Kansas Mental Health Professionals

INDIVIDUAL CONCERNS

Name: Date of Birth: Today's Date:

Please check any concerns that you have experienced within the past 6 months:

- ☐ Depressed Mood
- ☐ Loss of interest/pleasure
- ☐ Lack of energy
- ☐ Change in ability to concentrate
- ☐ Loneliness/Isolation
- ☐ ILow self-esteem
- ☐ Suicidal thoughts
- ☐ Non-suicidal self-harm
- ☐ Violent urges about others
- ☐ Significant weight change
- ☐ Problems with sleep
- ☐ Feeling hopeless/helpless
- ☐ Problems with guilt
- ☐ Frequent Nightmares
- ☐ Decreased need for sleep
- ☐ Racing thoughts
- ☐ Talkativeness
- ☐ Risky behaviors (financial, physical, sexual, etc.)
- ☐ Feeling "on the go"
- ☐ Impulsive behaviors
- ☐ Temper concerns
- ☐ Problems following rules
- ☐ Frequent lying or deceitfulness
- ☐ Problems with worry
- ☐ Difficulty relaxing (restlessness)
- ☐ Difficulty making decisions
- ☐ Panic Attacks
- ☐ Excessive fear(s) about objects or situations
- ☐ Avoidance of social situations
- ☐ Obsessive thoughts or behaviors
- ☐ Problems with aggression
- ☐ Destroying property
- ☐ Frequent Headaches
- ☐ Gastrointestinal problems
- ☐ Ongoing physical pain
- ☐ Witnessed/experienced a life-threatening event or injury
- ☐ Sexual issues
- ☐ Body Image concerns
- ☐ Hearing things that others do not
- ☐ Seeing things that others do not
- ☐ Drug use issues
- ☐ Alcohol use concerns
- ☐ Affair
- ☐ Relationship concerns
- ☐ Divorce/Separation
- ☐ Recent loss
- ☐ Parenting Problems
- ☐ Legal Concerns
- ☐ Learning/Academic concerns
- ☐ Other concern(s) that are not listed _____

Please list any prior counseling you have received:

Therapist	Approximate Dates of attendance	Any Diagnoses Given

Have you ever been hospitalized? If yes, please indicate for what reason and the approximate dates:

Have you ever tried to kill yourself?

Are you currently suicidal? If yes, do you have a plan?

Have you ever purposely harmed others?

Have you ever harmed yourself without suicidal intent? If so, do you still?

1009 S. Broadway Ave | Wichita, KS 67211 | phone: (316) 500-5419

Email: scott@KMHP.ofwichita.org

Do you have any past or current medical conditions?

Please list all medications you are taking:

Medication	Dosage	Prescribed by	Date prescription began

How much alcohol do you drink?

- ☐ None
- ☐ 1 or less drinks per week
- ☐ 2-4 drinks per week
- ☐ 5-10 drinks per week
- ☐ 11+ drinks per week

Do you take any non-prescribed substances or drugs? If yes, please indicate:

_____

Do you know of any history of mental illness in your family?

Relationship	Mental Illness/Concerns	Officially Diagnosed or Suspected?

Please circle any of the following that you have experienced:

Childhood physical abuse Childhood emotional abuse Childhood neglect Childhood sexual abuse

Adult physical abuse Adult emotional abuse Adult Assault Sexual Assault Domestic Violence

Natural Disaster (tornado, hurricane, housefire, etc.) Other: _____

Do you expect to be involved in any court-related matters?

Is there anything that you feel it is important for your therapist to know that has not been asked yet?

Thank you for completing this form. The information you provided will be helpful to your therapist in helping you with your concerns.

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Kansas Mental Health Professionals
Intake Form

DATE: _____ THERAPIST NAME: _____

PATIENT INFORMATION:

IF PATIENT IS AN ADULT, PLEASE COMPLETE:

Patient Name: _____
Address: _____
Street City, State, Zip
Phone: ( ) _____ ( ) _____
Home Work
Sex: Male____ Female ____

Date of Birth: _____ Social Security Number _____
Occupation: _____
Educational Level: _____
Spouse Name: _____
Marital Status: Single_____ Married_____ Divorced _____

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

Patient Name: _____
Address: _____
Street City, State, Zip
Phone: _____ Sex: Male____ Female_____
School: _____ Grade: _____
Date of Birth: _____
Father's Name: _____
Address: _____
Street City, State, Zip
Phone: ( ) _____ ( ) _____
Home Work
Social Security Number: _____

Mother's Name: _____
Address: _____
Street City State Zip
Phone: ( ) _____ ( ) _____
Home Work
Social Security Number: _____

MEDICAL HISTORY:

Significant Illnesses, Physical Conditions, Hospitalizations (include dates):

_____

_____

Medications currently using:_____

Name of Clinic/Doctor:_____ Phone: (__)_____

REFERRAL INFORMATION:

Whom were you referred by: _____

Church:_____ Pastor:_____

INSURANCE INFORMATION:

Insurance Carrier:_____

Please provide your insurance card to obtain a photocopy.

Insured's Name: _____ S.S. #_____
Date of Birth:_____
Relationship to Patient:_____
Employer:_____ Group No._____

I hereby authorize the release of medical information necessary to process my claims:

_____
Patient Signature (for Patients 12 years old and above) Date

I authorize payment of medical benefits to Kansas Mental Health Professionals and understand that I am responsible for charges not covered by my insurance:

_____
Patient or Responsible Party's Signature Date

Kansas Mental Health Professionals
Informed Consent for Mental Health Services

About psychotherapy, treatment plans and treatment outcomes:

I acknowledge that I have received, have read (or have had read to me), and understand the "Policy Information for Clients" sheet and/or other information about the mental services that I am considering. I have had all my questions answered fully. I do hereby seek and consent to take part in the mental health services rendered by the professional named below. I understand that developing a treatment plan with this professional 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 these services or of any procedures provided by this mental health professional.

About limits to confidentiality:

The staff of Kansas Mental Health Professionals abides by the stipulations regarding confidentiality as contained in the Confidentiality Act and the Mental Health Code[1], as well as the applicable licensure laws governing the license(s) of my mental health professional[2] and those of such professional organizations as the Kansas Behavioral Science Regulatory Board, the American Psychological Association, and the National Association of Social Workers. Our practice is also compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I acknowledge that I have received and read a copy of the KMHP privacy practices.

If you are an adolescent between the ages of 12 and 18, the same general rules apply as those with adults. Disclosure of information about you to your school or other professionals will generally be done only with your written consent as well as that of your parent(s). However, information may be disclosed about you to your parents without your consent, if, in the opinion of your mental health professional, the disclosure is deemed to be in your best interest.

About payment:

I am aware that I may terminate the services being provided by my mental health professional 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 will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel with sufficient notice or do not show up for the appointment, I may be charged for that appointment. Missed appointments cannot be charged to my insurance company.

I understand that I am ultimately responsible for payment of the fees for all services rendered. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment and refer me to another agency.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to Client (if necessary)

I, the mental health professional, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of mental health professional Date

_____

Kansas Mental Health Professionals

Waiver of Medical and Psychiatric Consultation

Kansas law KSA 65-6404 (b) (3) states that my counselor is required to consult with my primary care physician or a psychiatrist to determine if there may be a medical condition or medication that may be causing or contributing to any signs of a mental disorder that s/he may have observed while working with me or my minor children (under 17 years).

By signing below, I am waiving the immediate medical consultation between the counselor and my physician. Should the need arise for a medical consultation in the future, I will be asked to sign a Release of Information to allow for such consultation.

In the event that my counselor addresses the need for further consultation, and I or my minor child(ren) do not currently have a primary care physician or psychiatrist, I acknowledge that my counselor may recommend that I seek medical consultation or provide me with appropriate referrals.

I understand that I have the right not to sign this waiver and that doing so provides my counselor the full requirement to make immediate consultation. I am also aware that this waiver will become part of my client record.

Please list name(s) of adults being treated:

Please list name(s) children being treated:

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how health information about you may be used and disclosed and how you can get access to your health information.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY.

Our practice is dedicated to maintaining the privacy of your health information. In conducting our business, we will create records regarding you and the diagnosis, treatment and services we provide to you. We are required to:

- Maintain the privacy of your health information.
- Provide you with a notice of our legal duties and privacy practices with respect to information we collect.
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you have to communicate health information by alternative means or at alternative locations.

The terms of this notice apply to all records containing your health information that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times and you may request a copy of our most current Notice.

B. USE AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS.

The following categories describe the different ways in which we may use and disclose your health information.

1. **Treatment.** We may use your health information to treat you and reach a diagnosis. Additionally, we may disclose your health information to others who may assist in your care.
2. **Payment**. We will use and disclose your health information to bill and collect payment for the services you receive from us. We may provide your insurer with details regarding your treatment to determine if your insurer will cover your treatment. We also may use and disclose your health information to obtain payment from third parties that may be responsible for such costs. Also, we may bill you directly.
3. **Health Care Operations**. We may use and disclose your health information to operate our business. For example we may use and disclose your information to evaluate the quality of care you received from us.
4. **Release of Information to Family/Friends**: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, and general condition.
5. **Disclosure required by Law**. We will use and disclose your health information when we are required to do so by federal, state or local law.

C. SPECIAL CIRCUMSTANCES FOR DISCLOSURE OF YOUR HEALTH INFORMATION.

The following categories describe unique scenarios in which we may use or disclose your health information.

1. **Public Health Risks**: Our practice may disclose your health information to public health authorities for the purpose of:
   -reporting child abuse or neglect.
2. **Lawsuit and Similar Proceedings**: Our practice may use and disclose your health information in response to court or administrative order, if you are involved in a lawsuit or similar proceedings. We may disclose your health information in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

3. **Military:** Our practice may disclose your health information if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
4. **National Security**: Our practice may disclose your health information to federal officials for intelligence and national security activities authorized by law.
5. **Workers' Compensation**: Our practice may release your health information for worker's compensation and similar programs.

D. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding the health information we maintain about you:

1. **Confidential Communications**: You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than work. In order to request a type of confidential communication, you must make a written request to the Office Manager specifying the requested method of contact of the location where you wish to be contacted. Our practice will accommodate reasonable requests.
2. **Inspection and Copies**: You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records but not including psychotherapy notes. You must submit your request in writing to Heritage Professional Associates in order to inspect/obtain a copy of your health information. Our practice may charge a fee for the cost of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another health care professional chosen by us will conduct the review.
3. **Requesting Restrictions**: You have the right to request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction you must make written request describing the following:
    - the information you wish restricted;
    - whether you are requesting to limit our practice's use, disclosure or both, and
    - to whom you want the limits to apply.
4. **Amendment**: You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by our practice. You must make this request in writing and must provide us with a reason to support your request for amendment. Our practice will deny your request if it is not in writing and you fail to provide the reason for your request. Also, we may deny your request if you ask us to amend information that is in our opinion (a)accurate and complete; (b) not part of the patient information kept by our practice; (c) not part of the patient information which you would be permitted to inspect or copy, or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information
5. **Accounting of Disclosures**: You have the right to request a list of certain non-routine disclosures our practice has made of your patient information for non-treatment or operations purposes. All requests for this information must be made in writing and must state a time period which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. Our practice may charge you for lists of more than a 12 month period. Our practice will notify you of the costs involved and you may withdraw your request before you incur any costs.
6. **Right to a paper copy of this Notice**: You are entitled to receive a paper copy of our notice of privacy practices. To obtain a copy contact Heritage Professional Associates, Ltd. (630) 325-5300
7. **Right to File a Complaint**: If you believe your privacy rights have been violated you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. **Right to Provide an Authorization for Other Uses and Disclosures**: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your health information may be revoked at any time in writing.

POLICY INFORMATION FOR OUR CLIENTS

Thank you for selecting Kansas Mental Health Professionals to address your mental health needs. Our well-trained professional staff takes pride in providing quality care in a compassionate atmosphere. The following information is being provided to you to familiarize you with the policies of Kansas Mental Health Professionals regarding the scheduling of sessions, the payment of fees and the use of medical insurance.

Psychotherapy sessions are usually 45 to 55 minutes in length. We do charge for appointments that are either missed altogether or cancelled with less than 24 hours notice. Insurance companies and managed care companies do not reimburse for missed appointments.

Payment for each session is required at the time of your appointment. This payment may be made via cash, check or Visa/MasterCard.

It is your responsibility to file claims with your insurance company for any and all services that you receive from KMHP unless we are a contracted provider with your insurance company. Your therapist is obligated to bill your insurance company *only* if it is a contracted provider. If this is unclear to you, please discuss this with your therapist.

It is your responsibility to contact your insurance company prior to your first appointment to request authorization for services, if authorization is necessary. Please inform our office staff of your authorized sessions and billing information. Failure to comply with this may result in loss of benefits and you being held responsible for 100% of the fee assessed.

In case of emergency during non-working hours, please contact 911 or Comcare Crisis at 316-660-7500.

If you have any questions, please feel free to ask your therapist at the time of your session or call our business office for additional information. We wish you well in your treatment efforts at KMHP.

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.

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