CHRISTY KANE PsyD

Mental Health Intake Form

Dr. Christy Kane LLC provides counseling, evaluation, and referral for adolescents, adults, and older adults. Clinicians offer individual, family, and group counseling, as well as evaluations. Our staff is trained in accordance with the professional standards of psychology, social work, mental health counseling, and marriage and family counseling. Each provider is certified or licensed in their discipline by the State of Utah, or interns practicing within the authority of Christy Kane's CMHC license. We want to help you achieve your goals! Our providers have a variety of approaches and backgrounds. We specialize in treating trauma and anxiety-related concerns. Our providers have the experience and knowledge to help you on your journey of healing and growth. We are dedicated to helping you achieve the life you desire. **Please complete digitally or print legibly on these forms.** Send completed forms to hello@drchristykane.com.

Patient first name:	**Patient last name:**		
Name of person completing form (if different from patient):			
Date completed:	Patient date of birth:		
Mailing Street Address:	City:	State:	Zip:
Home Street Address:	City:	State:	Zip:
Email:	Cell Phone:		
Primary care physician:	Physician phone:		

Insurance company name:	
Policy holder name (if different from patient):	
Policy holder date of birth (if different from patient):	
Insurance phone number:	Group #
Policy member ID:	Copay amount:
Policy holder billing street address (if different from above):	
City:	State & Zip Code:

Therapy history:

Prior outpatient or inpatient treatment?	If yes, please describe (dates treated, by whom, for what reason):

Current symptoms checklist (please check appropriate columns)

	Mild	Medium	Severe		Mild	Medium	Severe
Agression				Memory impairment			
Agitation				Mood swings			
Anger				Obsessions			
Anxiety				Oppositional behavior			
Appetite change				Panic attacks			
Change in libido				Paranoia			
Compulsions				Phobias/fears			
Crying/tearful				Physical trauma perpetrator			
Cyber addiction				Physical trauma victim			
Delusions				Poor concentration			
Depression				Poor grooming			
Disorientation				Racing thoughts			
Difficulty getting out of bed				Recurring thoughts			
Difficulty making decisions				Self-mutilation			
Distractibility				Sexual addiction			
Eating disorder				Sexual difficulties			
Elevated mood				Sexual trauma perpetrator			
Emotional trauma perpetrator				Sexual trauma victim			
Emotional trauma victim				Sleep problems			
Excessive energy				Speech problems			
Fatigue				Social isolation			
Grief				Substance abuse			
Guilt				Suicidal thoughts			
Gambling				Worried			
Judgment errors				Worthlessness			
Loneliness				Other:			
Loss of interest in activities				Other:			

Medical history

Current medications:	Total daily dosage:	Estimated start date:

Current physical health:	Good	Fair	Poor	Do you exercise regularly?	Yes	No
Past nonpsychiatric hospitalizations or surgeries:						

Family history (has anyone in your family ever been treated for any of the following)?

	Yes	Who?		Yes	Who?
Depression			Schizophrenia		
Anxiety			Alcohol problems		
Panic attacks			Drug problems		
Post Traumatic Stress			ADHD		
Bipolar			Suicide attempts		

Present during childhood	Present entire childhood	Present part of childhood	Not present at all	**Parents' current marital status**
Biological mother				Married to each other
Biological father				Separated for ____________ years
Adoptive mother				Divorced for ____________ years
Adoptive father				Mother remarried ___________ times
Stepmother				Father remarried __________ times
Stepfather				Mother involved with someone
Brother(s)				Father involved with someone
Sister(s)				Mother deceased for _______ years Age of patient at mother's death: __________
Other:				Father deceased for _________ years Age of patient at father's death: __________

Developmental history

Problems during mother's pregnancy	None	High blood pressure	Kidney infection	Emotional stress
Other:	Drug use	Alcohol use	Cigarette use	Bleeding

Birth weight: ________ lbs _________ oz.	Normal delivery	Difficult delivery	Cesarean delivery
Other complications with patient's birth:			

Delayed Development Milestones (check only those milestones that did not occur at an expected age)

- ☐ Sitting
- ☐ Rolling over
- ☐ Standing
- ☐ Walking
- ☐ Feeding self
- ☐ Speaking words
- ☐ Speaking sentences
- ☐ Controlling bladder
- ☐ Controlling bowels
- ☐ Sleeping alone
- ☐ Dressing self
- ☐ Engaging peers
- ☐ Tolerating separation
- ☐ Playing cooperatively
- ☐ Riding tricycle
- ☐ Riding bicycle
- ☐ Other:

Childhood Health

- ☐ Chickenpox (age:)
- ☐ German measles (age:)
- ☐ Red measles (age:)
- ☐ Rheumatic fever (age:)
- ☐ Whooping cough (age:)
- ☐ Scarlet fever (age:)
- ☐ Lead poisoning (age:)
- ☐ Mumps (age:)
- ☐ Diphtheria (age:)
- ☐ Poliomyelitis (age:)
- ☐ Pneumonia (age:)
- ☐ Tuberculosis (age:)
- ☐ Mental retardation
- ☐ Autism
- ☐ Ear infections
- ☐ Asthma
- ☐ Allergies to:

Emotional/Behavioral Problems

- ☐ Drug use
- ☐ Alcohol abuse
- ☐ Chronic lying
- ☐ Stealing
- ☐ Violent temper
- ☐ Fire setting
- ☐ Hyperactive
- ☐ Animal cruelty
- ☐ Assaults others
- ☐ Disobedient
- ☐ Repeats words of others
- ☐ Not trustworthy
- ☐ Hostile/angry mood
- ☐ Indecisive
- ☐ Immature
- ☐ Bizarre behavior
- ☐ Self-injurious threats
- ☐ Frequently tearful
- ☐ Frequently daydreams
- ☐ Lack of attachment
- ☐ Distrustful
- ☐ Extreme worrier
- ☐ Self-injurious acts
- ☐ Impulsive
- ☐ Easily distracted
- ☐ Poor concentration
- ☐ Often sad
- ☐ Breaks things
- ☐ Other:

Social Interaction

- ☐ Normal social interaction
- ☐ Isolates self
- ☐ Alienates self
- ☐ Inappropriate sex play
- ☐ Dominates others
- ☐ Very shy
- ☐ Associates with acting out peers
- ☐ Other:

Intellectual/Academic Functioning

- ☐ Normal intelligence
- ☐ High intelligence
- ☐ Learning problems
- ☐ Authority conflicts
- ☐ Attention problems
- ☐ Underachieving
- ☐ Mild retardation
- ☐ Moderate retardation
- ☐ Severe retardation

Substance use history

No history	Active abuse	Early full remission
Early partial remission	Sustained full remission	Sustained partial remission
Substances used:		

SOCIO-ECONOMIC HISTORY

Living Situation:	**Social Support System:**	**Financial Situation:**
☐ housing adequate ☐ homeless ☐ housing overcrowded ☐ dependent on others for housing ☐ housing dangerous/deteriorating ☐ living companions dysfunctional	☐ supportive network ☐ few friends ☐ substance-use-based friends ☐ no friends ☐ distance from family of origin	☐ no current financial problems ☐ large indebtedness ☐ poverty or below-poverty income ☐ impulsive spending ☐ relationship conflicts over finances
Employment: ☐ employed and satisfied ☐ employed but dissatisfied ☐ unemployed ☐ coworker conflicts ☐ supervisor conflicts ☐ unstable work history ☐ disabled:	**Legal History:** ☐ no legal problems ☐ now on parole/probation ☐ arrest(s) not substance-related ☐ arrest(s) substance related ☐ court ordered this treatment ☐ jail/prison ______ time(s) total time served:	**Military History:** ☐ never in military ☐ served in military – no incident ☐ served in military – with incident ☐ currently serving in military ☐ honorable discharge ☐ other type of discharge:
Sexual History: ☐ straight/heterosexual orientation ☐ lesbian/gay/homosexual orientation ☐ bisexual orientation ☐ transsexual ☐ asexual ☐ unsure/questioning orientation ☐ currently sexually active ☐ currently sexually satisfied ☐ currently sexually dissatisfied ☐ age first sex experience: ____ ☐ age first pregnancy/fatherhood: ____ ☐ history of promiscuity age ____ to ____ ☐ history of unsafe sex age ____ to ____	**Cultural/Spiritual/Recreational History** Cultural Identity (ethnicity, religion): Describe any cultural issues that contribute to current problem(s): Currently active in community/recreational activities? ☐ Yes ☐ No Formerly active in community/recreational activities? ☐ Yes ☐ No Currently engage in hobbies? ☐ Yes ☐ No Currently participate in spiritual activities? ☐ Yes ☐ No **Relationship History and Current Family:** ☐ married ☐ children living at home ☐ divorced ☐ children living elsewhere ☐ single ☐ widowed ☐ in a relationship	

I verify that the information contained herein is true and accurate	
Signature:	Date:

PAYMENT AGREEMENT

Please provide your insurance card to our front desk on the day of your appointment. We will make a front & back copy of it for your patient file.

To contact our billing department email sharalynn@drchristykane.com or call 385-204-4405

Payment is due at the time of service by credit card or personal check. It is your responsibility to pay and know your co-pay amount. In the event that a client is not certain of co-pays and/or insurance coverage, the full price ($175) will be charged and reimbursement or credit will be offered based on the response from their insurance provider. In order to be reimbursed, you must meet your annual deductible. You will be responsible for each session if your deductible is not met. Some insurance plans require authorization before engaging in therapy or limit the number of visits. In the event that the client does not receive authorization or exceeds the allotted number of visits, the client is responsible for payment. Please contact your insurance provider directly if you have questions about your mental health coverage. We cannot guarantee reimbursement amounts or insurance processing times.

FEES

- Initial visit/Intake (45-60 min): $175
- Individual session (45-60 min): $150
- Couples session (45-60 min): $150
- Group therapy: $58 per session

MISSED APPOINTMENTS

We have reserved this time for you. T**o avoid a charge, cancellations or rescheduling must be made 48 hours in advance. You will be charged $150.00 if you miss your appointment or cancel/reschedule less than 48 hours before your appointment. This includes no-shows for in-person appointments, scheduled telehealth sessions, or for clients who are more than 15 minutes late to an appointment.**You may leave a message on our voice message machine or text 385-223-0777. You can also email us at shaira@drchristykane.com. Missed appointment fees cannot be billed to insurance. We end care with patients who repeatedly miss appointments. If Dr. Christy Kane LLC cancels an appointment with less than 48 hours notice, a new appointment will be scheduled without penalty to the client, subject to availability.***Credit card information is required for charging co-pays, and no-shows for appointments, and to cover any balances not covered by insurance. There will be a $25 charge for each personal check or credit card rejection.*

I understand that certain insurance policies may cover a portion of fees assessed for services received. I agree to provide copies of my membership card(s) and claim forms when required. I understand that I am responsible for the amount not covered by my insurance up to the full fee for service. I also understand that I am responsible for my co-pay amount to be paid at the time services are received. In the event that insurance and client fee payments exceed the fee payments or the fee for service, the excess paid will be reimbursed to the client after all services and claims have been processed. I authorize payment of benefits directly to Dr. Christy Kane, LLC for services rendered. I also authorize the release of information (for insurance payment purposes only) that is protected by Federal Confidentiality rules (42 CFR, Part 2, Section 2.31 of PL-03-282). I also certify that I have read, understand, and received a copy of the Dr. Christy Kane LLC payment agreement, consent to treatment and confidentiality statement, and a copy of the Client Rights.

Patient first name:	Patient last name:
_________ (please initial) I have provided my credit card information to Dr. Christy Kane, LLC _________ (please initial) I have provided a copy of my insurance card and/or insurance information	
Signature:	Date:

CLIENT RIGHTS

It is important to know you have many rights and responsibilities when you enter counseling. Please read and agree to these rights and responsibilities by signing below.

You have a right:

- to considerate and respectful care, which includes freedom from any physical, sexual, fiduciary (financial), or psychological abuse including humiliating, threatening, and exploiting actions;
- to understand what your problem is, what treatment is recommended and why, who will give the treatment, and what outcome to expect;
- to be involved in a process of informed choice, informed refusal, and/or expression of choice related to preference of your treatment services, choice of service provider and participation in research projects;
- to expect that all communications and records pertaining to your care will be treated as confidential; to have continuity of care when you are referred for services outside this agency;
- to examine and receive an explanation of your bill.
- to participate in all aspects of your treatment and development of your treatment plan.
- to have access to self-help and advocacy support services.
- to voice complaints or lodge an appeal without recrimination.
- to all legal protection and due process for status as an outpatient, both voluntary and involuntary, as defined under Utah law

Your responsibilities are:

- to be honest in your presentation of your problems and to tell those working with you how you feel about what is happening to you.
- to be actively involved in the development of your treatment plan that will outline your problems, needs, goals, and expected outcome(s);
- to be considerate of others and their privacy;
- to present to your counselor any questions, complaints or concerns about your counseling plans or goals so that you may reach an agreement on any problem hindering your progress.

Dr. Christy Kane LLC clinic does not discriminate against any individual based on race, color, creed, sex, sexual orientation, national origin, religion, disability, or economic situation including the ability to pay for services. Dr. Christy Kane LLC does not tolerate any form of harassment of clients or staff by any individual at any time. Dr. Christy Kane LLC is an equal opportunity employer and equal provider of services.

Patient first name:	Patient last name:
Signature:	Date:

CONFIDENTIALITY & HIPAA

Please read fully and sign to confirm receipt and understanding.

Confidentiality means that Dr. Christy Kane, LLC has a responsibility to safeguard information obtained during counseling. Use and Disclosure for Treatment, Payment, and Health Care Operations within Dr. Christy Kane LLC protects the privacy of your Personal Health Information (PHI).

- “Use” applies only to activities within Dr. Christy Kane, LLC (office, clinic, group, etc.) such as sharing, applying, utilizing, examining, employing, analyzing information that identifies you.
- “Disclosure” applies to activities outside the Dr. Christy Kane, LLC practice, such as releasing, transferring, providing information about you to other parties.
- “Treatment” is when Dr. Christy Kane, LLC provides, coordinates, or manages services related to your health care. An example of treatment would be when Dr. Christy Kane, LLC consults with another health care provider, such as your family doctor or another therapist.
- “Payment” is when Dr. Christy Kane, LLC submits PHI on your behalf. Insurance companies require personal identification information, diagnosis, symptoms, treatment goals, prognosis, evaluation of progress, and other information before reimbursement is considered. Such companies may also maintain the right to have a copy of your records. Dr. Christy Kane, LLC submits insurance claims on your behalf to ease the process with the insurance company. This is a courtesy service.
- “Health Care Operations” are activities that relate to the performance and operation of the Dr. Christy Kane, LLC practice. Examples include: quality assessment, improvement activities, business-related management such as audits, administrative services, case management, and coordination of care.

You must sign a Release of Information before information about you is given to anyone, except as mandated by law. In certain situations, Dr. Christy Kane, LLC is required by law to reveal information without your consent and without notification to you.

Please note the following exceptions to confidentiality:

- Confidentiality does not apply to cases of suspected abuse/neglect of children or the elderly.
- Confidentiality does not apply to cases of potential harm to self or others.
- Confidentiality does not apply to cases involving criminal proceedings, except communications by a person voluntarily involved in a substance abuse program.
- Confidentiality may not apply in cases involving legal proceedings affecting the parent-child relationship.
- Confidentiality may not apply to cases involving a minor. In such cases, Dr. Christy Kane, LLC may advise a parent or guardian of a minor, with or without the minor’s consent, of the treatment needed.
- We may disclose confidential information in proceedings brought by a client against a professional.

You have the right to:

- request a restriction on certain uses and disclosures of your information
- inspect and obtain a copy of your health record
- amend your health record as provided by regulation
- obtain an accounting of disclosures of your health information as provided by law
- request communications of your health care information by alternative means or locations
- revoke use or disclose health information except to the extent that action has already been taken

Patient first name:	Patient last name:
Signature:	Date:

ADDITIONAL INFORMATION

COUPLES THERAPY
Couples' counseling is typically not covered by insurance. Most health insurance companies don't consider marriage a health issue. In other words, they do not reimburse for relationship counseling. These services will usually require private payment.

COURT-ORDERED OR MANDATORY THERAPY
Mandatory or court-ordered therapy is typically not covered by insurance. These services will usually require private payment.

- Court-ordered/mandatory sessions: $2,000 retainer with $200 per session

CRISIS SERVICES
We are not a crisis service. If you are experiencing a life-threatening emergency, please call 911 or go to the nearest emergency room. You can also contact the National Alliance on Mental Illness (NAMI) for support by calling 800-950-6264 or by texting NAMI to 741-741.

RISKS OF COUNSELING
You may experience a variety of negative emotions during therapy as you remember and therapeutically resolve unpleasant events. Seeking to resolve concerns between family members, marital partners, and other persons can lead to discomfort as well as relationship changes. Further, counseling may not, by itself, resolve your concerns. Mental Health Professionals at Dr. Christy Kane LLC will do their best to assess progress and provide referrals to other sources if that is deemed necessary and appropriate.

BENEFITS OF COUNSELING
Participation in counseling can lead to the resolution of the concerns brought to therapy. Further benefits may be a better ability to cope with marital, family and other interpersonal relationships, and/or a greater understanding of personal goals and values.

Dr. Christy Kane LLC
5455 W 11000 N Suite 204 Highland UT, 84003
385.223.0777 | hello@drchristykane.com
www.drchrsitykane.com

MEDICAL RELEASE FORM

Patient first name:	**Patient last name:**
Date of birth:	SSN:
Cell Phone:	Email:
Mailing Street Address:	
City:	State & Zip Code:
*****************Releasing information of individual above to parties below*****************	

Information requested from:	
Dr Christy Kane LLC	Email: hello@drchristykane.com
5455 W 11000 N Suite 204, Highland UT, 84003	
Office phone: 385-223-0777	Fax number: 385-232-8079

Send information to:	
Name:	**Office/company:**
Phone number:	Email:
Fax number:	
Mailing Street Address:	
City:	State & Zip Code:

I ________________________________ (client's name), hereby grant Dr. Christy Kane LLC permission to communicate and release confidential health information about me by releasing a copy of my medical record, summary and/or narrative of my protected health information to the parties above (physician, person, facility, entity)

Signature of patient (only if over age 18) ____

Signature of parent/guardian if under age 18 _________________________