

A large, faint, light gray compass rose graphic is centered in the background of the page. It features a fleur-de-lis at the top and the cardinal directions (N, S, E, W) labeled. Two horizontal dotted lines cross the compass rose, one above and one below the center.

# Client Intake Packet

We welcome you as a new client. Please take the time to fill out the forms in this packet as accurately as possible so we can most appropriately address your emotional health.

The confidentiality of your health information is protected in accordance with federal protections for the privacy of health information under the Health Insurance Portability and Accountability Act (HIPAA).

# Registration Form

## Client information

Date of registration: \_\_\_\_\_ Referred by: \_\_\_\_\_

Client name: \_\_\_\_\_ Sex: \_\_\_\_\_

SS #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Phone number: \_\_\_\_\_ Alternate phone: \_\_\_\_\_

Email address: \_\_\_\_\_

Are you employed?  Yes  No **Type:**  Full-time  Part-time  Retired  Student **Shift:**  Day  Night  Varied

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

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Marital status:  Single  Married  Separated  Divorced  Widowed

Emergency contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone number: \_\_\_\_\_

## Parent/Guardian information

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

DOB: \_\_\_\_\_ Phone number: \_\_\_\_\_

Address (if different from client): \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

## Billing information *(Please complete if person responsible is not the client)*

Name of responsible party: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

SS #: \_\_\_\_\_ DOB: \_\_\_\_\_ Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

## Insurance information *(Please provide your insurance card to make a copy)*

Name of policyholder: \_\_\_\_\_ DOB: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to insured:  Self  Spouse  Parent/Guardian  Child  Other

Insurance company: \_\_\_\_\_ Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

### If you have secondary insurance, please complete below:

Name of policyholder: \_\_\_\_\_ DOB: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to insured:  Self  Spouse  Parent/Guardian  Child  Other

Insurance company: \_\_\_\_\_ Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

# Client Financial Agreement

Client name: \_\_\_\_\_

Responsible party name: \_\_\_\_\_  
*(if different from client)*

- Full payment is due at the time of services. All co-pays, deductibles, and co-insurance must be paid prior to receiving services.
- Please notify the office of any changes to your insurance plan.
- You are responsible for obtaining any required referrals prior to your first visit.
- Failed appointments or appointments cancelled with less than 24 hours advance notice will result in a \$75.00 fee.
- All appointment cancellations must be made by phone.
- Aspen Counseling & Consulting LLC reserves the right to suspend services if your account is past due.

You may pay at the time of service or you may store a credit or debit card that will be charged for any amount due.

Please indicate your choice:

- I will pay at the time of service.** I agree to reschedule appointments if I cannot pay the full amount. I understand that future appointments may be cancelled if I fail to make payments at the time services are provided.
- I authorize Aspen Counseling & Consulting, LLC to securely store my credit or debit card information through its electronic processing vendor, MX Merchant.** I authorize my credit or debit card to be charged at the time of service for any amounts due. I further authorize Aspen Counseling and Consulting, LLC to charge my credit or debit card for any future services.

Name on card: \_\_\_\_\_

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

Credit card number: \_\_\_\_\_

Expiration date: \_\_\_\_\_ / \_\_\_\_\_ Security code: \_\_\_\_\_ Zip code: \_\_\_\_\_

Cardholder's signature: \_\_\_\_\_ Date: \_\_\_\_\_

*This authorization is valid for one year from the date signed. You can opt out of auto payments at any time by contacting our office at 815-399-9700.*

**I accept the terms of this agreement.**

Client's /responsible party's signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Intake Assessment and Questionnaire

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

Client name: \_\_\_\_\_

## Presenting problem

Please check if you are experiencing any of the following concerns:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Alcohol/drug abuse        | <input type="checkbox"/> Family/Friends         | <input type="checkbox"/> Stress management |
| <input type="checkbox"/> Marital/Relationships     | <input type="checkbox"/> Physical health        | <input type="checkbox"/> Anxiety           |
| <input type="checkbox"/> Sexual issues/Orientation | <input type="checkbox"/> Occupational/Financial | <input type="checkbox"/> Depression        |
| <input type="checkbox"/> Death/Grieving            | <input type="checkbox"/> Mood swings            | <input type="checkbox"/> Other: _____      |

Please describe how and for how long this concern has been affecting you: \_\_\_\_\_

\_\_\_\_\_

Goals for treatment: \_\_\_\_\_

\_\_\_\_\_

## Psychiatric history

Have you ever taken medication for anxiety, depression, sleep, or other emotional conditions?  Yes  No  
If yes, what and when? \_\_\_\_\_

Have you ever seen a counselor/therapist before?  Yes  No  
If yes, by whom? \_\_\_\_\_

What did you enjoy/dislike about therapy? \_\_\_\_\_

What symptoms or problems led you to seek treatment in the past? \_\_\_\_\_

Have you ever been hospitalized for an emotional problem or psychiatric illness?  Yes  No  
If yes, where and when? \_\_\_\_\_

Have you ever intentionally hurt yourself or made a suicide attempt?  Yes  No  
If yes, how and when? \_\_\_\_\_

## Medical history

Please check if you are currently experiencing or have ever experienced:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Head injury                       | <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Asthma or hay fever              |
| <input type="checkbox"/> Heart (trouble, disease, surgery) | <input type="checkbox"/> Thyroid problem            | <input type="checkbox"/> Sinus problems                   |
| <input type="checkbox"/> Heart murmur                      | <input type="checkbox"/> Kidney or bladder problems | <input type="checkbox"/> Weight change/Change in appetite |
| <input type="checkbox"/> Heart pacemaker                   | <input type="checkbox"/> Liver disease              | <input type="checkbox"/> Glaucoma/Cataracts               |
| <input type="checkbox"/> Fainting spells                   | <input type="checkbox"/> Skin rashes/sores          | <input type="checkbox"/> Neurological disorders           |
| <input type="checkbox"/> Abnormal blood pressure           | <input type="checkbox"/> Hepatitis—type A, B, or C  | <input type="checkbox"/> Memory loss/forgetfulness        |

# Intake Assessment and Questionnaire (cont.)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Ulcers/Abdominal pain       | <input type="checkbox"/> Arthritis                | <input type="checkbox"/> HIV positive/AIDS/ARC |
| <input type="checkbox"/> Epilepsy (seizure disorder) | <input type="checkbox"/> Severe headaches         | <input type="checkbox"/> Hearing impaired      |
| <input type="checkbox"/> Lung disease or conditions  | <input type="checkbox"/> Hemophilia/blood disease | <input type="checkbox"/> Visual problems       |
| <input type="checkbox"/> Cancer/Tumors               | <input type="checkbox"/> Sickle Cell disease      | <input type="checkbox"/> Persistent cough      |
| <input type="checkbox"/> Excessive fatigue           | <input type="checkbox"/> Night sweats             | <input type="checkbox"/> Other: _____          |

Please explain any checked items above (major illnesses, surgeries, recent hospitalizations, etc.): \_\_\_\_\_

Are you currently experiencing any physical pain?     Yes     No    If so, where? \_\_\_\_\_  
 Are you currently receiving care for your pain?     Yes     No    If so, by whom? \_\_\_\_\_  
 Primary care physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Date of last medical exam: \_\_\_\_\_  
 Please list any allergies (especially to medications): \_\_\_\_\_

Current medications (Please include all prescription and over the counter medications)

Medications	Dosage and frequency	Reason	Physician

Do you use recreational drugs?     Yes     No  
 If so, please list type and frequency: \_\_\_\_\_

Please indicate which pharmacy you would like prescriptions sent (if applicable):  
 Name of pharmacy: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

## Family/social history

Briefly describe your relationship with your parents and siblings (if applicable): \_\_\_\_\_

Marital status:  Single  Married  Separated  Divorced  Widowed

Briefly list number of marriages, how long married, and reason for divorce (if applicable): \_\_\_\_\_

Who currently lives in your household? \_\_\_\_\_

Is there a history of depression, anxiety, substance abuse, or other mental health conditions in your family?  Yes  No

If yes, who? What was the problem? Did they receive treatment? \_\_\_\_\_

Did you grow up in a home in which a parent/guardian abused drugs or alcohol?  Yes  No

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

Have you ever experienced emotional, physical, or sexual abuse?  Yes  No

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

## Educational and vocational history

What is the highest grade level you completed? \_\_\_\_\_ Do you have a GED? \_\_\_\_\_

How did you do academically in school? \_\_\_\_\_

Did you attend college?  Yes  No If yes, where and what is your degree? \_\_\_\_\_

What is your current occupation? \_\_\_\_\_ For how long? \_\_\_\_\_

Do you like your job?  Yes  No Have you ever been fired? \_\_\_\_\_

Do you have any language or reading difficulties? \_\_\_\_\_

Are you having any current financial difficulties? \_\_\_\_\_

## Military history

Have you ever served in the military?  Yes  No If yes, what branch? \_\_\_\_\_

Date/Type of discharge: \_\_\_\_\_ Combat history? \_\_\_\_\_

## Legal history

Please indicate any past or current legal history:

Arrests  Yes  No Explain: \_\_\_\_\_

Restraining order  Yes  No Explain: \_\_\_\_\_

Divorce/Custody  Yes  No Explain: \_\_\_\_\_

Incarceration  Yes  No Explain: \_\_\_\_\_

Probation  Yes  No Explain: \_\_\_\_\_

# Notice of Privacy Practices

**This Notice describes how medical information about you may be used and disclosed and how you can get access to this information.**

**Please review this notice carefully.**

Your health record contains personal information about you and your health. State and federal law protects the confidentiality of this information. “Protected health information” or “PHI” is information about you, including demographic information that may identify you and relates to your past, present, or future physical or mental health or condition and related health care services. The confidentiality of mental health and alcohol and drug abuse client records is specifically protected by state and/or federal law and regulations. Rosecrance, Inc., Rosecrance Health Network, Rosecrance New Life, and Aspen Counseling & Consulting, LLC (collectively the “Covered Entities”) are required to comply with these additional restrictions. This includes a prohibition, with very few exceptions, on informing anyone outside the program that you attend/attended the program or disclosing any information that identifies you as a client with a mental health or substance use disorder. If you suspect a violation, you may file a report to the appropriate authorities in accordance with state and federal regulations. Additionally, the covered entities included in this joint notice will share protected health information with each other, as necessary, to carry out treatment, payment and healthcare operations. Rosecrance must legally maintain the privacy and security of your PHI and follow the duties and privacy practices described in this notice. Rosecrance will not use or share information other than as described here unless authorized in writing.

## **How we may use and disclose health information about you**

- **For treatment.** We may use medical and clinical information about you to provide you with treatment or services, coordinating care, or managing your treatment. If you are a substance abuse client, we may disclose PHI to other providers after obtaining your authorization. If you are a mental health client, we may coordinate your care with other providers without authorizations. For example, Rosecrance may need to request a list of your current medications prescribed by your primary care physician.
- **For payment.** With your authorization, we may use and disclose protected health information about you so that we can receive payment for the treatment services provided to you. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.
- **For health care operations.** We may use and disclose your protected health information for certain purposes in connection with the operation of our program, including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes, PHI will be disclosed only with your authorization.
- **Required by law.** Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the privacy rule.
- **With authorization.** We must obtain written authorization from you for all other uses and disclosures of your PHI.
- **Without authorization.** Applicable law also permits us to disclose information about you without your authorization in a limited number of other situations, such as with a court order. These situations are explained below.
  - **Health oversight.** We may disclose PHI to a health oversight agency for activities authorized by law, such as for audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third party payors) and peer review organizations performing utilization and quality control. If we disclose PHI for substance abuse clients to a health oversight agency, we will have an agreement in place that requires the agency to safeguard the privacy of your information.

## Notice of Privacy Practices (cont.)

- **Public health.** We may disclose your PHI for public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority. In certain circumstances outlined in the privacy regulations, we may disclose your PHI to a person who is subject to the jurisdiction of the Food and Drug Administration with respect to the reporting of certain occurrences involving food, drugs, or other products distributed by such person. In certain limited circumstances, we may also disclose your PHI to a person that may have been exposed to a communicable disease or may otherwise be at risk of spreading or contracting such disease, if such disease is authorized by law. For example, we may disclose PHI regarding the fact that you have contracted a certain communicable disease to a public health authority authorized by law to collect or receive such information.
- **Fundraising.** Rosecrance may use your protected health information to communicate with you to request a donation for a fundraising effort in support of or on the behalf of Rosecrance. You have the right to opt out of receiving fundraising communications. You can write to the Development Coordinator at 1021 N. Mulford Road, Rockford, Illinois 61107 or email [giving@rosecrance.org](mailto:giving@rosecrance.org) with your request to opt out of future communications.
- **Program evaluation.** We may use your protected health information to contact you for evaluation and follow-up studies conducted by Rosecrance staff in order to determine effectiveness of Rosecrance services. Rosecrance may also disclose PHI to external program evaluators (including the Secretary of HHS for HIPAA rules, compliance and enforcement purposes), with an agreement in place, if substance abuse records are requested to be sent to or taken with the evaluator.
- **Medical emergencies.** We may use or disclose your protected health information in a medical emergency situation to medical personnel only and as legally permissible if you are a substance abuse client. If you are a mental health client, Rosecrance can disclose your information in a medical emergency.
- **Coordination of care.** For mental health clients, Rosecrance staff may disclose PHI for the purposes of continuity of care without consent. The purpose of coordination will be limited to admission, treatment, planning, coordinating care, discharge, or governmentally mandated public health reporting. For substance abuse clients and situations that are not emergencies, authorization is needed to coordinate care with third parties.
- **Mandated Reporting.** We may use your protected health information in order to comply with rules and regulations mandating Rosecrance staff to report to law enforcement or government agencies. Examples of situations where reporting may be necessary include abuse and neglect, FOID reporting to DHS, and duty to warn situations. Duty to warn situations occur when someone indicates a specific act of violence towards themselves or another individual.
- **Deceased client.** We may disclose PHI regarding deceased clients for the purpose of determining the cause of death, in connection with laws requiring the collection of death or other vital statistics, or permitting inquiry into the cause of death.
- **Research.** We may disclose PHI to researchers if (a) an Institutional Review Board reviews and approves the research and waiver to the authorization requirement; (b) the researchers establish protocols to ensure the privacy of your PHI; (c) the researchers agree to maintain the security of your PHI in accordance with applicable laws and regulations; and (d) the researchers agree not to redisclose your protected health information except back to Rosecrance.
- **Criminal activity on program premises/against program personnel.** If you are a substance abuse client, we may disclose your PHI to the law enforcement officials if you have committed a crime on program premises or against program personnel or have threatened to do so. If you are a mental health client, your information may be disclosed if Rosecrance believes a violation of criminal law or other serious incident has occurred in Rosecrance program.
- **Legal.** We may disclose your PHI to respond to lawsuits and legal actions. If you are involved in a legal issue where Rosecrance is not a party, Rosecrance may disclose your information with your authorization or court order for situations involving family matters, worker's compensation, civil actions, or other legal issues.
- **Court order.** We may disclose your PHI if the court issues an appropriate order and follows required procedures.
- **Special government functions.** If you are an active military member or veteran, we may disclose your PHI as required by military command authorities. We may disclose your PHI to authorized federal officials for national security and intelligence reasons and to the Department of State for medical suitability determinations.



# Notice of Privacy Practices (cont.)

## Your rights regarding your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to the Aspen Medical Records Department at 8616 Northern Ave, Rockford, IL 61107. If you have any questions, you may contact the privacy officer at 815.391.1000.

- **Right to revocation.** It is your right to revoke any authorizations, at any time by sending written notification to the Medical Records Department to the addresses listed above.
- **Right of access to inspect and copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a “designated record set.” A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the privacy officer if you have any questions.
- **Right to an accounting of disclosures.** You have the right to request an accounting of certain disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to request restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to request confidential communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a copy of this notice.** You have the right to a copy of this notice.

## Complaints

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our privacy officer at 1021 North Mulford Road, Rockford, IL 61107, 815.391.1000. You may also file a complaint with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling 202.619.0257. We will not retaliate against you for filing a complaint.

## Confidentiality of alcohol and drug abuse client records

The confidentiality of alcohol and drug abuse client records is protected by additional federal law and regulations. The covered entities are required to comply with these additional restrictions. This includes a prohibition, with very few exceptions, on informing anyone outside the covered entities that you attend a substance abuse treatment program or disclosing any information that identifies you as an individual with a substance use disorder. Some of the exceptions to this general rule include:

- The disclosure is allowed by a court order.
- The disclosure is made to medical personnel in a medical emergency.
- The disclosure is with your written consent.

## Notice of Privacy Practices (cont.)

The violation of federal laws or regulations by this program is a crime. If you suspect a violation, you may file a report to the appropriate authorities in accordance with federal regulations.

### **Confidentiality of mental health client records**

The confidentiality of mental health client records is protected by state law and regulations. The covered entities are required to comply with these additional restrictions. This includes a prohibition, with limited exceptions, on informing anyone outside the Covered Entities that you are a recipient of mental health treatment or disclosing any information that identifies you as a mental health client.

Some of the exceptions to this general rule include:

- The disclosure is allowed by a court order.
- The disclosure is made to medical personnel in a medical emergency.
- The disclosure is with your written consent.
- The disclosure for purposes of health information exchange, in accordance with the requirements of the Illinois Mental Health and Developmental Disabilities Confidentiality Act. Unless you have chosen to opt-out of the health information exchange as specified in that Act.

The violation of state laws or regulations by this program is a crime. If you suspect a violation you may file a report to the appropriate authorities in accordance with State law.

*If you have any questions about this Notice of Privacy Practices, please contact our privacy officer:*

**Privacy Office**  
**1021 North Mulford Road**  
**Rockford, IL 61107**  
**815.387.5600**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (“PHI”) in accordance with all applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will make available a revised Notice of Privacy Practices by posting a copy on our website: [www.rosecrance.org](http://www.rosecrance.org), sending a copy to you in the mail upon request, or providing one to you at your next appointment.

*The effective date of this notice is August 3, 2016.*