



## Adult Intake Assessment

### Client Information

Client Name:	Age:	Today's date:
Date of Birth:	SSN:	
Address Including City, State, and ZIP:		
Primary Phone Number:	<input type="checkbox"/> I give permission to leave a message at this number about appointments and/or payments	
Mobile Phone Number:	<input type="checkbox"/> I give permission to leave a message at this number <input type="checkbox"/> I give permission for text messages to be sent to this number	
Email:	<input type="checkbox"/> I give my permission to be contacted by email	
Self-identify as: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Religious Preference:	
Are services voluntary: <input type="checkbox"/> or court ordered <input type="checkbox"/>		
Emergency Contact Name:	Relationship:	Phone Number:
Ethnicity/National Origin: <input type="checkbox"/> Caucasian (White) <input type="checkbox"/> African American <input type="checkbox"/> Native American (Tribal) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Other _____		
Name and Address of Employer:	Phone Number of Employer:	

### Payment and Insurance Information

**Person initiating services is financially responsible regardless of insurance information provided below**

<b>Medicaid:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Medicaid Number:	Employee Assistance Name: Authorization Number: Number of visits:
Clients Relationship to Policyholder: <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> child <input type="checkbox"/> 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.

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

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

LIST OF BASIC FEES AND SERVICES	
Court Appearance	\$500
NO SHOW/or less than 24-hour cancellation fee Therapy/Medication Management	\$50.00/\$65.00 per incident
Returned Checks	\$35 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 the Therapist or Medication Management provider at Lifepath to treat the patient identified on these documents. This treatment may include individual, family, or group psychotherapy, counseling, customary care, psychiatric evaluation, management and administration of medication, therapy, treatment, tests, and procedures considered advisable, including emergency treatment. This treatment may include consultation with other care providers such as social services, medical, educational, probation, law enforcement or court personnel, or view prescription monitoring program. I understand the provider routinely staff's cases and consults with other clinicians, doctors and providers to ensure 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 Client

\_\_\_\_\_  
Date

### How did you Hear about Lifepath Counseling & Wellness?

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

# 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 charge a **\$50.00/\$65.00 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.

**CANCELLATION AND NO SHOW POLICY:** If you need to cancel or change your appointment, please do so as soon as possible. If cancellation does not occur at least 24-hours in advance or you no show for your appointment, you may be charged for that appointment. In the case of extenuating circumstances, the fee will then be negotiated between the client and therapist. The therapist must document the circumstances. **Broken appointments** represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. **In the event of any client who no-shows, their recurring or 'standing' appointment will be removed from the schedule unless the therapist wishes to keep a client on his/her calendar. A behavioral contract may be initiated at this time at the discretion of each therapist. If a client no-shows three times consecutively, they will need to wait until they have paid all associated fees and a minimum of 90 (ninety) days before they may schedule another appointment.**

**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 VOLUNTARILY AGREE TO ITS PROVISIONS.**

Signature of Client: \_\_\_\_\_ Date: \_\_\_\_\_

## Office Policy

**OFFICE HOURS:** Our office hours are currently Monday – Thursday 8:30 am to 6:00pm, some Friday and Saturday hours are available.

**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 LIFEPAATH 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.

**Drug Screening: We have the right to obtain a urine drug screen and controlled medication count if deemed necessary by your prescriber**

**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**

**ILLNESS:** Under no circumstances come into this office with Covid or Flu-like Symptoms (fever, cough, shortness of breath, sore throat, or vomiting). We offer Telemedicine if you are unable to reschedule and must be seen

**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.

**TRANSPORATION:** I give my permission for LIFEPAATH, 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:** LIFEPAATH 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:**

If you feel you are not compatible with your clinician, arrangements can be made for you to be seen by another provider.

If you are not complying with your clinician orders, he/she may request to discontinue treatment.

If you are not meeting financial obligations, your clinician may discontinue treatment.

If you are disruptive or inappropriate towards the staff, care may be terminated.

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.

**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. LIFEPAH 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 LIFEPAH 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/](http://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 LIFEPAH 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  
Updated February 3<sup>rd</sup>, 2023



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](http://www.lifepathidaho.com).

I have read and understand the above policies. I authorize payment of medical benefits from my insurance company. I further authorize any holder of medical information about me to release pertinent information of the Health Care Financing Administration or my insurance company any information needed to determine benefits for related services. I also take full responsibility for payment of charges, regardless of payment or denial of payment from my insurance company.

\_\_\_\_\_  
(Signature)

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

\_\_\_\_\_  
(Printed Name)

**Lifepath Counseling & Wellness Adult Intake Assessment**

Please take a moment to complete this questionnaire thoroughly, but be brief with your responses when possible. Feel free to put 'NA' or a question mark when the answer is not known. But please respond to every item-medical record accuracy and completeness make for a good foundation for successful treatment. Know that we honor your confidentiality: consequently, you can be sure that none of your medical record information, including what is provided on this form, will be released without your full knowledge and/or expressed consent. Thank you.

Clients Name \_\_\_\_\_ AGE: \_\_\_\_\_ Todays Date: \_\_\_\_\_

Name of person completing this form (if different than patient) and relationship to patient:
Please, briefly describe the reason you are here / current problem(s):
Will your family, if necessary, be ready and motivated to participate in services to help you achieve your treatment goals?

Medical Information		
Primary Care Provider:	Phone:	
Psychiatrist or Med Provider:	Phone:	
Other current treating clinicians or therapeutic interventions?		
When was your last check up or medical exam? If it has been more than 12 months we encourage you to schedule one as soon as possible.	<b>When</b> and by <b>whom</b> ?	
Current Medications	Treatment For:	Dosage prescribed:
Past Medications	Treatment For:	Dosage prescribed:

Current Psychiatric Medications		
Name of Medication:	Treatment For:	Dosage prescribed:

Current Psychiatric Care	
<b>Other Mental Health Providers:</b> <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Developmental Therapy <input type="checkbox"/> Case Management <input type="checkbox"/> Service Coordination <input type="checkbox"/> CBRS <input type="checkbox"/> Peer Support <input type="checkbox"/> Other:	
Of the psychiatric medications listed above, what were the benefits and/or side effect you had from them?	
Medical hospitalizations, surgeries, chronic serious illnesses, or injuries?	
Condition: _____ Year: _____	Condition: _____ Year: _____
Condition: _____ Year: _____	Condition: _____ Year: _____
Please list <b>all</b> allergies including drug allergies:	

SYMPTOMS SCREENER				
Over the past <i>two weeks</i> have you...	Not at All	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself – or that you are a failure or have let yourself or family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Moving or speaking so slowly that other people could have noticed? – or the opposite – being so fidgety or restless that you have been moving around more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thoughts that you would be better off dead or hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>How much distress would you say these symptoms caused you?</b>	<b>Mild</b> <input type="checkbox"/>	<b>Moderate</b> <input type="checkbox"/>	<b>Severe</b> <input type="checkbox"/>	

Over the past <i>two weeks</i> have you experienced...	Not at All	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Not being able to sleep or control worrying?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Worrying too much about different things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Trouble relaxing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Being so restless that it is hard to sit still?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Becoming easily annoyed or irritable?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Feeling afraid, as if something awful might happen?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If you checked off any problem, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	<b>Not at All</b> <input type="checkbox"/>	<b>Somewhat difficult</b> <input type="checkbox"/>	<b>Very difficult</b> <input type="checkbox"/>	<b>Extremely difficult</b> <input type="checkbox"/>

Has there ever been a period of time when you were not your usual self and...		
1. You felt so good or hyper that other people thought you were not your normal self or were so hyper that you got into trouble?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. You were so irritable that you shouted at people or started fights or arguments?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. You felt much more self-confident than usual?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4. You got much less sleep than usual and found you didn't really miss it?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5. You were much more talkative or spoke much faster than usual?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6. Thoughts raced through your head or you couldn't slow your mind down?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7. You had much more energy than usual?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8. You were much more active or did many more things than usual?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9. You were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10. You were much more interested in sex than usual?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
11. You did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
12. Spending money got you or your family into trouble?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
*G ZPV DIFDLFE :&4 UP NPSF UIBO POF PG UIF BCPWF, IBWF TFWFSBM PG UIFTF FWFS IBQQFOFE EVSJOH UIF TBNF QFSJPE PG UJNF	:FT <input type="checkbox"/>	/P <input type="checkbox"/>

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you...		
1. Have had nightmares about it or thought about it when you did not want to?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Were constantly on guard, watchful, or easily startled?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4. Felt numb or detached from others, activities, or your surroundings?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
How much distress would you say these experiences caused you?	Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	

When thinking about substance use, including illegal drug use and prescription drug use other than as prescribed...		
1. Have you ever felt that you ought to cut down on your drinking or drug use?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Have people annoyed you by criticizing your drinking or drug use?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Have you ever felt bad or guilty about your drinking or drug use?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
How much distress would you say these experiences caused you?	Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	

Life problem currently effecting you...	
<input type="checkbox"/> Problems/losses within my family <input type="checkbox"/> Problems/ losses among my friends/community <input type="checkbox"/> Educational problems <input type="checkbox"/> Occupational problems <input type="checkbox"/> Housing problems <input type="checkbox"/> Careless, high-risk behavior	<input type="checkbox"/> Financial/economic problems <input type="checkbox"/> Can't get adequate health care <input type="checkbox"/> Problems with the law, legal system <input type="checkbox"/> Discipline <input type="checkbox"/> Problems at work

Medical History		
<input type="checkbox"/> Chest Pain <input type="checkbox"/> Heart Attack <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Stroke	<input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Hormone Problems <input type="checkbox"/> Fever or Sweats <input type="checkbox"/> Blood Disease <input type="checkbox"/> Anemia <input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Muscle Cramps <input type="checkbox"/> Muscle Stiffness <input type="checkbox"/> Weakness <input type="checkbox"/> Tremors <input type="checkbox"/> Numbness <input type="checkbox"/> Difficulty Walking <input type="checkbox"/> Uncontrolled Movements

<input type="checkbox"/> Heart Palpations <input type="checkbox"/> Heart Surgery <input type="checkbox"/> Pace Maker Implant <input type="checkbox"/> Neurological Disorders <input type="checkbox"/> Seizures <input type="checkbox"/> Epilepsy <input type="checkbox"/> Fainting <input type="checkbox"/> Vertigo <input type="checkbox"/> Dizziness <input type="checkbox"/> Motor Difficulties <input type="checkbox"/> Serious Head Injury <input type="checkbox"/> Recurring Headaches <input type="checkbox"/> Memory Problems <input type="checkbox"/> Early Fatigue <input type="checkbox"/> Daytime Sleepiness <input type="checkbox"/> Difficulty Sleeping <input type="checkbox"/> Concentration Problems <input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Nose Bleed <input type="checkbox"/> Sexually Transmitted Disease <input type="checkbox"/> HIV <input type="checkbox"/> Sexual Difficulties <input type="checkbox"/> Gynecological Problems <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Cancer <input type="checkbox"/> Lung Disease <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Bronchitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Sinus or Nasal Problems <input type="checkbox"/> Recurrent Infection of any kind <input type="checkbox"/> Arthritis	<input type="checkbox"/> Liver Disease <input type="checkbox"/> Jaundice <input type="checkbox"/> Hepatitis <input type="checkbox"/> Stomach Ulcers <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Unusual Diet <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Skin Rash <input type="checkbox"/> Skin Ulcer/Lesion <input type="checkbox"/> Glaucoma <input type="checkbox"/> Visual Spots <input type="checkbox"/> Double Vision <input type="checkbox"/> Hearing Problems <input type="checkbox"/> Speaking Problems <input type="checkbox"/> Depressed Immune System <input type="checkbox"/> Recent Trauma <input type="checkbox"/> Other: _____
<b>Family History of Illness:</b> <input type="checkbox"/> None <input type="checkbox"/> Diabetes <input type="checkbox"/> Dementia/Alzheimer's <input type="checkbox"/> Cancer <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Epilepsy <input type="checkbox"/> Hormone Imbalance <input type="checkbox"/> Asthma <input type="checkbox"/> Thyroid <input type="checkbox"/> Migraines <input type="checkbox"/> Heart Disease <input type="checkbox"/> If other, explain:		

Educational History			
High School Graduate?	Yes	No	If no, Last grade attended?
GED?	Yes	No	
Special Education?	Yes	No	
College?	Yes	No	Degree?
Academic performance			
<input type="checkbox"/> Failing <input type="checkbox"/> Below average <input type="checkbox"/> Average <input type="checkbox"/> Above average <input type="checkbox"/> Well above average			

Employment History			
Currently Employed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If no, year last employed?
Who is your employer?	Last type of employment/work performed?		

Social Development			
How would you describe your social skills?	<input type="checkbox"/> Below Average	<input type="checkbox"/> Average	<input type="checkbox"/> Above Average
Do you have difficulty making friends?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
How many friends do you have?	<input type="checkbox"/> No friends	<input type="checkbox"/> 1 – 3 friends	<input type="checkbox"/> 4 – 6 friends <input type="checkbox"/> More than 7 friends
Friends are mostly...	<input type="checkbox"/> Younger	<input type="checkbox"/> Same Age	<input type="checkbox"/> Older
I would describe myself as?	<input type="checkbox"/> Very shy	<input type="checkbox"/> Somewhat shy	<input type="checkbox"/> Average <input type="checkbox"/> Outgoing <input type="checkbox"/> Very outgoing

Adult Relationships	
<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Cohabiting <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Other _____	
If divorced and remarried, at what age and how many times?	
With whom do you live and how are you supported at present?	

Current Living Situation
Do you live in a(n)? <input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/> Manufactured Home Do you <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Other _____
Do you live in <input type="checkbox"/> Boise <input type="checkbox"/> Meridian <input type="checkbox"/> Eagle <input type="checkbox"/> Kuna <input type="checkbox"/> Nampa <input type="checkbox"/> other _____

Do you live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If no, who else do you live with? _____			
Do you have plans to move in the near future? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, where? _____			
Do you have any pets? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please List: _____			
<b>Psychosocial and Family History</b>			
Are there any current community resources you or your family are already accessing?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, please list services
Are there any spiritual or cultural barriers that could impact your treatment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, please explain
Childhood Okay?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If no, briefly state <b>why</b> ?
Have you <b>experienced</b> neglect or emotional abuse?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	At what <b>age</b> and which <b>issue</b> and by <b>whom</b> ?
Does your family have a history of substance abuse?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, please list who.
Have you <b>experienced</b> physical or sexual abuse?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	At what <b>age</b> and which <b>issue</b> and by <b>whom</b> ?
Have you <b>witnessed</b> violence or domestic abuse?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	When?
Have you experienced or witnessed an accident, natural disaster or other traumatic event?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, what?
Did your parents stay together while you were growing up?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How old were you when they separated?
Where did you grow up?			
Father's occupation while you were growing up?			
Mother's occupation while you were growing up?			
How many siblings do you have?			
<b>Past Psychiatric History</b>			
Do you have a current mental health diagnosis?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	What is it, and at what age?
Have you ever received counseling or psychotherapy in the past?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If so <b>when, where</b> and with <b>whom</b> ?
Have you been hospitalized for <b>psychiatric</b> reasons?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, how many <b>times</b> ?
Do you have any family, immediate or extended, with <b>psychiatric</b> illness?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If so, <b>how old</b> and <b>who</b> suffers from <b>what</b> ?
Have you had any past <b>suicide attempts</b> ?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, how many <b>times</b> and by what <b>method</b> ?
If you have attempted suicide more than once, how old were you when first attempted, and when last?			
<b>Legal History</b>			
Legal Problems in the past?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Describe
Current Legal Problems?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Describe
<b>Safety Information</b>			
Do you have access to large quantities of medication?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Comments
Do you have any Firearms or other weapons?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	List which types
Have you ever intentionally hurt yourself?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Comments

Have you ever intentionally hurt someone else?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Comments
Are you worried for your safety?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Comments
Are you worried for the safety of others because of your behavior?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Comments

Social Supports			
Is there anyone you trust or confide in during times of trouble?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	(First Name Supports)
Do you have any religious/spiritual ties or involvement in a church?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Please describe:

Drug and Alcohol History (Check if none) <input type="checkbox"/>					
SUBSTANCE	DATE OF FIRST AND OF LAST USE	PROBLEMS RELATED TO USE		TREATMENT REQUIRED	
Alcohol (hard alcohol)		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Beer and/or Wine		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Benzodiazepines (Valium, Xanax, Ativan)		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Caffeine		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Marijuana		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cocaine		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Designer Drugs (Club Drugs: G, X)		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hallucinogens (LSD, Mushrooms)		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Methamphetamines (Speed, Ice, Ritalin)		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Opiates/Methadone (Vicodin, Oxycontin, Heroin)		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Inhalants (Gasoline, Glue, Aerosol)		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Tobacco Use?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Amount Per day? _____	

Client Name \_\_\_\_\_ Todays Date: \_\_\_\_\_

Signature of Person completing form \_\_\_\_\_ Printed Name \_\_\_\_\_

**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) prohibit 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.