**Lisa A. Arick, LCSW**

**Phone: (317) 506-5161**
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**9135 N. Meridian Street, Ste B2**
**Indianapolis, IN 46260**

# NEW CLIENT INTAKE FORM

**TODAY'S DATE: ___________**

## A. Identification

Your name: _________________________________ Date of birth: _______________ Age: _____

What are your preferred gender pronouns? (She/Her, He/Him, They, Other):__________

Home street address: ___________________________________________ Apt.: _________________
City: _____________________________________ State: _________ ZIP: ______________________
Email Address: __________________________________(confidentiality not able to be guaranteed)

Home/evening phone: _______________________ , okay to text and/or leave voicemail? Yes:___ No:___

Work/daytime phone: _______________________ , okay to text and/or leave voicemail? Yes:___No:___

What time of day is best to reach you? ____am ____pm

Current Employer: ________________________Address:__________________________________
City: _____________________________________ State: _____ ZIP:______

Have you served in the U.S. Military? Yes: ___ No:___ If yes, which branch of service and dates?
_________________________________________________________________________________

What is your current occupation? Describe your current fulfillment and job satisfaction?
______________________________________________________________________

Highest level of education completed and field of study?
__________________________________________________________

Relationship status: Married: ___ Partnered:___ Single: ___ Divorced: ___ Widowed: ___

Spouse/Partner name: _________________________ Length of Marriage/Commitment _____

Spouse/Partner address (if different than yours) ___________________________________

City:___________________ State:__________ ZIP:___________

Emergency Contact Person:________________________ Relationship:__________________
Home / Evening Phone:__________________ Work / Evening Phone:____________________

Do you plan to submit receipts for therapy to your insurance company? Yes: ___ No:___
(If yes, I will need to copy your insurance card)

## B. Referral

**How did you learn about these therapy services?**

personal referral (by whom?) _____________________
professional listing (if so, which one?) ______________
website:__________________
other (please describe) _________________________________________

## C. Your medical care:

Primary Care Physician or Group

Clinic/doctor's name: _____________________________________Phone: _______________
Address: ____________________________ City _____________State ___ Zip ___________
Present Medical Concerns: _______________________________________________________
Prior Surgeries/Serious Illnesses/Concerns: __________________________________________
_____________________________________________________________________________

## D. Past mental health care

Have you sought mental health care in the past? Yes:___ No:___
(If yes, where from or whom did you receive treatment?) ________________________________

Name of clinician/therapist/clinic: _________________________________ Date:____________
Condition/Reason: _____________________________________________________________

Name of clinician/therapist/clinic: _________________________________ Date:____________
Condition/Reason: _____________________________________________________________

Name of clinician/therapist/clinic: _________________________________ Date:____________
Condition/Reason: _____________________________________________________________

Are you presently on any medication for a mental health condition? Yes:___ No:___

If yes, please list present medications:
_____________________________________________________________________________

Do you have any children living with you? (including stepchildren): Yes:___ (list below) No:___
_____________________________________________________________________________

Name/Names:__________________________ Age/Ages:_________________
Name/Names:__________________________ Age/Ages:_________________

Does anyone else besides your spouse/partner or children live with you? Yes:___ No:___
If yes, whom? Name:______________________ Age:____ Relationship:___________________

## E. Present therapy

1. What is your most pressing concern/challenge right now that you wish to address in your therapy experience?

______________________________________________________________________________

______________________________________________________________________________

2. What outcome or results do you most desire from this therapy experience?

______________________________________________________________________________

3. Do you have any fears/concerns about pursuing therapy at this time? Yes:___ No:___
If yes, what concerns do you feel comfortable sharing?

______________________________________________________________________________

4. What other things would you like to see change in your life (family, career, health, relationships, etc.?

______________________________________________________________________________

______________________________________________________________________________

5. Please list 3 strengths about yourself (or that others say about you and offer examples, if possible.)
   1) ____________________________________________________________
   2) ____________________________________________________________
   3) ____________________________________________________________

6. In the past year, have there been any significant changes in your life?
(moves, job change, surgeries, deaths, health, sleep, family, overall functioning, etc.)?

______________________________________________________________________________

7. What do you currently do for self-care, wellness (i.e., healthy food choices, exercise, yoga, limiting screen time, stress mgmt., leisure activities, hobbies, etc.?) Please given examples:

______________________________________________________________________________

8. What can you identify that helps you achieve balance in your life?

______________________________________________________________________________

9. Do you have any Spiritual and/or religious practices, beliefs, activities that you find supportive? If so, please describe:

______________________________________________________________________________

10. Who would you say your support system is (people, organizations, or affiliations)?

______________________________________________________________________________

11. If you are currently in a relationship, please describe your relationship?

______________________________________________________________________________

______________________________________________________________________________

## F. Family of Origin History

Were you adopted? Yes: ____ No:____ If yes, please describe what you feel comfortable sharing about your adoption:

______________________________________________________________________________

______________________________________________________________________________

## G. Biological and/or Adoptive Family of Origin

| **Relative** | **Name** | **Current Age** | **Death/Illness** | **Occupation** |
|---|---|---|---|---|
| Father: | __________ | _____ | __________ | __________ |
| Mother: | __________ | _____ | __________ | __________ |
| Brothers: | __________ | _____ | __________ | __________ |
| Brothers: | __________ | _____ | __________ | __________ |
| Sisters: | __________ | _____ | __________ | __________ |
| Sisters: | __________ | _____ | __________ | __________ |

Please describe your relationship with your parents:

(Mother)____________________________________________________________

(Father) ____________________________________________________________

How would you describe your overall upbringing?

______________________________________________________________________

______________________________________________________________________

How would you describe your relationship with your siblings?

______________________________________________________________________

______________________________________________________________________

## SOME IMPORTANT QUESTIONS I MUST ASK:

Have you ever had thoughts of suicide? Yes:___ No:___

If yes, please explain:________________________________________________________________

Have you ever planned and/or attempted suicide? Yes:___ No:___

If yes, please explain: ________________________________________________________________

Has anyone in your family or close to you died by suicide? Yes:___ No:___

If yes, please explain: ________________________________________________________________

Have you ever experienced physical, emotional, verbal and/or sexual abuse? Yes:___ No:___

If yes, please explain: ________________________________________________________________

Are you currently in a relationship where you feel powerless and/or spouse/partner is hurting you in some way? Yes:___ No:___

Have you experienced a traumatic event where you thought yours or another's life was threatened?
If so, please explain: Do you have reoccurring nightmares or flashbacks, or do you avoid anything that is uncomfortable or painful?

________________________________________________________________________________

________________________________________________________________________________

Have you ever been divorced or ended a long term intimate relationship? Yes:___ No:___
If yes, how long was the relationship (or relationships)?

1) ______________________________________
2) ______________________________________

Do you currently use currently use alcohol? Yes:___ No:___ If yes, how much?
______________________________________

Do you currently use currently use drugs? Yes:___ No:___ If yes, how much?
______________________________________

*Thank you very much for taking the time to complete these forms and questions.*
*I very much look forward to getting to know you.*|

**LISA**

**9135 N. Meridian Street, Ste B2, Indianapolis, IN 46260 - 317.506.5161**

# THERAPEUTIC AGREEMENT FOR INDIVIDUALS

Your healing needs are of up most importance as we work together in this therapeutic process. Suggestions may be made as optional interventions, however, should not be taken as Medical Advice. Please consult your physician or healthcare provider for needed medical/physical care as you deem appropriate. Some of the modalities Lisa uses in working with clients involve professional and non-intrusive touch. This will never be employed without your consent, but may be suggested as a healing aide.

I do hereby seek and consent to take part in the treatment with the therapist named above. I understand that developing a treatment plan with this therapist and being an active participant along with regularly reviewing our work toward meeting the treatment goals are in my best interest. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

Every attempt will be made to schedule appointments at times convenient for you. In cases other than emergency, a 24-HOUR CANCELLATION NOTICE is required for appointments you are unable to keep. Failure to honor this notification will result in a charge of full session fee payable prior to scheduling next session. Please inform Lisa if you need an invoice to submit for insurance coverage.

I understand that by typing my name below, that I am electronically signing this document.
Please enter your full name in the text box below to accept the policy.
Signature of Client/Representative: ______________________________________________ Date:__________

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative) and agree to uphold my professional responsibilities and terms of this agreement. My observations of this person's behavior and responses give me no reason to believe that this person is not fully able to give informed and willing consent.

Signature of therapist _________________________ Date: _________

# LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

**Duty to Warn and Protect**

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

**Abuse of Children and Vulnerable Adults**

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

**Prenatal Exposure to Controlled Substances**

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

**Minors/Guardianship**

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

**Insurance Providers** (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

*I agree to the above limits of confidentiality and understand their meanings and ramifications.*

_____________________________________________________________

Client Signature (Client's Parent/Guardian if under 18)

Today's Date: ______________________________

# PRACTICE GUIDELINES

Thank you for considering me as your potential provider. The following information provides you with some basic information about my practice and what to expect. For a more detailed explanation of some of these policies please review specific forms on the documents page.

**Scheduling**
Clients are seen by appointment only. If you are a prospective client, please contact me by phone or email to schedule.

**Fees/Insurance**
Clients pay at the time of our appointment. I accept checks, cash and credit cards for payment (including many HSA cards). A $40 fee will be charged for a NSF returned check. Charges are based on 60 and 90-minute sessions. Please call for current session rates. I do not participate “in network” for any insurance companies. I will gladly provide you with a receipt suitable for submission to your insurance provider for reimbursement for any part of our session fees.

**Cancellations**
Because I have reserved a specific appointment time to meet with you, I ask that you cancel or re-schedule an appointment at least 24-hours in advance of our scheduled appointment. If you do not show for your appointment or cancel less than 24 hours in advance (with exception to emergencies and illness), you will be responsible for full payment..

**Availability**
If you need to contact me between sessions the best way to do so is by telephone. I will make every attempt to return non-urgent phone calls during scheduled office hours
(Monday-Friday) within 24 hours. If you have not heard from me within 24 hours, please call again. If you have an urgent need to speak to me, please indicate that when leaving a voicemail message. In the event of a medical emergency, please call 911 for emergency assistance. You may also contact Crisis Hotline at (317) 251-7575.

**Text Messaging, Email, and Social Media**
Please be aware that confidentiality can not be assured when communicating through these means. I will not respond with lengthy emails or texts should you choose to communicate with me through these means. I prefer to speak with you on the telephone. Please do not use messaging on social networking sites such as Twitter, Facebook, or LinkedIn to contact me. Engaging with me this way could compromise your confidentiality and privacy and therefore, the safety of our therapeutic relationship

**DISCLAIMER**
Important Notice: Meditation, guided imagery, hypnosis, Thought Field Therapy®, Emotional Freedom Techniques®, HeartMath®, applications of bio-energy modalities such as Reconnective Healing® or Reiki, The Emotion Code®, The Body Code®, Brainspotting and similar interventions should be considered complementary to treatment by licensed healthcare practitioners. All statements on this website are for informational purposes only. No information on this website should be considered as a medical diagnosis, treatment recommendation, or in any way a substitute for proper medical treatment by a licensed healthcare provider.

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.**

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

## HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

### For Treatment

Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

### For Payment

We may use or disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

### For Health Care Operations

We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

### Required by Law

Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

### Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization

| | |
|---|---|
| **Abuse and Neglect** | **Judicial and Administrative Proceedings** |
| **Emergencies** | **Law Enforcement** |
| **National Security** | **Public Safety (Duty to Warn)** |

**Without Authorization**
Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

• Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or health department)
• Required by Court Order
• Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

**Verbal Permission**
We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

**With Authorization**
Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked

**YOUR RIGHTS REGARDING YOUR PHI**
You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to our Privacy Officer, Lisa Arick, at Lisa Arick, Inc.:

• **Right of Access to Inspect and Copy** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost- based fee for copies.

• **Right to Amend** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information, although we are not required to agree to the amendment.

• **Right to an Accounting of Disclosures** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

• **Right to Request Restrictions** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

• **Right to Request Confidential Communication** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

• **Breach Notification** If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself

• **Right to a Copy of this Notice** You have the right to a copy of this notice.

**COMPLAINTS**
If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Lisa Arick, our Privacy Officer, at Lisa Arick, Inc., or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

**The effective date of this Notice is (date of first appt.) ________________**

9135 N. Meridian St., Ste B2 Indianapolis, IN 46260• 317.506.5161

**Notice of Privacy Practices**
**Receipt and Acknowledgment of Notice**

Patient/Client Name: ___________________________________________
DOB: _____________________________

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Lisa Arick, Inc. Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Officer at Lisa Arick, IN 317.506.5161.

Digital Signature of client/patient:

_________________________________

Digital Signature or Parent, Guardian or Personal Representative*

(if applicable): _________________________________

Date:_______

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.) __________________________________

❑ Patient/Client Refuses to Acknowledge Receipt:

_______________________________________________ Date:________

Signature of Staff Member:________________________ Date:______

# CANCELLATION POLICY

I will make every attempt to find a convenient time to schedule our visits.
If you fail to cancel a scheduled appointment within 24 hours, I am unable use this time for another client.   Please note that if we have scheduled a 60 min. session, you will be billed for that 60 min. rate and the same would be true if we had previously scheduled a 90 min. session.  Your card on file will be charged these fees or payment, otherwise will be arranged prior to your next visit.  Therefore, I must bill for the cost of your missed appointment.

A full fee is charged for missed appointments or no show cancellations with less than a 24 hour notice unless due to illness or an emergency**.**  A bill will be mailed to you in such situations.

Thank you for your consideration regarding this important matter.

____________________________________________________________

Client Signature (Client's Parent/Guardian if under 18)

________________________________

Today's Date