

**INTAKE FORM - CONFIDENTIAL**  
**Angela Gurno, MS, LPC, NCC**  
**Licensed Professional Counselor**

Date: \_\_\_\_\_

This form will help your counselor understand more about you and will be part of your case file.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: Male  Female

Ethnicity: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Client SSN# \_\_\_\_\_ Email: \_\_\_\_\_

**Please fill in the number where we may call to reach you and/or leave messages:**

Home Phone:	Work Phone:	Cell Phone:
May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Prior Marriages: \_\_\_\_\_ Education: \_\_\_\_\_

Spouse Last Name: \_\_\_\_\_ Spouse First Name: \_\_\_\_\_ Spouse MI: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Children:

Name	Sex	Age	Relationship to you

Primary Care Provider/Doctor \_\_\_\_\_ Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

**\*\*I would like for the Therapist to communicate with my Primary Care Provider regarding my Treatment: Yes or No**

**INSURANCE INFORMATION**

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Insurance Telephone Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Subscriber's Name/Insured Name: \_\_\_\_\_

Insured SSN: \_\_\_\_\_ Insured Birth date: \_\_\_\_\_

Relationship to client: \_\_\_\_\_

Who referred you: Self      Dr. \_\_\_\_\_      Web      Insurance      Other: \_\_\_\_\_

**Primary Concern:**

What brought you here today?

<b>Please use the following scale to answer the next three questions:</b>		1	2	3	4
		Not at all	Mildly	Moderately	Highly
1.	How serious do you consider your present concern(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	How motivated are you to resolve your concern(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	How optimistic are you that your concern(s) can be resolved?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Previous Counseling? Yes / No    Counselor: \_\_\_\_\_    Date: \_\_\_\_\_

**Please list your current medications and doses:**

Prescription:	Over the Counter:
---------------	-------------------

Please list any Food or Drug Allergies or any adverse reactions you have experienced:

**Please list any medical problems:**

Medical Problem	Date of Diagnosis

**DEVELOPMENT (If client is a child or adolescent)**

**Please check any if there were problems in the following areas:**

<input type="checkbox"/> During Pregnancy	<input type="checkbox"/> After birth	<input type="checkbox"/> Talking
<input type="checkbox"/> During Birth	<input type="checkbox"/> Walking	<input type="checkbox"/> Sitting up
<input type="checkbox"/> Other		

If yes, please explain: \_\_\_\_\_

**FAMILY and MEDICAL TREATMENT HISTORY**

**Please check any medical and /or mental health conditions that apply to any family members:**

<input type="checkbox"/> Heart Disease/Condition	<input type="checkbox"/> Headaches	<input type="checkbox"/> Eating Disorders
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizures	<input type="checkbox"/> Depression
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Panic Attacks
<input type="checkbox"/> Stroke	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bipolar Disorder
<input type="checkbox"/> Use or Abuse Alcohol or Drugs	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Cancer	<input type="checkbox"/> Other Medical Conditions:	<input type="checkbox"/> Other Mental Health Conditions:

<b>Family History Continued</b>	Mother's Age _____ If deceased, how old were you when she died? _____
	Father's Age _____ If deceased, how old were you when he died? _____
	If your parents are separated, how old were you then? _____
	Number of brother(s) _____ What are their ages? _____
	Number of sister(s) _____ What are their ages? _____

If you were adopted or raised with parents other than your natural parents please explain:

Briefly describe your mother's personality:	Briefly describe your stepparent(s) personality:
Briefly describe your father's personality:	

**Briefly describe your past and current relationships with your:**

Mother	Father
Stepmother	Stepfather

<b>Religious Affiliation</b>	<input type="checkbox"/> Jewish	<input type="checkbox"/> Christian/Other _____
	<input type="checkbox"/> Catholic	<input type="checkbox"/> None, but I believe in God
	<input type="checkbox"/> Protestant _____	<input type="checkbox"/> Atheist or agnostic
	Do you desire to have your religious beliefs and values incorporated into the counseling process? (Please check one)	
	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Not Sure

**Please mark all of the following that apply**

Feelings		Thoughts	
<input type="checkbox"/> Helpless	<input type="checkbox"/> Anxious/Fearful	<input type="checkbox"/> Confused	<input type="checkbox"/> Racing
<input type="checkbox"/> Depressed/Sad	<input type="checkbox"/> Out of Control	<input type="checkbox"/> Fragmented	<input type="checkbox"/> Obsessive
<input type="checkbox"/> Shameful	<input type="checkbox"/> Afraid/Scared	<input type="checkbox"/> Worthless	<input type="checkbox"/> Distracted
<input type="checkbox"/> Angry	<input type="checkbox"/> Burnt out/worn out	<input type="checkbox"/> Unmotivated	<input type="checkbox"/> Intrusive Memories
<input type="checkbox"/> Guilty/Remorseful	<input type="checkbox"/> Relaxed	<input type="checkbox"/> Unattractive	<input type="checkbox"/> Paranoid
<input type="checkbox"/> Hopeless/Hopeful	<input type="checkbox"/> Happy/Excited	<input type="checkbox"/> Unlovable	<input type="checkbox"/> Worry
<input type="checkbox"/> Lonely	<input type="checkbox"/> Irritable	<input type="checkbox"/> Confident	<input type="checkbox"/> Sensitive
<input type="checkbox"/> Grieved	<input type="checkbox"/> Empty/ Numb	<input type="checkbox"/> Worthwhile	<input type="checkbox"/> Distrust
<input type="checkbox"/> Stressed	<input type="checkbox"/> Insecure	<input type="checkbox"/> Suicidal/Homicidal	<input type="checkbox"/> Positive
<input type="checkbox"/> Unhappy/Unfulfilled	<input type="checkbox"/> Mood Swings		
<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____	

<b>Symptoms/Behaviors</b>		
<input type="checkbox"/> Eating More or Less	<input type="checkbox"/> Acting Out Sexually	<input type="checkbox"/> Financial Difficulties
<input type="checkbox"/> Procrastinating	<input type="checkbox"/> Acting Aggressively	<input type="checkbox"/> Legal Problems
<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Phobia/Panic Attacks	<input type="checkbox"/> Parent/Child Conflicts
<input type="checkbox"/> Irritability	<input type="checkbox"/> Post Traumatic Stress Disorder	<input type="checkbox"/> Marital Problems
<input type="checkbox"/> Crying	<input type="checkbox"/> Attention Deficit Disorder/ADHD	<input type="checkbox"/> Relationship Concerns
<input type="checkbox"/> Passivity	<input type="checkbox"/> Injuring self	<input type="checkbox"/> Withdrawal from Family/Friends
<input type="checkbox"/> Acting Compulsively	<input type="checkbox"/> Sexual Concerns	<input type="checkbox"/> Job Problems
<input type="checkbox"/> Poor Self-Image	<input type="checkbox"/> Legal/Illegal Drug Use	<input type="checkbox"/> Spiritual Issues
<input type="checkbox"/> Poor Concentration/Memory	<input type="checkbox"/> Alcohol Use/Abuse	<input type="checkbox"/> Victim or Perpetrator of Abuse
	<input type="checkbox"/> Tobacco Use	<input type="checkbox"/> Seeing/Hearing things others don't
	<input type="checkbox"/> Other Addictions	<input type="checkbox"/> Other _____
<b>Physical Symptoms</b>		
<input type="checkbox"/> Insomnia	Will you be sharing any important Cultural values that might impact your therapy process: Yes___ No___	
<input type="checkbox"/> Tired/ Easily Fatigued		
<input type="checkbox"/> Restlessness/Tense		
<input type="checkbox"/> Rapid Speech		
<input type="checkbox"/> Headaches		
<input type="checkbox"/> Tightness In Chest		
<input type="checkbox"/> Dizziness or Light-headedness		
<input type="checkbox"/> Numbness or Tingling	Please share anything else that might be helpful for your counselor to know:	
<input type="checkbox"/> Pain		
<input type="checkbox"/> Rapid Heart Beat		
<input type="checkbox"/> Weight Gain or Loss		
<input type="checkbox"/> Excessive Sleep		
<input type="checkbox"/> Loss of Memory		
<input type="checkbox"/> Eating Problems		
<input type="checkbox"/> Other _____		

I authorize Angela Gurno to use my health information to activate my insurance benefit program. The purpose will be to process claims for insurance payment. I also understand my privacy will be respected and procedures will follow the HIPAA Privacy Notice that I have received.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature (if client is under 18)

\_\_\_\_\_  
Date

## Angela Gurno, MS, LPC, NCC

### Licensed Professional Counselor **OUTPATIENT SERVICES CONTRACT**

#### **COUNSELING SERVICES**

Welcome to my practice. This document contains important information about professional services and business policies. Please read it carefully and jot down any questions you have so they can be discussed. When you sign this document, it will represent an agreement between us.

Counseling is not easily described in general statements but depends on the counselor, client and the particular problems presented. Counseling calls for an interaction between therapist and client and for therapy to be successful, clients are to employ concepts, strategies and techniques discussed during sessions. Therapy can have some unpleasant aspects that may be coupled with uncomfortable feelings. However, these experiences often lead to improved relationships, solutions to problems, and a reduction in feelings of distress.

#### **COUNSELING SESSIONS**

Issues and concerns are evaluated during the first session and continue throughout the therapeutic process. During this time, it can be determined if the client/therapist relationship will be able to generate the desired treatment goals. Counseling sessions are 45-50 minutes and begin on a weekly or bi-weekly schedule and are then scheduled less frequently based on progress. The client is responsible for scheduling their sessions and canceling them if they are unable to attend. **We request a twenty-four hours notice or a \$25.00 fee will be assessed for the first missed session and a \$50.00 fee for each additional missed session without twenty-four hour notice.** This fee cannot be billed to your insurance and must be paid out of pocket at the next session. The office answering machine is on 24 hours a day for your convenience.

#### **PROFESSIONAL FEES AND BILLING SERVICES**

The fee for the initial therapy session which includes the initial evaluation and initial treatment planning is \$95.00. The hourly fee for subsequent therapy sessions is \$70.00. Payment is expected from the client at the time of service or from the insurance company. Insurance is to be activated before scheduled therapy. The billing person works with the client concerning pre-certification and explanation of benefits. Other professional services such as preparation of documents or treatment summaries will be billed at the same rate as counseling.

**PLEASE NOTE:** The therapist does not participate in legal proceedings but will refer the client to another clinician or entity that deals with legal issues. Please discuss this with the therapist if the need arises.

#### **CONTACTING ME**

The office telephone is answered by support staff from 8:30 AM and 7 PM, Monday thru Thursday and partially on Fridays; however, voicemail is available 24 hours a day. The therapist is usually in session and not available by telephone. Please leave a message with the support staff or on the voice mail. Every effort will be made to return all calls as soon as possible. In case of an urgent need or emergency on weekends, the client may use the therapist's home telephone number that is located on their business card. If the client cannot reach the therapist and can't wait for a return call, they are encouraged to call 911 or go the nearest emergency room.

#### **PROFESSIONAL RECORDS**

The laws and standards for counseling in Texas require the therapist to keep treatment records. These records are confidential and will not be released to anyone without the client's consent. Please be aware that the client may choose not to release these records if they can be emotionally or legally damaging. The therapist will make these records available to another mental or medical health professional at the client's request.

#### **MINORS**

The therapist is committed to providing confidentiality for adolescent clients. The therapist will provide generalized (not specific) information about the therapy sessions to the parents/guardians of the client. The therapist will

provide more specific information as approved by the adolescent client. Parents of children in therapy are involved in the process and participate in formulating the treatment goals.

**PLEASE NOTE:** The therapist will ask for help from a parent or guardian if the client is at risk of seriously harming him/her self or someone else. There are also other situations that may require the therapist to release the records of minors.

### **CONFIDENTIALITY**

The privacy of all communications between a client and therapist is protected by law, and the therapist can only release information about their work with the client's written permission. However, there are exceptions:

- The therapist is legally obligated to take action to protect a child, elderly person or disabled person from abuse by reporting the action to the appropriate state agency.
- The therapist will contact family members or others if there is a threat of serious self harm or harm to another. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. In these cases, a more intensive treatment plan will be developed by the therapist, the client and their family members.
- The therapist is legally obligated to release the client's therapy notes (or a summation) if requested by a court of law.

On occasion the therapist may need to consult with other professionals about a case. During these consultations, cases are discussed without revealing the identity of the client. The consultant is also legally bound to keep all information confidential.

Questions or concerns about confidentiality can be discussed with the therapist

### **FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**

This law insures the confidentiality of all electronic transmission of information about the client. Whenever the therapist transmits information about the client electronically (i.e. sending bills or faxing information), it will be done with special safeguards to insure confidentiality. If the client elects to communicate with the therapist by email, please be aware that email is not completely confidential. Any email the therapist receives from the client and any responses sent, will be printed out and kept in the client's treatment record.

Your signature indicates that you have read this document and consent to treatment. This will serve as a contract between you and the provider:

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client Printed Name

\_\_\_\_\_  
Date

***If client is under 18, parent/guardian consent is needed.***

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

### Coordination of Care between Health Care Providers / Release of Information

Communication between behavioral providers and your primary care physician (PCP), other behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health provider to share protected health information (PHI) with your other provider or person you designate below. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

#### Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting the practitioner’s office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

#### Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request. **This consent expires twelve (12) months from the date of my signature below unless otherwise stated herein.**

Angela Gurno is authorized to release protected health information related to the  
(Provider Name-Please Print)

evaluation and treatment of \_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_.  
(Member Name) (Date of Birth – MM/DD/YYYY)

PCP Name: \_\_\_\_\_ PCP Phone/Fax: \_\_\_\_\_  
PCP Address: \_\_\_\_\_

BH Provider Name: \_\_\_\_\_ BH Provider Phone/Fax: \_\_\_\_\_  
BH Provider Address: \_\_\_\_\_

Other Name: \_\_\_\_\_ Other Phone/Fax: \_\_\_\_\_  
Other Address: \_\_\_\_\_

Disclosure may include the following verbal or written information: (check all that apply)

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Face sheet                       | <input type="checkbox"/> History & physical                           | <input type="checkbox"/> Laboratory/diagnostic testing results   | <input type="checkbox"/> School information                 |
| <input type="checkbox"/> Discharge summary                | <input type="checkbox"/> Medication records                           | <input type="checkbox"/> Behavioral health/psychological consult | <input type="checkbox"/> Psychological eval/testing results |
| <input type="checkbox"/> ER record report                 | <input type="checkbox"/> Psychiatric evaluation                       | <input type="checkbox"/> Psychosocial assessment                 | <input type="checkbox"/> Other                              |
| <input type="checkbox"/> Substance abuse treatment record | <input type="checkbox"/> Summary of treatment records & contact dates |  |   |

I hereby refuse to give authorization for any release of information

\_\_\_\_\_  
(Signature of Patient, Parent, Guardian or Authorized Representative)

\_\_\_\_\_  
(Date)

If signed by a guardian or authorized representative, please provide legal documentation that proves such authority under state law (i.e. Power of Attorney, Living Will, or Guardianship papers, etc.)