Insurance plan (Specify Insurance Company) **Please provide your card ………..Or copy of your insurance card! This is needed for billing!** **EAP?____Yes_____No**	**Authorization Code:** **Number of sessions authorized?** **Copay? $______Due at the time of service!**
Policy and Group #: **If you DID NOT bring a copy of your card, copy the EXACT information from your card here ..Include phone numbers !**	**(SOCIAL SECURITY #) The person who's insurance will pay for services**
Name of the INSURED (Last, Middle, First) **Name of the PATIENT (Last, Middle, First)**	**(INSURED--DOB and Sex) The person who's insurance will pay for services** **(PATIENT--DATE of BIRTH and SEX)**
Patient Address (Street address only) City Zip	**Phone (Best time to reach you?)** **Email?**
Insured Address (If different from Patient address) City Zip **Place of Employment** (Include Address, phone, Zip)	**Children?** (Names, ages, and who they live with?) **Martial Status?**

Center for Music Psychotherapy & Family Therapy
Kim McMillin RN, MA, MT-BC, LMFT
Board Certified Music Therapist
Licensed Marriage and Family Therapist
P.O. Box 6, Lafayette, CO 80026 (303) 666-9091
musicfamilyther@ecentral.com

INTAKE FORM

ALL INFORMATION IS CONFIDENTIAL------COMPLETE ONLY WHAT APPLIES TO YOU AND YOUR FAMILY

PLEASE PRINT Today's Date: ____/____/____

Patient's full name: ________________________Phone: ___________________Date of Birth: ____________M: ____F:_____

Street Address: ____City:__________________State:________Zip:__________

Spouse:________________________________Phone:______________________Date of Birth__________M:____F_______

Street Address: ____________________________City:______________________State:________Zip:________________

Patient's Employer: ____________________________________ ___________________Work Phone: __________________

Spouse Employer:____Work Phone:__________________

Name and address **Family Physician**: ______________________________Family Physician phone #_____________________

Who can I thank for referring you? How did you find us?:____

Phone where can we reach you?______________________When is the best time to reach you? __________________________

****

Couples only:

How long have you been together?_________years/months _________ married?___________ Divorced?__________

Separated?_________ Death of Spouse?_________

How many times have you been married? ______What brought you together?____________________________________

Information about Children What are the names and ages of your Children?

NAME	AGE	M/F	WHO DOES THE CHILD LIVE WITH?
1.			
2.			
3.			
4.			

Is this a blended Family? Yes ___No_____ Shared Custody? _________Full Custody?___________________________

How long have the biological parents been separated? _______ Divorced____?

Are there legal issues current or in the past ?____Yes _____No. If yes, please explain___________________________
____

How often do the children get to see the biological parent(s)? (What are the arrangements for visitation?)
____
____

How are your children doing in school?

HEALTH/ PSYCHOLOGICAL INFORMATION

In your own words, what are the major stressors in your life right NOW?____

____

Circle All That Apply

Have you experienced any of the following in the past year?
(Check all that apply)

? Frequent colds/flu
? Backaches
? Problems with vision
? Dizziness
? Headaches
? Change in eating habits
? Weight loss/gain
? Irritability
? Fatigue
? Sleep problems
? Memory/Concentration problems
? Thoughts about suicide
? Depression
? Anxiety or nervousness
? Stomach problems
? Intrusive thoughts/sounds
? Pre-menstrual problems
? High blood pressure
? Excessive stress
? Problems with hearing
? Sexual problems
? Difficulty breathing
? Problems concentrating
? Thoughts of hurting others

Have any of the following events occurred in your life in the past year?
(Check all that apply)

? Death of friend or family member
? Change in close personal relationship (e.g., divorce, separation)
? Serious problem with friend/family member
? Personal injury, illness or accident
? Family injury, illness or accident
? Major change in employment status
? Serious job-related difficulties
? Accused of crime/victim of crime
? Major geographic relocation
? Sexual/physical abuse or rape
? Sexual harassment
? Marriage
? Birth of child
? Abortion
? Miscarriage
? Surgery
? Legal Problems
? Financial Problems
? Gambling Problems
? Other :____.

USE OF ALCOHOL/DRUGS – Current

Do **you/ or family member** have (check all that apply):

____hangovers ____sleep disturbance ____blackouts ___relationship conflicts

____overdose/drink too much ____feel suicidal ____become aggressive ____Binge

____Job loss ____history of DUI/arrests ____seizures

Do you currently use alcohol or drugs? (? Yes ? No) If Yes, answer the following:

ALCOHOL/DRUGS	USE OR OCCURRENCE	FREQUENCY OF USE *(DAYS PER WEEK)*	AMOUNT PER USE *(Specify)*
Beer	? Yes ? No	1 2 3 4 5 6 7	
Wine	? Yes ? No	1 2 3 4 5 6 7	
Hard Liquor	? Yes ? No	1 2 3 4 5 6 7	
Marijuana	? Yes ? No	1 2 3 4 5 6 7	
Cocaine	? Yes ? No	1 2 3 4 5 6 7	
Amphetamines	? Yes ? No	1 2 3 4 5 6 7	
Narcotics	? Yes ? No	1 2 3 4 5 6 7	
Diet Pills	? Yes ? No	1 2 3 4 5 6 7	
Other	? Yes ? No	1 2 3 4 5 6 7	

****

USE OF ALCOHOL/DRUGS – Past

****

Did you/ or family member experience (check all that apply):

____hangovers ____sleep disturbance ____blackouts ___relationship conflicts

____overdose/drink too much ____feel suicidal ____become aggressive ____Binge

____Job loss ____history of DUI/arrests ____seizures

****

FAMILY ALCOHOL/DRUG USE and/ ABUSE HISTORY-

****

Did anyone in your family of origin use drugs/alcohol?
(Who? mother, father, grandparents, aunt, uncle etc. Include extended family here). What effect did this have on you and your family?)____
____

Has there been treatment for yourself or family member? Tell me about it (when? Who in your family?, when?, What were the circumstances?)____
____

****

FAMILY/CLIENT MENTAL HEALTH HISTORY: Circle all that apply!

Have you or any of your family members had histories of:

Problem Area	*Client History*	*Family History*	*Who in Family*	*Side of Family*
Alcoholism	? Yes ? No	? Yes ? No		father / mother
Drug Abuse	? Yes ? No	? Yes ? No		father / mother
Eating Disorders	? Yes ? No	? Yes ? No		father / mother
Depression	? Yes ? No	? Yes ? No		father / mother
Manic Depression	? Yes ? No	? Yes ? No		father / mother
Emotional Problems	? Yes ? No	? Yes ? No		father / mother
Physical Disability	? Yes ? No	? Yes ? No		father / mother
Obesity	? Yes ? No	? Yes ? No		father / mother
Schizophrenia	? Yes ? No	? Yes ? No		father / mother
Physical Abuse	? Yes ? No	? Yes ? No		father / mother
Sexual Abuse	? Yes ? No	? Yes ? No		father / mother
Emotional Abuse	? Yes ? No	? Yes ? No		father / mother
Severe Accident	? Yes ? No	? Yes ? No		father / mother
Severe Trauma	? Yes ? No	? Yes ? No		father / mother
Suicide	? Yes ? No	? Yes ? No		father / mother
Homicide	? Yes ? No	? Yes ? No		father / mother

Were you ever:

Type of Abuse	*Incidence*	*By Whom?*	*How Often?*	*What Age(s)?*
Physically Abused	? Yes ? No			
Sexually Abused	? Yes ? No			
Emotionally Abused	? Yes ? No			
Severely Disciplined	? Yes ? No			

Have you ever:

	Incidence	*How Often?*	*What Age(s)?*
Attempted Suicide	? Yes ? No		
Attempted Homicide	? Yes ? No		
Committed Homicide	? Yes ? No		

Has there been any physical fighting in the family? ___Yes___No_____ If yes, please explain.

Is anyone in trouble with the law? Yes___No___-If yes, Please explain. (Who, When, Where….)

Has anyone in your family been admitted to a psychiatric hospital in the past or currently? Tell me about it (when, where, how long, for what condition. Was it a good experience? How did it affect you and your family? Please explain.

Is anyone in the family taking **medications for anxiety, depression or other mental health issues**______Yes_____No
If so, please list them below. You can list any medications you take for other health reasons HERE.

List all current medications, dosages, and the reasons for taking them:

Medication	*Dosage*	*Prescribing MD*	*Physician Phone*	*Condition*

Your Description of 'The Problem".

In your own words what is bringing you in for counseling? How long has it been going on?_______________
Be specific!

****

Solution and Problem Solving: Setting Goals---You have the power to change your life experience!

Together we can help you learn to:

a) Identify the triggers of your stress
b) Take control of the stressors in your life where possible
c) Let go of the stressors you have no control over
d) Establish and maintain a balance in your life

What are the goals for yourself and your family in counseling?
How will you know that the issues that brought you here have been resolved? BE SPECIFIC!

1.

2.

3.

4.

5.

****

RELATIVE OR FRIEND TO CONTACT IN CASE OF AN EMERGENCY:

Name:____ Phone Number:

Address:

OFFICE BILLING AND INSURANCE POLICY

1. **I understand that insurance does not cover missed sessions or sessions I do not attend.**
2. I authorize use of this form on all of my insurance submissions. I authorize the release of information to my insurance company(s).
3. **Payment is expected at the time of service. I understand I am responsible for the full amount of my bill for services provided. I understand that it is my responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balance not paid by my insurance at the time services are rendered.**
4. I accept checks and cash only. There will be a $ 25.00 service charge on all returned checks. Delinquent accounts will be sent to collections or small claims court after 60 days. In the event your account goes to collections or small claims court, you will be liable for all collection fees, attorney fees and court costs.
5. If therapeutic services are not covered by insurance, I agree to pay $100/session.
6. I hereby permit a copy of this policy to by used in place of an original.
7. **There is a 48 hour cancellation policy. I understand I must cancel my appointment at least 48 hours in advance to avoid being charged my full fee of $100/session**.
8. **I understand that if I do not call to cancel or reschedule my appointment at least 48 hours in advance, I will be charged $100 to cover the cost of each session I did not attend. I understand that insurance does not cover missed sessions. This policy is intended to allow other clients the opportunity to access services in a timely manner. Thank you for your cooperation and courtesy to others.**

Name: ____ ID/Policy # ________________

Signature: ____ Date: ____________________

Center for Music Psychotherapy & Family Therapy
Kim McMillin RN, MA, MT-BC, LPC, LMFT
P.O. Box 6
Lafayette, CO 80026
(303) 666-9091 www.musicfamilytherapy.com
musictfamilyther@.ecentral.com

Consumer/Client Rights, Limits of Confidentiality and Consent to Treat

We are providing the following information to let you know what your rights are as a client of counseling in the state of Colorado.

CONSUMER/CLIENT RIGHTS

The practice of counselors is regulated by the Colorado State Department of Regulatory Agencies. Any questions or complaints may be addressed to director of this agency and/or to:

Mental Health Occupations Grievance Board
1560 Broadway, Suite 1340, Denver, CO 80202
303-894-7766

- **Basic rights.** You have the right to be treated with dignity, courtesy and respect.
- **The best outcome begins with your willingness to** create a partnership with me in your journey as a client. My role is to provide a safe, nonjudgmental place for you to experiment with new ways of feeling, being, perceiving and acting. I ask that you are honest with me and with yourself. I ask that you keep scheduled appointments, make payments when services are rendered, and complete homework assignments on time. Please ask if you have any concerns or questions.
- **My Training and Licenses.** You may request information concerning my training, educational degrees, licenses and credentials at any time. You can review these on my website at www.musicfamilytherapy.com
- **Counseling methods and techniques.** You are entitled to receive information about my counseling methods and techniques, the length of counseling and cost (if it can be determined). Please ask any questions.
- **Financial Policies.** You have the right to be given information about our fee structure and financial policies. Unpaid balances will be sent to a collection agency. Please ask if you have any questions!
- **Records.** In most cases, (there are exceptions) you have the right to see your medical/counseling record.
- **Ending Counseling/ Second opinion.** You may seek a second opinion from another counselor or may end counseling at any time
- **Sexual intimacy between a counselor and a client.** You should know that sexual intimacy between a counselor and a client is never appropriate and should be reported to the Grievance Board.
- **Emergencies &Returning phone calls.** You need to know that I DO NOT carry a pager. I have a part time practice. I check my messages regularly M-F. I will return your phone calls as soon as possible. If you have a psychiatric emergency you can: Go to Centennial Peaks Hospital, or the ER at any hospital or call 911.
- **Cancellations:** You should know that I have a 48 hour appointment cancellation policy. If you DO NOT call at least 48 hours BEFORE your appointment, I will charge you my full fee of $100.00/session. I am not able to charge your insurance for sessions that you did not attend.
- **Insurance:** You are responsible for determining if my services are covered under your particular insurance plan. YOU are responsible for ALL charges not covered by your insurance.
- **Supervision/Consultation with other professionals.** In order to provide you with the best possible treatment, I may chose to consult with other professionals. In such cases the name of the client or identifying information is withheld. I may ask you to sign a release of information, to facilitate this.

LIMITS OF CONFIDENTIALITY

Information you provide during counseling is confidential, EXCEPT during the following cases:

- **When I have reasonable cause to suspect that a child (anyone under the age of 18) or an adult (**who is a ward of the state or has a guardian) has been subjected to abuse and/or neglect.
- **Duty to Warn and Protect:** If you appear to be at serious risk for hurting yourself or others I am required to warn the intended individual and report this to the legal authorities.
- **In the event of a client's death**, the spouse or parents of the deceased have a right to access their family members records

- **When an insurance company or other 3rd party payors requests information regarding services provided to you the client. Every effort is made to limit identifying information. See Notice of Privacy Practices.**
- **When making phone calls to facilitate setting appointments, to give/receive information, or reminders, every effort is made to preserve confidentiality. Please indicate below where we may reach you, and how you would like us to identify ourselves. See the Procedure for Phone Calls below.**
- You should know that cell phone and facsimile are used at this office and meet HIPAA requirements for maintaining confidentiality.
- **When I receive a court order from a judge to release your records.**
- **When you have signed a release of information form usually as a part of facilitating communication with other health care professionals with the express purpose of increasing the quality of care you receive**
- If **you are involved in a criminal proceeding** (i.e. charged with a crime)
- When you or your representative **files a lawsuit against your counselor**
- When **your counselor is in consultation on a case that prompts a lawsuit**
- When a **review of your counselor is conducted by the Grievance Board**

Please ask if you have ANY questions about these exceptions.

TELEPHONE CONTACT POLICY:

These will be followed UNLESS you give us permission to identify ourselves at your request. SEE BELOW

1. **We will ask to speak to the client/ guardian with out identifying the name of the office or the therapist**
2. **If the person answering the phone asks for more identifying information, we will say that it is personal call. We will NOT identify the name of the office, the nature of the call nor the name of the therapist to protect confidentiality**
3. **If we reach an answering machine or voice mail we will follow the same guidelines**

Please check where you may be reached by phone. Indicate the phone numbers and how you would like us to identify ourselves when contacting you

4. **From time to time I may send you a practice newsletter or similar material. Plese check here if you DO NOT want to receive this kind of mail: _______.**

_____HOME Phone #____________________________
Should we identify that we are calling from the
"Center for Music Psychotherapy and Family Therapy"? ____Yes ____No
Can the Therapist identify themselves? ____Yes ____No

_____WORK Phone #____________________________
Should we identify that we are calling from the
"Center for Music Psychotherapy and Family Therapy"? ____Yes ____No
Can the Therapist identify themselves? ____Yes ____No

CONSENT TO TREAT

Your fee/co pay will be $_____ per 50 minute session. Total EAP sessions available are ____.

I have read this document and am willing to participate in counseling. I understand my rights as a consumer of counseling services. I understand that I am responsible for all charges not covered by my insurance. I understand and agree to the limits of confidentiality, and the 48 hour Cancellation/No Show policy. I have read and understand the 'Telephone Contact Policy'. I understand that I can ask for more information at any time.

_______________________________ COUNSELOR

_______________________________ DATE

_______________________________ CLIENT

_______________________________ CLIENT

---------------------- DATE

Center for Music Psychotherapy & Family Therapy
Kim McMillin RN, MT-BC, LMFT
Licensed Marriage and Family Therapist
Board Certified Music Therapist
P.O. Box 6, Lafayette, CO 80026
www.musicfamilytherapy.com
(303) 666-9091 musicfamilyther@ecentral.com

NOTICE OF PRIVACY PRACTICES

We respect our client's confidentially and only release information about you in accordance with state and federal laws. This form will be retained in your health care record.

THIS NOTICE DESCIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY!

Effective Date April 14, 2003

This notice describes our policies related to the use of the records of your care at the Center for Music Psychotherapy and Family Therapy. We are required to give you this Notice about 1) the use and disclosure of your health information, 2) Our legal responsibilities and 3) your rights concerning your health information and to abide the terms of this notice.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional information contact: Privacy Officer, The Center for Music Psychotherapy and Family Therapy., PO Box 6, Lafayette, CO 80026, 303-666-9091.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

We use and disclose the minimum necessary health information about you for your treatment, for payment for your services, and for The Center for Music Psychotherapy and Family Therapy operations.

For Treatment. We may use and disclose your health information to

1. **Provide, manage or coordinate care**. For example I may ask you to fill out a release of information form, if I need more information to treat you safely or to refer you to another health care professional/ organization.
2. **Consult with other professionals**
3. **Refer you to other professionals**

For Payment. We may use and disclose your health information to obtain payment for services we provide to you. For example, we may need to give insurance companies or other agencies the minimum necessary information in order for them to pay us.

1. To Verify insurance and coverage
2. To Process claims and collect fees

For Health Care Operations. For example, we may review your record to assure quality, or use your information to tell you about services, educational activities, and programs that we feel might be of interest to you.

We may use and disclose health information for:

1. Review of Treatment procedures
2. Review of business activities
3. Certification
4. Staff training
5. Compliance and Licensing activities

INFORMATION DISCLOSED WITHOUT YOUR CONSENT

Under Colorado and federal law, information about you may be disclosed without your consent in the following circumstances

1. **Emergencies**. Sufficient information may be shared to address an immediate emergency you facing.
2. **Judicial and Administrative proceedings.** We may disclose your personal information in the course of a judicial or administrative proceeding in response to a valid court order or other lawful process.
3. **Duty to Warn and Protect.** If we felt you were an immediate danger to yourself or others, we may disclose health information about you to the authorities, as well as alert any other person who may be in danger.
4. **Child/Elder Abuse.** We may disclose health information about you related to the suspicion of child and or elder abuse or neglect.

5. **Criminal Activity or Danger to Others.** We may disclose health information about you if a crime is commuted on our premises or against our personnel, or if we believe there is someone who is in immediate danger.
6. **Marketing** . The Center for Music Psychotherapy and Family Therapy may send you newsletters or information about service we provide in which we feel you may be interested. You may at any time request that your name be removed from our data base. We do not release information to telemarketers, direct mailers, or email marketing or other 3rd party organizations.
7. **Scheduling Appointments.** We may use your phone number to call you and leave messages or remind you of appointments.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

1. Right to inspect a copy.

a. You have the right to look at or get copies of your health information and medical billing information with limited exceptions. If you request a copy of the information, a reasonable charge may be made for the costs incurred.

2. Right to release your medical records

a. You must provide written authorization to release health information to other professionals and/or organizations.
b. You have the right to revoke the relies of information in writing
c. Revocation is no valid to the extent that you have acted in reliance on such previous authorization

3. Right to add information or amend you medical records.

a. You have the right to request that we amend your health information
b. Your request must be in writing and it must explain why the information should be amended
c. We have the right to deny your request under certain circumstances.
d. If we deny your request, you may file a written disagreement statement
e. Your disagreement statement and your response will be filed in the record

5. Right to Accounting of disclosures

a. You have the right to receive a list of instance in which we have disclosed your health information for a purpose other than treatment, payment or healthcare operations.
Exceptions include: Disclosures pursuant for signed release, disclosures to you the client, disclosures for national security or law enforcement
b. You must submit your request in writing to the Privacy Officer at the address on this notice.
c. Accountings are available for a 6 year period beginning April 14, 2003

6. Right to request restrictions on uses and disclosures of your healthcare information

a. You have the right to request a restriction or limitation on the health information we use or disclose about you. For example, you could ask that we not share information with an insurance company in which case you would be responsible to pay in full for the services provided.
b. We are not required to agree to your request, but we will consider the request very seriously.
c. If we comply with your request, we will abide by our agreement unless the information is needed in an emergency or by law.

7. Right to Request confidential communication.

a. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you may ask that we contact you only by mail or at work.
b. You must make this request in writing and it must specify the alternative means or location that you would like us to use to provide you information about your health care. We will make every effort to accommodate reasonable requests.

8. Right to Obtain a paper copy of this notice and any amended notice upon request.

a. We have the right to amend and change our privacy practices provided that such changes are permitted by law. You can obtain an updated notice by contacting the privacy officer at the address listed on this notice

9. Right to Complain.

a. If you believe your privacy rights have been violated please contact us first.
b. You have the right to file a complaint with the U.S. Dept of health and Human Services.
c. We will not retaliate if you chose to file a complaint.

By my Signature below I acknowledge receipt of the NOTICE *OF PRIVACY PRACTICES.*

_______________________________ _______________________

PRINTED NAME OF CLIENT **DATE**

____

SIGNATURE OF CLIENT OR AUTHORIZED REPRESENTATIVE