2203 S Higgins Ave, Unit B, Missoula, MT 59801
(406) 290-9788 Elizabeth@ElizabethKennard.com

PATIENT INTAKE QUESTIONNAIRE

General Information:

Patient Name ____

Birthdate ____________________ Social Security # ______________________

Street Address ____

City _______________________ State______ Zip_______________

Home phone__________________ Cell phone_________________________

May a voicemail or text message be left at the above number? ______________________

(Please indicate voice and/or text)

Responsible Party for Patient (if different than above):

Name______________________ Relationship to the patient:___________________

Street Address____________________City______________State_____Zip___________

Home Phone Number________________ Cell Phone Number__________________________

Emergency Contact:

Person to contact in emergency__________________ Relationship to you________________

Phone(s)__________________ Address______________________________________

Relationship Information:

List the persons with whom you are now living and their relationship to you (include ages of children)____

____

____

List the names, ages and location of children who do not reside with you at this time?

____

____

Relationship Status ___Married ___Single ___Divorced ___Widowed ___Other

Social Information:

Occupation ____________________________________ Education level __________________

Employer _______________________________________ Work phone ___________________

Address ____

Length of employment at above ____________

Were/are you a member of the armed services? _____ If so, when? ________

What branch? _________

If you are actively involved in a community of faith/church, please indicate which one?

____

Who referred you to Elizabeth's practice? ____

Medical Information:

Describe any physical problems you have that require medication or physical care:

____

____

____

____

Are you currently under a physician's care? ____ No ____ Yes

Name of physician: ________________________ Date of last physical examination:

__________ Are you currently under psychiatric care?____ No _____ Yes

Name of psychiatrist ______: _________________

Please list any medications you are currently using.

____

____

____

Do you have a past history of substance abuse or addiction? _____ No _____ Yes

If yes, please describe any past treatment, length of sobriety and any current concerns with substance use? ____

____

Therapeutic History:

Have you had any prior counseling?________ How helpful was your previous counseling?____

____

____

Current stressors:

(In the fields below please note areas of stress and rate the intensity on a scale of 1-10, 1 being barely noticeable and 10 being extremely distressing):

Marriage and home ____

Children/parents____

Work/school ____

Financial ____

Social ____

Spiritual ____

Sexual ____

Other ____

Major present stressors ____

____

List any current or past legal history or current legal problems (trouble with the law)?

____

____

Please explain any childhood history of abuse (physical, sexual, emotional or spiritual)?

____

____

In your own words, briefly describe the main problem that prompted you to seek therapy?

____

____

How can therapy be most helpful to you? ____

____

____

____

What would you like to change about your situation? (e.g., goals) _______________________

____

____

____

What have you done so far to find solutions to the problem? Has anything been helpful?

____

____

____

Is there anything else that you believe might be important for your therapist to know at this time?

____

____

____

This is a strictly confidential client medical record.

Re-disclosure or transfer is expressly prohibited by law.

Insurance Information (If you have a copy of your insurance card you may disregard this section.)

PRIMARY INSURANCE: ____

Group No.: ______________ Ins. I.D. Number: _______________________

Policy Holder: ____

Relationship to Patient:____________________Birthdate:_____________

Effective Date: ____________________ Employer:____________________________________

City & State: __________________________________

SECONDARY INSURANCE: ____

Group No.: _____________ Ins. I.D. Number: ______________________

Policy Holder: ______________________________________

Relationship to Patient:___________________Birthdate:____________

Effective Date: ___________________ Employer:

____

City & State: ________________________________

Please see the next page for consent and assignment of benefits.

INFORMATION AND CONSENT TO TREATMENT

Thank you for entrusting your therapeutic care to Elizabeth Kennard, MSW, SWLC. Elizabeth provides client centered, confidential, psychotherapeutic counseling to individuals. She will help individuals look at many aspects of their life; physical, emotional, mental, relational, and spiritual using professional clinical training. Elizabeth promotes inner healing and wholeness according to the needs of each person, and believes in the dignity, value and worth of each individual life. She believes there is hope even in the most challenging life circumstances.

Elizabeth is a Social Worker Licensure Candidate, practicing under the supervision of Jennifer Walrod, LCSW. As such, billing will be processed under Jennifer Walrod, LCSW and this may reflect on your billing receipts.

I acknowledge that I have received, have read (or have had read to me), and understand the privacy policy and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in behavioral health treatment with Elizabeth Kennard, MSW, SWLC.

- I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest.
- I agree to play an active role in this process.
- I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.
- I understand that the intake diagnostic fee is $175 with subsequent session fees at $125/per clinical hour. If insurance is billed, you are responsible for co-pay amounts at the time of services. These fees also apply to the preparation of assessment reports, court appearances, consultations, or meetings you have authorized as part of your therapeutic process. If payment for the services I receive is not made, Elizabeth, though reluctantly, may stop my treatment. **Please contact your insurance company prior to treatment to understand any copay or deductible you may be responsible for.**
- I have the right and responsibility to choose a therapist and treatment modality that best suits my needs and purposes.

- Once sessions begin, the duration and termination of therapy is something that should be a joint decision. Thoughts and feelings around wanting to stop therapy are important and encourage you to raise these concerns in counseling sessions.
- I am aware that I may stop my treatment with Elizabeth Kennard, MSW, SWLC, PLLC at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered).
- I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel and do not show up, I will be charged the full amount for that appointment.
- Records maintained by Elizabeth Kennard, MSW, SWLC, PLLC are considered medical records and protected health information. She places a high value on confidentiality and will make every effort to ensure your privacy. Consultation with individuals or organizations regarding your treatment will require your written consent. There are, however, some exceptions and limitations to confidentiality as required by law. These specific situations are:
    1. Any known or reasonably suspected cases of child abuse or neglect.
    2. Any known or suspected intentions of harming oneself (suicide).
    3. Any known or suspected intentions of harming others.
    4. When written consent is given by the client to release information.
    5. When charges are brought against a counselor in response to a subpoena from a court of law or administrative agency.

Privacy Policy and Assignment of Benefits

The **HIPAA Notice of Privacy Practices and Authorization to Disclose Limited Mental Health Information** provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I acknowledge receipt of this document and my signature below indicates that I understand and consent to treatment under these conditions.

I acknowledge and authorize Elizabeth Kennard, MSW, SWLC, PLLC to use and disclose my individual identifiable health information for the purpose of providing treatment to me, receiving payment from responsible parties for behavioral health care services rendered and / or engaging in behavioral health care operations. My signature below allows Elizabeth Kennard, MSW, SWLC, PLLC to receive all benefits which are or shall become payable from any third-party payer. I authorize and direct all third-party payers to pay all benefits directly to Elizabeth Kennard, MSW, SWLC, PLLC.

I understand that I have the right to request a restriction on the use or disclosure of my Health information. I further understand that I have the right to revoke this consent, in writing. I acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices from Elizabeth Kennard, MSW, SWLC, PLLC which provides a description of the uses and disclosures of protected health information.

With my signature I acknowledge I have read and understand the nature of counseling services, my rights, responsibilities, HIPAA Notice of Privacy Practices and hereby consent to treatment with Elizabeth Kennard, MSW, SWLC, PLLC.

____ ____________________

Signature of patient (or authorized representative) Date

____ ____________________

Printed name Relationship to client

PLEASE SUBMIT PAYMENT AT TIME OF SERVICE

Phone: (406) 290-9788 Elizabeth@ElizabethKennard.com Fax: (406) 215 - 9744

HIPAA Notice of Privacy Practices

The following information describes how medical information may be used and disclosed and how patients can gain access to their clinical information.

Elizabeth Kennard, MSW, SWLC will use the information about a client's health primarily to provide treatment, arrange for payment of services and health care operations.

Clients Health Information Rights:

- You have the right to inspect and obtain a copy of your health record with a signed authorization as provided in 45 CFR 164.524.
- You have the right to request in writing that the clinician restrict and/or not use or disclose your protected health information as provided in 45 CFR 164.522 but we do not have to agree to accept your restrictions.
- You have the right to request in writing that Elizabeth Kennard, MSW amend your protected health information as provided in 45 CFR 164.528.
- You have the right to request in writing to receive confidential communications from us by alternative means or at an alternative location as provided in 45 CFR 164.522.
- You have the right to revoke your authorization to use disclosed health information except to the extent that action has already been taken as provided in 45 CFR 164.508.

Elizabeth Kennard, MSW, SWLC is Responsible by law to:

- maintain the privacy of client health information.
- provide you with notice about our privacy practices.
- privacy practices that are described in this notice, however, we reserve the

right to change or modify our practice and to make the new provisions effective for all protected health information we maintain. Should our information practice change, we will post the revised privacy notice.

Questions or Complaints:

- If you need more information or have questions about the privacy practices described above, please let us know.
- If you are concerned with how your protected health information has been used or if you believe your privacy rights have been violated, please let us know.
- You have the right to file a written complaint with the offices of Elizabeth Kennard, PLLC or with the Office of Civil Rights, U.S. Department of Health and Human Services, 1961 Stout Street Room 1426 FOB, Denver, CO 80294-3538.
- Elizabeth Kennard, MSW, SWLC will not in any way limit your care or take action against you if you complain.

Acknowledgment of Receipt of Privacy Notice

I acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices from Elizabeth Kennard, PLLC which provides a description of the uses and disclosures of protected health information.

____ ____________________

Signature of Patient Date

____ ____________________

Signature of Parent/Guardian/Legal Representative Date

Phone: (406) 290-9788 Elizabeth@ElizabethKennard.com Fax: (406) 215 - 9744

Credit Card Authorization Form

Elizabeth Kennard, PLLC requires a card be kept on file for co-pays, late cancellation fees, or missed appointment fees. Clients must call to cancel an appointment at least 24 hours before the time of the appointment. Cancellations with less notice and missed appointments will be charged the full amount.

Please complete all fields. You may cancel this authorization at any time by contacting Elizabeth Kennard, PLLC. This authorization will remain in effect until canceled.

Credit Card Information
Card Type ● Master Card ● Visa ● Discover ● AMEX ● Other ____
Credit Card Number __________________________________
Expiration Date ___________________ CVV _____________
Cardholder ZIP Code _________________________________

I, ____________________________________, authorize Elizabeth Kennard, PLLC to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transitions on my account.

____________________________ ______________________________

Customer Signature Date