Lifepath
Counseling & Wellness

Child Intake Assessment

Client Information		
Client Name:	Age:	Today's date:
Date of Birth:	SSN:	
Address Including City, State, and ZIP:		
Parent initiating treatment Date of Birth:	Parent initiating treatment Social Security Number:	
Email:	☐ I give my permission to be contacted by email	
Primary Phone Number:	☐ I give permission to leave a message at this number ☐ I DO NOT give permission to leave a message at this number	
Mobile Phone Number:	☐ I give permission to leave a message at this number ☐ I DO NOT give permission to leave a message at this number	
Are the child's parents: ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Cohabitating ☐ Other, explain:_____		
Mothers name, list address and phone number if different from above:		
Fathers name, list address and phone number if different from above:		
Legal Guardian name, list address and phone number if different from above:		
Self-identify as: ☐ Male ☐ Female ☐ Other	Religious Preference:	
Are services voluntary: ☐ or court ordered ☐		
Emergency Contact Name: Relationship: Phone Number:		
Ethnicity/National Origin: ☐ Caucasian (White) ☐ African American ☐ Native American (Tribal) ☐ Hispanic or Latino ☐ Hawaiian/Pacific Islander ☐ Asian ☐ Other_____		
Name and Address of School:	School Phone Number:	

If the minor's parent's marriage is intact, treatment only requires the signature of one parent. To provide treatment to minors of separated or divorced parents, Lifepath must have signed consent from both parents unless one parent has sole legal custody with medical decision-making capabilities. Informed consent from a person who lacks the authority to give consent is the same as NO consent at all. If consent is unable to be obtained from the other parent, do you have the legal authority and capacity to authorize consent for the treatment of this minor?
By signing below, I confirm that I have the legal right to consent to this child's treatment without the consent of any other individuals.

_____ _____
Signature of Authorizing Parent or Guardian Date

We must have a copy of the custody orders, including parenting plan, or any documentation related to medical decision-making or custody (guardianship, power of attorney etc.) prior to treatment. Do you have these documents with you? **Yes ☐ or No ☐**, If no, please explain when and how these documents will be provided to Lifepath Counseling & Wellness prior to treatment of the child?

Authorization for Release of Information to Custodial or Non-Custodial Parent

Lifepath Counseling and Wellness requires that a release of information be on file for the custodial or noncustodial parent that did not initiate treatment unless a court order is provided specific to the contrary.

I,_____ hereby authorize Lifepath Counseling and Wellness and _____
(Your name) (Other parents name)
to exchange treatment information related to the treatment of _____ DOB _____
(Child's name) (Child's DOB)

_____ _____
Signature of Authorizing Parent or Guardian Date

As a matter of POLICY, providers at Lifepath Counseling and Wellness DO NOT write letters providing any professional opinions, recommendations, or provide any documentation outside the scope of the standard treatment records. We do not make child custody recommendations, do child custody evaluations, assess children for child abuse, or provide professional opinions/recommendations regarding the client for legal purposes. Our services are solely for the treatment of the above listed minor.

By signing below, I acknowledge that Lifepath Counseling and Wellness does not provide any written documentation for recommendations, legal issues, or professional opinions, under any circumstance in regards to the treatment of the client.

_____ _____
Signature of Authorizing Parent or Guardian Date

Payment and Insurance Information

Parent/Guardian initiating services is financially responsible regardless of insurance information provided below

Medicaid: ☐ Yes ☐ No Medicaid Number:	Employee Assistance Name: Number of visits: Authorization Number:
Clients Relationship to Policyholder: ☐ self ☐ spouse ☐ child ☐ other _____	Primary Insurance Company Name:
Policy Holder Name:	Policy Holder DOB:
Policy Holder SSN:	Employer:
Member ID:	Group:
If applicable, Secondary INS:	Member ID:
Primary Insurance Holder Address Including City, State, and ZIP:	

Lifepath Counseling and Wellness Financial Agreement

REGARDING PAYMENT/INSURANCE:

Though we accept most insurance, our providers do not accept all insurances so please check with your insurance company prior to coming in to verify the provider you are scheduling with accepts the insurance you have. Payment is due at time of service. You are responsible for fees regardless of insurance coverage. Your health insurance company may reimburse Lifepath Counseling and Wellness for your services however, your insurance is a contract between you and the insurance company and Lifepath Counseling and Wellness is not party to the contract. We will bill your primary and secondary insurance as a service to you as long as you provide us accurate information and your account is current. If you have an outstanding balance, full payment will be required before further services can be performed. Benefits quoted are not a guarantee of payment. You are responsible for any deductibles, co-payments, or balances applicable to your individual policy. If your insurance requires an authorization or referral for services, **you are responsible to obtain this referral.** We realize that people have financial difficulty. Therefore, we may advise that due to your financial situation you seek services through an agency that is more able to work with your financial situation.

By signing, I understand the Lifepath Counseling & Wellness fee schedule, appointment arrival policy, cancellation and no-show policy, and the financial agreement regarding insurance and payment.

_____ _____

Signature of Authorizing Parent or Guardian Date

Credit/Debit Card Authorization Agreement.

Instructions: Please fill out the below form completely. Do not omit any fields, signature and date required. We ask all clients to submit a credit/debit card authorization sheet. In the unlikely event that you have a balance owed for more than 60 days, the overdue amount will be charged to your account. You may also choose to be billed at time of services or monthly. I understand that if I decide to terminate any of the services and my account is paid up in full, I may withdraw the authorization to charge my credit in the future provided I communicate revocation of authorization in writing to Lifepath Counseling and Wellness in office, by mail or fax. Please notify us if your credit card information changes or expires. Thank you.

Name on Credit/Debit Card:		
Credit Card Type (please circle): Visa MasterCard AMEX Discover		
Credit Card#:		
Expiration Date:	3-Digit Code:	Zip Code (where credit card bill is mailed):
As a convenience to you, if necessary, would you like this credit/debit card to be billed for deductibles, copays and/or co-insurance due at the time of each reoccurring appointment? _____ No, thank you _____Yes, please do bill them for me with the information provided		
The undersigned hereby authorizes Lifepath Counseling and Wellness to keep my signature on file and to charge my credit/debit card account for any deductibles, co-payments, or co-insurances due for services rendered or balance due resulting from no- shows/late cancellation fees that are 60 days overdue; or sooner if specified above.		

Signature of Cardholder:_____Date:_____

LIST OF BASIC FEES AND SERVICES	
Initial Medication Management Visit	$300-$360
Medication Management Established Patient Follow-up	$250
Initial Visit with Therapist	$210
Individual Therapy w/ Therapist 16-37 minutes	$120
Individual Therapy w/ Therapist 38-52 minutes	$140
Individual Therapy w/ Therapist 53+ minutes	$170
Court Appearance	$500
Family Therapy w/Therapist with or without patient present	$150
NO SHOW/or less than 24-hour cancellation fee	$50.00 per incident
Returned Checks	$25 per incident

Lifepath Provider Information

Lifepath Counseling and Wellness will assign providers and will make every attempt to match you to a provider based on, but not limited to: your choice, in network providers, availability, and area of expertise.

Consent for Treatment

- This is to certify that I give permission to a Lifepath therapist or medication provider to treat the patient identified on these documents. This treatment may include individual, family, or group psychotherapy, counseling, testing or medication management.
- This treatment may include consultation with other care providers, such as medical, educational, probation officers or court personnel.
- I understand that the therapists routinely staff cases and consults with other clinicians, doctors, and providers to insure continuity of care.
- I understand that my provider will not provide services outside the scope of their practice, and may refer me to different providers depending on my need. I understand that my provider will explain the limitations and scope of their practice and that I may ask questions about this at any time. I understand that services are voluntary.

_____ _____

Signature of Authorizing Parent or Guardian Date

To comply with Idaho Code (16-2428) regarding the confidentiality of records for children over the age of fourteen (14) years of age, parents/guardians and children for which this code applies should take note of the following:

16-2428. CONFIDENTIALITY AND DISCLOSURE OF INFORMATION. All certificates, applications, records, and reports directly or indirectly identifying a patient or former patient or an individual whose involuntary treatment has been sought under this chapter shall be kept confidential and shall not be disclosed by any person except with the consent of the person identified or his legal guardian, if any, or as disclosure may be necessary to carry out any of the provisions of this chapter, or as a court may direct upon its determination that disclosure is necessary and that failure to make such disclosure would be contrary to public interest.

(1) No person in possession of confidential statements made by a child over the age of fourteen (14) years in the course of treatment may disclose such information to the child's parent or others without the written permission of the child, unless such disclosure is necessary to obtain insurance coverage, to carry out the treatment plan or prevent harm to the child or others, or, unless authorized to disclose such information by order of a court.

(2) The child has the right of access to information regarding his treatment and has the right to have copies of information and to submit clarifying or correcting statements and other documentation of reasonable length for inclusion with his treatment record.

(3) Nothing in this section shall prohibit the denial of access to records, by a child when a physician or other mental health professional believes and notes in the child's medical records that the disclosure would be damaging to the child. In any case, the child has the right to petition the court for an order granting access.

(4) Access to records by the state protection and advocacy system shall be governed by 42 U.S.C. 10108 et seq., as amended.

Signature of Minor:_____Date: _____

Signature of Authorized Parent/Guardian:_____Date: _____

How did you Hear about Lifepath Counseling & Wellness?

- ☐ Yellow pages, Internet, or brochure
- ☐ Previous experience with LIFEPATH
- ☐ Referred by a friend/relative
- ☐ LIFEPATH accepts Medicare and/or Medicaid
- ☐ LIFEPATH accepts your private Insurance
- ☐ Referred to a specific therapist at LIFEPATH
- ☐ Referred by MD, Medical Provider, Hospital Discharge Planner, Medical Social Worker, or other Medical personnel
- ☐ Referred by a public agency (H&W, Juvenile Court Service, P&P, Victim Witness Coordinator, Child Protection, etc.)
- ☐ Other_____

PLEASE READ THIS FORM FULLY

Lifepath Counseling and Wellness Appointment, Attendance, and Cancellation Agreement

Welcome to Lifepath Counseling and Wellness. We are honored to assist you with your therapy goals. By signing this agreement, you are indicating your understanding and agreement to the following:

- I understand that it is very important I attend all of my therapy appointments to achieve the best possible outcome.
- I understand that Lifepath requires at a minimum of 24 hours' notice for any changes in my appointments.
- I understand that if I cancel **within less than 24 hours' notice** or do not show up for an appointment, Lifepath reserves the right to change a **$50.00 no show fee** that must be paid before further appointments may be scheduled.
- I understand that Lifepath has a waiting list and when I do not show up for an appointment, this prevents another client from receiving care.
- I understand that **3 cancellations** may result in my discharge from therapy services. (Definition of cancellation means those appointments that are canceled with or without 24 hours' notice or more, as required)
- I understand that I may be discharged from therapy services after 2 no-shows. (Definition of no-show means appoints that are canceled less than 24 hours' notice before the scheduled appointment OR not showing up for the appointment with no contact.)

ARRIVAL TIME: Please arrive to your appointment at least 5 minutes prior to the scheduled time. All our services have a specific time that is reserved just for you, and early arrival allows for time to update paperwork or other necessary requirements. Likewise, if you are a new patient and you arrive at the scheduled appointment time and not early to complete your forms as instructed, you will be asked to reschedule.

LATE ARRIVAL POLICY: In order to sufficiently meet your mental health needs we strive to ensure all appointments begin and end on time so that the next client is not delayed. If you are an established client and you arrive more than 5 minutes late for a medication management appointment or more than 10 minutes late for your counseling appointment you will likely be asked to reschedule, unless the providers schedule can still accommodate you. Priority will be given to the clients who arrive on time and you may have to be worked in between them. This may mean you will have a considerable wait. If this is not convenient for you, you may choose to reschedule. One or two late clients cause the entire daily schedule to fall behind. This is an inconvenience to everyone. We strive to see clients as close to their appointment time as possible.

PROVIDER LATE POLICY: Our providers try their very best to be on time for each scheduled appointment. At times, due to a crisis or emergency situation out of their control, occasionally appointments may run over. Our policy is to have a wait time of less than 15 minutes. If this causes a schedule disruption, please see reception and we will happily get you scheduled in the next available appointment time. Thank you for your patience and understanding.

THIS FORM HAS BEEN FULLY EXPLAINED TO ME AND I CERTIFY THAT I HAVE READ IT, UNDERSTAND ITS CONTENTS AND VOLUNTARITY AGREE TO ITS PROVISIONS.

Signature of Authorized Parent/Guardian:_____Date: _____

Office Policy

OFFICE HOURS: Our office hours are currently Monday – Thursday 8:30 am to 6:00pm

EMERGENCY SITUATIONS: For after hour emergencies, please call 911 or go to your local emergency room. In case of emergency, In the event that the named EMERGENCY CONTACT individual can't be reached: I give my consent for the client to be treated medically in an emergency situation. I also allow LIFEPATH to release any information that may be necessary to aid in providing accurate and quality care in the event that I may not be reached.

Returned Checks: There will be a $35 service charge for all returned checks.

Balances not paid with the credit card on file; Payment is due at time of services: If your account balance cannot be paid in full within 60 days, your account will be referred to Chapman Financial Services. Once the account has been handed off, Lifepath Counseling and Wellness will no longer handle any of the account payment details. Chapman Financial Services at (800) 594-9866 will handle all inquiries.

Provider Emergency Coverage: In case of an emergency, if your specific provider is unable to see you for more than 48 hours, Lifepath Counseling and Wellness will provide a "covering provider" whom will be able to respond to your emergency needs, either by telephone or with a face-to-face session. The provider will be given very basic potential clinical emergency information so that he/she may appropriately and sensitively assist you in the absence of your provider. Upon your providers return, the "covering provider" will inform your provider of any contacts (telephone or face-to-face session) and write a progress note for the contact that will be put into your clinical chart. Any fees which may be charged by the covering provider will also be discussed with you in advance of the scheduled coverage.

UNATTENDED CHILDREN: Please note that our office **does not allow and are not responsible** for unattended children in the lobby.

MEDICATION MANAGEMENT POLICY:

Lifepath Counseling and Wellness strictly adheres to the State of Idaho's regulations concerning controlled substances and will not be able to fill these early for any circumstance. Also, be aware that we regularly check the Board of Pharmacy, and will be notified if you seek controlled substances elsewhere.

PHONE CONSULTS: **If you need to speak with the nurse, there may be a fee charged for this service. The fees are charged on the quarter hour and range from $5.00 onto $20.00 depending upon the length of time spent with the nurse.**

MEDICATION REFILLS: Please call your pharmacy for all refill requests. You will need the following information to give to them: your name, phone number, date of birth, date of last refill, name of your physician, name and dosage of medication and the date of your next appointment. Please take a moment to look at your current prescription bottle to ensure that you do not have a refill waiting at your pharmacy. Please keep in mind that we require a 48-hour notice for all non-controlled substance medication refills and a 72-hour notice for all controlled substance medication refills.

CRISIS/CALL TIMES: We will make every effort to see or talk with each person as soon as possible. However, if you are in a crisis or it is a medical emergency please call 911, OR IF YOU ARE MEDICAID CALL OPTUM'S 24-HOUR CRISIS LINE AT 1-855-202-0973 or our crisis line at 208-780-3907

INFECTIOUS DISEASE: It is your responsibility to self-report infectious diseases immediately upon your knowledge to one of our staff members. This will be reported to the local health authorities.

TRANSPORTATION: I give my permission for LIFEPATH, its owners, agents, and employees to transport my child or person of guardianship to activities and treatment sessions as deemed necessary by the program employees.

MEDICATION AND FOOD ALLERGIES: It is your responsibility to self-report any medication, food or other substance allergies immediately upon your knowledge to one of our staff members. We do offer medication Management. We monitor medication and medication recalls. If you have been notified of a recall on a medication we have prescribed to you, please surrender it to the prescribing doctor or PA/NP immediately.

COURT TESTIMONY: LIFEPATH employees will testify in court only in response to a subpoena from a judge. Such time is not reimbursable by Medicaid or other insurances and additional charges will accrue. Most CBRS specialists are not licensed professionals and are unable to offer expert witness testimony. If they are called to testify in a custody dispute, child protection case, etc., they will describe what they have seen and heard (within the limits of the law), but will offer no opinions or interpretations. Most therapists are not qualified as "custody evaluators," and are ethically obligated to say as much if they are called upon to testify. Our therapists are not qualified as "custody evaluators".

REASONS FOR TERMINATION OF CLINICIAN-PATIENT RELATIONSHIP:

1. If you feel you are not compatible with your clinician, arrangements can be made for you to be seen by another provider.
2. If you are not complying with your clinician orders, he/she may request to discontinue treatment.
3. If you are not meeting financial obligations, your clinician may discontinue treatment.
4. If you are disruptive or inappropriate towards the staff, care may be terminated.
5. Dishonesty and/or deceitfulness may require termination of treatment.

Informed Disclosure and Consent

The Purpose of Therapy:

- Provide an environment that is supportive and safe in which you can explore areas of individual and family concern.
- Assists you in the process of making life decisions by exploring different options.
- Assists you to more effectively handle areas of concern in your life.

Possible Therapy Goals:

- To gain an understanding of the patterns that may be disturbing to you and others.
- To gain understanding of positive life patterns that support desired outcomes.
- To learn new information about the significant components of personal and family relationships including styles of communication, conflict resolution, and responsibility.
- To gain insight into effective methods of establishing a wellness-orientated lifestyle.
- Provide an environment that is supportive and safe in which you can explore areas of individual and family concern.
- Assists you in the process of making life decisions by exploring different options.
- Assists you to more effectively handle areas of concern in your life.

Client Rights:

- If you pay for a service or health care item out of pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- To receive appropriate services and be treated with respect.
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- To know how decisions are made so that you can participate in the process.
- A full explanation of services offered (i.e., therapy modalities, purposes, goals, techniques, procedures, limitations, potential risks/benefits). You have the right to choose your provider and the type of services in which you would like to participate. You have the right to refuse services.
- To be served in an environment that promotes independence, self-sufficiency and productivity.
- To make an informed decision regarding your consent for outpatient mental health services.
- You have the right to revoke your informed consent at any time to indicate a desire to discontinue treatment.
- To choose whether or not you desire Enhanced Outpatient Mental Health Services.
- The following are several mental health services providers who provide comparable services:
- Tidwell Social Work Services (208-853-5095) Sage Health Care (208-323-1125) Mountain States Group (208-336-5533)

Client Responsibilities:

- To set and keep appointments or cancel as soon as possible if you are unable to attend appointments.
- Assist in planning your service goals.
- Follow through with agreed upon goals.
- Report any changes in circumstance (i.e., financial, residential, marital, and number in household).
- Provide verification of information required.

Counseling Process:

During the process of counseling, with the use of Play Therapy, Family Therapy, Cognitive Behavioral Therapy, and Solution-Focused Therapy, we will explore possibilities for change to discover what is best for you and your family. As therapists, we will be approaching these sessions objectively, keeping your interests and concerns as top priority. We will search together for resolutions to concerns in your life whether they are past or present issues. We will attempt to find what is most helpful in each session to assist you in dealing with any issues that arise. After recognizing these issues we will set realistic goals of how you would like to see things at the end of counseling. These will be goals toward which we will work collaboratively.

There will be times when many emotions are expressed, some stronger than others. We will try to create the safest environment possible in order to assist in the expression of these feelings. You and your family should always feel free to leave counseling at any time without fear of judgment from our organization. If the decision to leave is made, we will be glad to provide you with referrals. Remember that although we do our best, desired outcomes are not always achieved.

Possible Side Effects of Counseling:

The idea of counseling is that it is supposed to help you feel better. However, there may be times during the process when you might actually feel worse, and you may question whether or not therapy is effective. Most often, this experience is temporary and usually marks an opportunity for overall improvement and progress toward your goal. If you encounter this experience and you have any questions or concerns, please feel free to contact your counselor.

Counseling Session:

A counseling session is normally 45 to 60 minutes in length. These sessions are usually scheduled once a week depending on

your need. The average individual will come for three to six months. Services may be tailored to specifically meet your needs in regard to time, dates, frequencies, objective, goals, and exit criteria. Counseling sessions will be scheduled on a week-to-week basis. If you are in crisis or have an emergency, you should contact your local police or emergency services by calling 911.

Professional Standards:

Therapists are required to adhere to the code of ethics of their professional association (i.e., National Association of Social Workers, American Counseling Association). The licensure of any individual under the laws of Idaho does not imply or constitute an endorsement of that therapist, nor guarantee the effectiveness of treatment.

You may at any time throughout your treatment, seek a second opinion. It is the responsibility of the client to choose the provider and the client may terminate treatment at any time.

Minors:

If you are thirteen years of age and younger, please be aware that the law may provide your parents the right to examine your treatment records. We will provide them only with general information about the clinical work done together, unless they request further information or there is a high risk of self-destructive behaviors, indicators of serious harm toward yourself or someone else. In this case, the therapist will notify them of their concern. The Therapist will also provide them with a summary of your treatment when it is complete. Before giving them any information, the therapist will discuss the matter with you, if possible, and do their best to handle any objections you may have with what they prepared to discuss.

Professional Records:

The laws and standards of this profession require that treatment records be kept. Clients are entitled to receive a copy of their treatment plan and clinical diagnostic assessment. Therapist's notes will not be released, but instead a summary of this information can be prepared for review or records requests. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers and can cause undue harm. If you wish to see your records, we recommend that you review them in the presence of the therapist so that the contents can be discussed. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

Cultural Considerations:

It is the policy of Lifepath Counseling & Wellness to provide services to clients that are respectful of non-dominant languages and cultures. The following actions will ensure that all services adhere to this policy:

- Actively recruit professional staffs that are multilingual and multicultural.
- Advertise our services to diverse populations.
- Ensure that paperwork and forms necessary for service delivery are available either through interpretation or written translation to diverse populations.

Discrimination Policy:

Lifepath Counseling and Wellness does not permit, condone, or tolerate discrimination in any form. We welcome all families and individuals and members will not be discriminated against in the delivery of health care services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment. Any breach of this policy by employees may result in disciplinary action, and /or termination.

Confidentiality: (Please refer to our Privacy Policy for more detailed information)

Privacy Policy

Lifepath Counseling & Wellness is committed to providing the highest quality professional services while maintaining the security of your personal health information. You may have a copy of this policy by requesting it at any time. Please read the following information carefully so that you may understand Lifepath Counseling & Wellness's policies about the protection and use of your protected consumer health information.

You have the following rights regarding your mental health and medical information, provided that you make a written request to invoke the right.

1. Right to request restriction: you may request limitations on how we use or disclose your mental health and medical information. We are not required to agree to any restrictions you request, but any restrictions that are agreed to by us in writing are binding.
2. Right to confidential communications: You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
3. Confidentiality (unless reporting is required by law or regulation). You can ask us **not** to use or share certain information about treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
4. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

5. Right to inspect and copy: you have the right to inspect and to request (requests are to be in writing and specify the exact information sought) a copy of your information regarding decisions about your care; however, progress notes may not be inspected and/or copied. We may charge a $15 fee for copying, mailing, and supplies. Requests will be processed within seven (30) business days. Under limited circumstances, your request may be denied. You may request review of the denial by another licensed health care professional chosen by Lifepath Counseling & Wellness (Records released to you may contain private information that if knowingly or unknowingly is released further may result in unforeseeable consequences.)
6. Right to request an amendment: if you believe that the information we have about you is incorrect or incomplete, you may request an amendment in writing. LIFEPATH is not required to accept the amendment. We may say "no" to your request but we'll tell you why in writing within 60 days.
7. Right to a copy of the agreement: you may request a paper or electronic copy of this agreement at any time.
8. Right to complain: if you believe your privacy rights have been violated, you may file a complaint with LIFEPATH or with the Idaho State Occupational Licensing board. You will not be penalized or retaliated against in any way for making a complaint. It is the policy of the agency that we will have a process for clients and family members of clients to register any complaints they might have about services or any other aspect of our program. We will create an open atmosphere in our clinic that will respect and welcome suggestions for change and complaints. Please request a grievance form from the receptionist if needed. You can also complain, you can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.
9. Lifepath Counseling & Wellness operates on a 'need to know' basis only. This means that only those who need access to your private information for treatment and billing purposes will access your information and they will only access what they need for their specific purpose.

Confidentiality and Limitations

The law protects the privacy of all communications between a client and a mental health therapist. In most situations, we can only release information about your treatment to others if you sign a written Release of Information form. There are other situations that require only that you provide written, advanced consent. Confidentiality contains the following:

1. Your therapist may be required to consult other health and mental health professionals either because of your insurance, or to ensure compliance with the Board of Occupational Licenses about their work with you. During a consultation, every effort is made to avoid revealing the identity of the client. Other professionals are also legally bound to keep the information confidential. If you do not object, you will not be informed about these consultations unless your therapist feels that it is important to your work together.
2. You should be aware that we may need to share protected information with supervisors and staff for both clinical and administrative purposes, such as scheduling, billing, and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been trained about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

There are some situations where we are permitted and/or required by law to disclose information without either your consent or authorization.

1. If you are involved in a court proceeding and a request is made for information concerning your treatment, we cannot provide such information without your (or your legal representative's) written authorization, or a court order signed by a judge. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order your mental health provider to disclose information.
2. If a government agency is requesting information for health oversight activities, your therapist may be required to provide information for them.
3. If a client filed a lawsuit against LIFEPATH pertinent information may be disclosed regarding that client in order to provide a defense.

There are some situations in which your mental health provider is legally obligated to take actions, which are necessary to attempt to protect others from harm. Some information may have to be revealed regarding a client's treatment. The following may be situations where this could occur.

1. If child neglect or abuse is suspected or if a child is observed being subjected to conditions that are likely to result in abuse or neglect, the law requires the information be reported to the state Department of Health and Welfare. If it is believed the child has suffered serious physical abuse, sexual abuse, or sexual assault, the law requires that your therapist report to the police. Once such a report is filed, additional information may be required.
2. If it is believed that a client presents a clear and substantial danger or imminent injury to another, protective actions may be required including notifying the potential victim, contacting the police, or seeking hospitalization for the client.

If such a situation arises, we will attempt to limit our disclosures to what is necessary and relevant. While this summary of exceptions to confidentiality should provide helpful information about potential problems, it is important that any questions or concerns about this issue be discussed with your provider.

To comply with Idaho Code (16-2428) regarding the confidentiality of records for children over the age of fourteen (14) years of age, parents/guardians and children for which this code applies should take note of the following:

1. No person in possession of confidential statements made by a child over the age of fourteen (14) years in the course of treatment may disclose such information to the child's parent or others without the written permission of the child, unless such disclosure is necessary to obtain insurance coverage, to carry out the treatment plan or prevent harm to the child or others, or, unless authorized to disclose such information by order of a court.
2. The child has the right of access to information regarding his treatment and has the right to have copies of information and to submit clarifying or correcting statements and other documentation of reasonable length for inclusion with his treatment record.
3. Nothing in this section shall prohibit the denial of access to records, by a child when a physician or other mental health professional believes, and notes in the child's medical records, that the disclosure would be damaging to the child. In any case, the child has the right to petition the court for an order granting access.

This policy is subject to change. We will communicate any significant changes to you as required by applicable law.
If you have any questions about this policy, please don't hesitate to address them to your service provider.
Our designated Privacy Officer is: Ann Turner at (208) 780-3900
We hope to be able to assist you in the journey that you have undertaken. Please sign this sheet to indicate you have read the information and understand your rights as a client. Also, by signing, you are stating that you were given the opportunity to ask any questions regarding the above presented information and that you have agreed to receive service through Lifepath Counseling & Wellness.
I have read and understand the Lifepath Counseling & Wellness Arrival Policy, Office Policy, Informed Disclosure and Consent, and Privacy Policy. I agree to assign insurance benefits to Lifepath Counseling & Wellness whenever necessary. I acknowledge that I can ask for a paper copy of this notice at any time, even if I have agreed to receive the notice electronically; a prompt copy will be provided. This policy is also available at all times at www.lifepathidaho.com .

_____ _____

(Signature of Authorized Parent/Guardian) (Date)

_____

(Printed Name

Lifepath Counseling and Wellness Child Intake Form

This information will be used for evaluation purposes and will become part of the psychiatric record.
All information will be kept confidential.

Personal Information

Child's Name: _____ Age: _____ Grade: _____

Father's Name: _____ Occupation: _____

Mother's Name: _____ Occupation: _____

Address: _____ Home Phone: _____

_____ Work Phone: _____

_____ Cell Phone: _____

Permission to Leave Message: Yes ☐ No ☐

I do ☐ do not ☐ give permission for my child's photograph to be taken for his/her chart.

Child's Strengths, Hobbies and Interests: _____

_____

_____

_____

Why are you bringing your child in for a psychiatric evaluation? _____

_____

_____

_____

Please briefly list your major concerns regarding your child's behavior/mental health: _____

_____

_____

_____

Has your child been exposed to any <u>recent</u> stresses or changes? If so, please list them: _____

_____

_____

_____

_____

Please list any information regarding your child's past psychiatric/behavioral treatment. (Evaluations, with whom, when, and results):

Name/Address of Past Provider	Dates of Treatment	Purpose of Treatment

Psychiatric Medications: (List past medications and reasons for stopping/changing.) (List current medications – doses and times):_____

_____

_____

_____

Often loses temper: Yes ☐ No ☐ If yes, how often? _____ How long do the episodes usually last? What does your child do during these episodes? What usually triggers the tantrums? How do you usually intervene? _____

_____

_____

_____

Has your child ever been physically abused? Yes ☐ No ☐ If yes, please give details: _____

_____

_____

_____

Has your child ever been sexually abused? Yes ☐ No ☐ If yes, please give details: _____

_____

_____

_____

Does your child express any unusual fears? Yes ☐ No ☐ If yes, please give details: _____

_____

_____

_____

Has your child ever complained of hallucinations? (e.g. hearing voices, seeing things) Yes ☐ No ☐

If yes, please give details: _____

_____

_____

Has your child exhibited paranoia? (Worries that others are out to hurt him/her) Yes ☐ No ☐

If yes, please give details: _____

_____

DEVELOPMENTAL HISTORY:

Was pregnancy for this child planned? Yes ☐ No ☐

What was the mother's mood during this pregnancy? _____

_____

_____

_____

Was the mother healthy during pregnancy with this child? Yes ☐ No ☐

Was the mother involved in any accidents or falls during pregnancy? Yes ☐ No ☐

If yes, please give details: _____

_____

_____

_____

During pregnancy did the mother use?

Prescription medications? Yes ☐ No ☐ _____

Over the counter medications? Yes ☐ No ☐ _____

Alcohol? Yes ☐ No ☐ (if yes, what kind and amount) _____

Illegal Drugs? Yes ☐ No ☐ _____

Tobacco/cigarettes? Yes ☐ No ☐ (If yes, how many packs a day?)_____

Any problems with labor and delivery? Yes ☐ No ☐ If yes, please give details: _____

_____

_____

What was the weight of the baby at birth? _____

Was the baby born full term? Yes ☐ No ☐
(If not, how much earlier or later did the baby arrive?) _____

How long did mother and baby stay in the hospital? _____

DEVELOPMENT OF CHILD:

At what age did the child:

Sit up alone _____ Toilet training started at what age: _____

Stand _____ At what age was bowel control established? _____

Crawl _____ When did bed-wetting stop? _____

Take first steps _____ When did wetting in day-time stop? _____

Walk unaided _____ Were there any lapses? Yes ☐ No ☐

Speak isolated words (da da) _____ If so, at what age? _____ Speak in simple phrases_____

Did the child have difficulty with speech and/or language development? Yes ☐ No ☐ (if yes, please give age and explanation) _____

_____

MEDICAL HISTORY:

Allergies: _____

Pediatrician: _____ Last physical exam: _____

Current medications: _____

_____

_____

Medical hospitalization(s): _____

_____

Surgeries: _____

_____

Are immunizations up to date? Yes ☐ No ☐

Traumatic Injuries *(e.g.– broken bones, loss of consciousness, etc.)* _____

_____

_____

Chronic Illnesses: _____

_____

_____

Is your child currently experiencing any physical pain or discomfort? Yes ☐ No ☐ *If yes, please indicate severity of current pain on a scale of 1 (mild) to 10 (severe):* _____

_____

_____

Seizures: _____

_____

_____

Has child experimented with or used: (if yes, please list amount and frequency)

Substance	Date last used	Age first used	Amount and frequency
Cannabis			
Cocaine			
Alcohol			
Opiates/Methadone			
Hallucinogens			
Designer (G, Ecstasy)			
Inhalants			
Cigarettes			
Caffeine			
Benzodiazepines			
Methamphetamines			
Other			

FAMILY HISTORY:

Mother: Age: _____

History of mental health problems: _____

_____

_____

Education: _____ Occupation: _____

History of mental illness, legal problems, drug/alcohol problems, suicides, etc., in any relatives: _____

_____

Father: Age: _____

History of mental health problems: _____

_____

_____

Education: _____ Occupation: _____

History of mental illness, legal problems, drug/alcohol problems, suicides, etc., in any relatives: _____

_____

Brothers/Sisters: Names and ages: _____

_____

Any mental health problems: _____

_____

_____

Where are they living? _____

Who is the child living with? (If not living with the biological parents, why?): _____

_____

Besides the care givers, are there other children or adults living in the home? (If yes, please give explanation) _____

_____

_____

SOCIAL HISTORY:

Does your child have friends? _____

Does your child participate in any organized activities or sports? _____

_____

Does your child participate in school activities? _____

_____

Do you know if your child sexually active? _____

Does your child have any hobbies? _____

_____

What does your child do with his/her free time? _____

_____

How does your child do when playing with other children? _____

_____

Does child have any legal charges/involvement with the juvenile justice system? Yes ☐ No ☐ *If yes, please explain*:

_____

_____

_____

Does your child have a part-time job? Yes ☐ No ☐ _____

SCHOOL HISTORY:

Current School: _____ Current Grade: _____

Names of different Schools attended (list dates and grades): _____

_____

Any early problems with:

Academics: _____

_____

Conduct: _____

_____

Motivation: _____

_____

Any current problems with:

Academics: _____

_____

Conduct: _____

_____

Motivation: _____

_____

Any grades repeated? _____

Any problems with: Truancy ☐ Suspension ☐ Expulsion ☐ _____

_____

LEARNING DISABILITIES:

Has/does your child receive(d) any special services in school? _____

_____

_____

OTHER COMMENTS: _____

_____

_____

Check all that apply

- ☐ Fails to give close attention to details; careless mistakes
- ☐ Difficulty sustaining attention
- ☐ Does not seem to listen when spoken to directly
- ☐ Does not follow through on instructions; fails to complete tasks
- ☐ Avoidant of tasks that require sustained mental effort
- ☐ Often loses things
- ☐ Easily distracted by things less important
- ☐ Forgetful in daily activities
- ☐ Fidgets with hands/feet, squirms in seat
- ☐ Cannot remain seated
- ☐ Runs about or climbs excessively
- ☐ Difficulty playing or engaging in other activities quietly
- ☐ Often on the go
- ☐ Often talks excessively
- ☐ Blurts out answers
- ☐ Difficulty awaiting turn
- ☐ Often interrupts or intrudes
- ☐ Bullies, intimidates, or threatens others
- ☐ Initiates physical fights
- ☐ Child used a weapon or dangerous object against self or others
- ☐ Physically cruel to people
- ☐ Physically cruel to animals
- ☐ Sexual acting out or sexually inappropriate behavior
- ☐ Deliberately engaged in fire-setting
- ☐ Deliberately destroyed other property
- ☐ Broken into someone else's home
- ☐ Lies excessively
- ☐ Stealing or shoplifting
- ☐ Bed wetting
- ☐ Soiling or wetting pants during day
- ☐ Stays out at night or all night without permission
- ☐ Has run away from home
- ☐ Often truant from school
- ☐ Often argues with adults
- ☐ Actively defies rules/refuses to comply with requests
- ☐ Often deliberately annoys people
- ☐ Often blames others
- ☐ Touchy/easily annoyed by others
- ☐ Angry and resentful
- ☐ Spiteful and vindictive
- ☐ Irritable mood
- ☐ Appetite changes
- ☐ Activity level changes
- ☐ Physical complaints with no real medical problem confirmed
- ☐ Low energy level
- ☐ Lots of energy for certain periods of time
- ☐ Able to stay up for days without sleep
- ☐ Frequent crying
- ☐ Tries to isolate self from others
- ☐ Physical restlessness during sleep
- ☐ Problems falling asleep
- ☐ Gory dreams/nightmares
- ☐ Difficulty getting up in the morning
- ☐ Frequent fights
- ☐ Problem with destructiveness
- ☐ Hostile and rejecting attitude
- ☐ Confused thinking
- ☐ Racing thoughts
- ☐ Over eating/over weight
- ☐ Anorexia/under eating – under weight
- ☐ Bulimia (makes self vomit)

Form completed by: _____ Date: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name: _____ DOB: _____

I hereby authorize **Lifepath Counseling & Wellness** to use and or disclose my individually identifiable Protected Health Information ("PHI") in the manner described below. I understand that the person or entity receiving my PHI, may re-disclose my PHI, and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such re-disclosure by the person or entity receiving my PHI. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form.

_____Obtain information from: AND/OR _____Disclose information to:

Name and Address: _____

Phone #: _____ Fax# _____

Category and Time Period of PHI Please initial the Category of PHI you wish to release:

____Initial Evaluation _____Claims/Billing Information _____Lab Results _____ Medication List _____CDA ____Treatment Plan(s) ____Entire Medical Record _____Appt. Scheduling and info. _____History and Physical ____Verbal and written communication. _____other

Time period of healthcare treatment records you wish to be included:

_____Anytime ____ Healthcare provided between (date)_____ and (date) _____.

Limit of PHI I understand that this authorization extends to all of any part of the records/information designated above which may include treatment for physical and mental illness, alcohol/drug abuse; HIV/AIDS test results or diagnosis. I understand that if I wish to limit the use and disclosure of my PHI, I would have indicated below by initialing the appropriate category of PHI I DO NOT wish to be released.

_____ HIV/AIDS test results or diagnosis _____Alcohol/drug abuse _____ Other_____

Please limit the use and disclosure of my PHI to only include the following dates: _____. [Example: laboratory results from July 1998; mental health records from January 2001 to present"]

Purpose of PHI _____Continuity of Care _____Contact with Referring Supervisor _____Family Involvement _____ Aftercare Planning _____ Referral _____other_____

I understand that this authorization will expire on the following date or event: _____. If no specific date or event is stated, this authorization will expire one (1) year from the date of this authorization. I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying the above provider in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by the provider mentioned above in reliance on this authorization before the provider mentioned receives my request for revocation or modification. I must sign my written request and send it to: 8675 W Ardene St. Boise, ID 83709. Phone (208)780-3900. Fax (208)375-2882.

Signed: _____Date: _____

Parent or Guardian: _____Date: _____

Witness signature: _____Date: _____

Note to Agency/Person receiving information: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42CFR Part 2.1) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.