, or attempted to seriously hurt or kill someone else? If yes, please explain. _____

Have you experienced any of the following types of trauma or loss?

- Emotional abuse
- Sexual abuse
- Physical abuse
- Parent substance abuse
- Teen pregnancy
- Neglect
- Violence in the home
- Crime victim
- Parent illness
- Placed a child in adoption
- Lived in a foster home
- Multiple family moves
- Homelessness
- Loss of a loved one
- Financial problems
- Miscarriage/Stillborn
- Other: _____

Relationship History and Current Family:

How would you identify your sexual orientation? _____

If in a relationship, how would you describe the quality of the relationship? _____

Are you currently married? _____ If so, how long? _____
 Have you had any prior marriages? _____ If so, how many? _____
 Do you have children? _____ If so, how many & what are their names & ages? _____

Medical Information & History

Primary Care Physician Name: _____

Phone Number: _____

Primary Care Physician Address: _____

Date of last physical exam: _____

Starting with childhood, list all diseases, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had.

Age	Illness/Diagnosis	Treatment Received	Treated By	Result
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Describe any allergies you have.

Allergy:	Reaction:
_____	_____
_____	_____

List all medications or drugs you take or have taken in the last year (prescribed, over-the-counter, and especially list any psychotropic medications).

Medication/Drug:	Dose:	Taken for:	Prescribed/Supervised by:
_____	_____	_____	_____
_____	_____	_____	_____

Have you received mental health treatment previously? Yes ___ No ___ If yes, please explain:

Treatment Type	When:	Provider/Program	Reason for Treatment
Outpatient counseling	_____	_____	_____
Psychiatric (Medication)	_____	_____	_____
Psychiatric Hospitalization	_____	_____	_____
Drug/Alcohol Treatment	_____	_____	_____
Self-help/Support Group	_____	_____	_____

Substance Use History

Have you had withdrawal symptoms when trying to stop using any substances? _____

If yes, please describe: _____

Have you gambled in the past 6 months? _____

If yes, have you ever felt the need to bet more and more money? _____

Have you ever had to lie to people important to you about how much you gambled? _____

Have you had problems with work, relationships, health, the law, etc. from substance abuse? _____

If yes, please describe: _____

<i>Substance</i>	<i>Current Use (last 6 Months):</i>	<i>Frequency</i>	<i>Amount</i>	<i>Past usage</i>
Tobacco	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____
Cocaine/Crack	_____	_____	_____	_____
Ecstasy	_____	_____	_____	_____
Heroin	_____	_____	_____	_____
Inhalants	_____	_____	_____	_____
Methamphetamines	_____	_____	_____	_____
Pain Killers	_____	_____	_____	_____
PCP/LSD	_____	_____	_____	_____
Steroids	_____	_____	_____	_____
Tranquilizers	_____	_____	_____	_____

Family Mental Health History:

Please note if any family members have had any of the following mental health problems:

<i>Mental Health History</i>	<i>Who?</i>
ADHD	_____
Sexual Abuse	_____
Depression	_____
Bipolar Disorder	_____
Suicide Attempt/Self-harm Behaviors	_____
Anxiety Problems/Panic Attacks	_____
OCD	_____
Anger/Abusive Behaviors	_____
Schizophrenia	_____
Eating Disorder	_____
Drug/Alcohol Abuse	_____
Autism	_____
Other	_____

Interpersonal/Social/Cultural Information

Please describe your social support network

- o Family
- o Neighbors
- o Support/Self-help group
- o Friends/Students
- o Co-workers
- o Religious/Spiritual Center
- o Community Group
- o Other: _____

To which cultural or ethnic group do you belong? _____

Would you like spiritual/religious beliefs to be incorporated into your counseling? _____

Please describe your strengths, skills, and talents? _____

Describe any special areas of interest or hobbies (art, books, physical fitness, etc.): _____

Miscellaneous Information

What is the highest level of education you have received? _____

Have you been/are you currently in the military? _____

Branch: _____ Rank: _____

Date of discharge: _____ Type of discharge: _____

How would you describe the impact of your military experience? _____

Legal History:

Have you ever been arrested? _____ Do have any pending legal problems? _____

Have you ever been convicted of a misdemeanor or felony? _____

If yes, please explain: _____

Are you currently involved in any divorce or child custody proceedings? _____

If yes, please explain: _____

★ **Signature:** _____ **Date:** _____

TINA FLAHERTY, MSW LISW FLAHERTY COUNSELING & CONSULTING, INC

2435 KIMBERLY ROAD, 165-S
BETTENDORF, IA 52722
563.232.1878 563.232.1879 (FAX)

www.flahertycounseling.com tina@flahertycounseling.com

Agreement and Consents

Welcome to Flaherty Counseling and Consulting! We are committed to providing you with the highest quality care, which begins with a clear understanding of our services. You will find below a brief description of our office, privacy, and financial procedures. **Please initial where appropriate and sign at the end of this document.** I will be happy to discuss any questions you might have.

SCHEDULING AND CANCELLATIONS

Sessions are typically 50-60 minutes long. Please be aware that any appointment that cannot be kept must be canceled no less than 24 hours before the appointment time or a \$175 fee will be applied. Insurance companies will not pay for the missed sessions, so payment for these will be your sole responsibility. *You will be charged ½ the fee the first time, and full fee thereafter.

CREDIT CARD AUTHORIZATION

It is the preference of this business for clients to carry a zero balance, as to eliminate the need to send invoices. Payment is expected at the time of service. As a convenience, a credit card may be kept on file in an encrypted billing system. Please authorize a minimum of \$190.00 and include a maximum amount to cover your responsibility according to your insurance company. You may revoke this at any time, or agree to provide updated information as necessary.

Name on Card: _____

Billing Street Address: _____

Maximum Amount Authorized: _____

Signature: _____

FINANCIAL POLICIES

By the end of the your first session, I will explain your financial obligations, based upon your particular insurance plan or lack thereof, as well as answer any questions you may have regarding the cost of and payment for treatment. If I am submitting claims to your insurance company, you authorize us to receive the reimbursement directly. If I am not in network with your insurance company, then I will submit to your insurance, if you like, and you will be responsible for what they say your out of network benefits are. If you are not submitting your claims to an insurance company, the agreed upon fee will be due at the time of service.

Initial ____ I have read the financial policies, including the cancellation policy above, and I understand my responsibilities. I will not hesitate to seek any clarification from Tina or her office staff.

Initial ____ As my client, you agree to accept responsibility to pay this account at the time of service. Balance could include fees from out of pocket expenses, fees made responsible to you by your insurance company, as well as any late cancel or no call no show fees.

CONFIDENTIALITY AND ITS LIMITS

Ethically and legally, I will protect your confidentiality and adhere to my Notification of Privacy Practices (NPP), which is detailed in a separate document, HIPAA Notification of Privacy (You may have a copy and/or review it at www.flahertycounseling.com). Iowa Law mandates that I break your confidentiality if I have reason to believe that you are in imminent danger of harming yourself or someone else. While it is common for a depressed person to have suicidal thoughts or plans, if I believe that you are going to carry out these plans imminently (or acts of harm to others) I will be required to share this information to prevent you from doing so. Also, if I am in direct contact with a minor or dependent adult who discloses to me that she or he is being abused, I am mandated by Iowa Law to report this abuse to the Department of Human Services. Please feel free to discuss confidentiality and its limits with me at any time.

Initial ____ I understand my confidentiality and its limits.

Initial ____ I understand that two mental health businesses share this space and although charting is not accessible by the other business, in rare instances there may be clinical consultation or emergency back-up from the other business, Hendershott Counseling & Consulting.

COMMUNICATION POLICIES

My general policy is to leave our office name and phone number when we return phone messages. Please initial if you give consent for me or my staff to leave more detailed treatment information on the voicemail of your choice:

Initial ____ I authorize Flaherty Counseling & Consulting to leave treatment information on my voicemail at the following number (____)____-____.

I provide free appointment reminders via text, email or voicemail. Please initial below for consent. Many of my clients like to communicate via email. By initialing below, you acknowledge that text and email is not a secure form of communication and confidentiality cannot be guaranteed.

Initial ____ I authorize Flaherty Counseling & Consulting to send appointment reminders. Please refer to Appointment Reminder agreement on following page to indicate how you wish to be notified.

Initial ____ Please initial here, acknowledging that, in an emergency, you agree to call 911 or go to your nearest emergency room. You may also contact the Crisis Line at Robert Young at (309)779-2999, the Genesis Community Crisis Line at (563)421-2975, or the National Suicide Hotline at (800)273-8255.

SOCIAL MEDIA

The Iowa Board of Social Work considers it unethical for Licensed Independent Social Workers to interact and "friend" clients on social media. Please understand that if you send me a friend request to my personal social media pages, I will not respond per my ethics board. I do have professional social media pages to promote my business. If you choose to post on my business pages, please be aware that it opens the possibility that the general public may discover that you are a client.

Initial ____ I understand the limitations of communication and contact on social media with Tina Flaherty, LISW.

CONSUMER RIGHTS

Since you are a consumer of psychotherapy services, it is your right to discuss any questions you have about the services you are receiving with me. I invite you to communicate openly and directly with me about your thoughts and reactions to therapy.

Initial ____ I have read and agree to this statement of standard care.

INFORMED CONSENT/WAIVER FOR NON-CONVERED, NON-THERAPY, OR UNUSUAL SERVICES

I would like you to know that not all services I provide are covered by insurance, and would like you to be aware of my policies regarding these services. I will do my best to remind you if I receive a request to provide any services of this nature. I will not release any information without proper signed releases of information from all parties involved in therapy. I may also request that you sign a separate consent for certain specific services.

Please be advised, that legal involvement is not part of the services that I offer. If such a situation does arise, please let me know in advance and we can discuss my role, if any. Should an unusual circumstance arise, and I agree to assist in such services, please be aware of the following: Due to the complexity and difficulty of legal involvement, court involvement (including preparation, portal-to-portal time, and court attendance) is billed at a separate rate of \$200 per hour.

In addition to therapy sessions, please be aware that you will be charged a fee (not covered by insurance) prorated at the hourly out of pocket rate for work conducted between sessions. This includes, but is not limited to: phone, email or text conversations which exceed 15 minutes in length.

Other non-therapy requests for report writing, meetings with schools, etc. will be discussed on a case by case basis, and will also be billed at a rate of \$200 per hour, paid in advance.

Initial ____ I understand that I will be billed for my time and I acknowledge responsibility for paying for these services in full.

FINANCIAL RESPONSIBILITY AGREEMENT

* I offer two plans for payment of fees. * **Please initial the payment plan you would like to use** *

____ Plan A: Private pay which means you pay in full at each appointment by cash, check or credit card. The agreed upon amount for psychotherapy services is \$190 for 50-60 minute psychotherapy sessions.

____ Plan B: I bill your insurance company and you pay your co-pay at each visit.

It is my policy to bill your insurance company as a courtesy. Please remember that you are responsible for fees not covered by your insurance company. If paying by check, please write your check in advance so that time during our session will not be taken up with preparing payment.

PRIVACY AND CONFIDENTIALITY POLICIES

Initial ____ I have received the Notice of Privacy Practices, describing how my confidential information may be used and disclosed.

Initial ____ I consent to the use of disclosure of any information in the patient record for the purpose of conducting treatment, payment, or health care options. I understand this consent is valid until revoked by me.

I understand and take full responsibility for the information above.

★ Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

TINA FLAHERTY, MSW LISW FLAHERTY COUNSELING & CONSULTING, INC

2435 KIMBERLY ROAD, 165-S
BETTENDORF, IA 52722
563.232.1878 563.232.1879 (FAX)

www.flahertycounseling.com tina@flahertycounseling.com

Authorization to Release/Obtain Information

Client Name: _____ Date of Birth: _____

I hereby authorize Flaherty Counseling & Consulting to release and/or obtain information concerning the above named client with:

Person/Agency: _____ Phone Number: _____

Information to be released and/or requested from FCC

- Evaluation Results/Assessment/Forms
- Diagnosis/Medication list
- Treatment Summary or Service Plan
- Progress/Prognosis/Treatment
- Discharge Summary
- Billing Information
- Social & Family History
- Records of Contact
- Legal Status/Legal History
- Grades, Test Scores, Conduct, Attendance
- Educational/Vocational Plans
- Other: _____

The information being released and/or requested will be used for the following purpose(s):

- Ongoing evaluation and treatment
- Coordination of services and supports
- Coordination of medical treatment
- Referral
- Academic planning and placement
- Personal file
- Litigation
- Insurance
- Other: _____

This agreement will expire 2 years from the date of signature, unless previously revoked or otherwise indicated (specify date or event of expiration): _____

This authorization is voluntary and I may cancel this consent to release information at any time by sending written notice to FCC. I understand that the person or agency receiving this information, in accordance with state regulations, will be notified not to disclose this information without further written consent. However, I understand that FCC cannot guarantee that the recipient will not redisclose this information to a third party. The recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a client in a federally assisted alcohol or drug abuse program, the recipient is prohibited under federal law from making any further disclosures of such information unless further disclosures are expressly permitted by written consent of the client or as otherwise permitted under federal law governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2). I understand that any release which was made prior to my cancellation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that I may review the disclosed information or ask questions by contacting FCC at the above address. I understand that FCC may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of research related treatment or creating information for disclosure to a third party, refusal to sign may result in denial of those services. I understand that my refusal to sign this authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.

Specific Authorization For Release of Information Protected By State or Federal Law

Must INITIAL to specifically authorize Release of Information Protected by State or Federal Law related to:

Substance /Alcohol Use/Abuse _____ Mental Health _____ HIV/AIDS related info _____ Infections Diseases _____

Signature of Client/Legal Representative: _____ Date: _____

Signature of Minor, If required: _____

Witness Signature: _____ Date: _____

_____ Check here if patient/client refuses to sign authorization

_____ Check here if patient/client would like a copy of this authorization

To the recipient of mental health information: Disclosure of mental health information may only be made pursuant to the written authorization of the individual or their legal representative, or as otherwise provided in Iowa Code 228. The unauthorized release of mental health information is unlawful, and civil damages and criminal penalties may be applicable to the unauthorized disclosure of mental health information.