PROMISING HORIZONS
Counseling & Assessment

CLIENT INFORMATION Please answer all information as completely as possible. Information will be managed as protected health information. If you need assistance, please ask. Your Counselor will review this information with you.

Client: _____ Date: _____

Last First MI

Address: _____

Street City State ZIP

Email Contact: _____ May we contact you by email? YES ☐ NO ☐

Home Phone: _____ Work Phone: _____ Cell Phone: _____

May we leave a message: YES ☐ NO ☐ May we leave a message: YES ☐ NO ☐ May we leave a message: YES ☐ NO ☐

Date of Birth _____ Age: _____ SSN: _____ Gender: _____ Employer: _____

EMERGENCY CONTACT: _____

Name Relationship Phone

EAP? YES ☐ NO ☐

Auth/Case/MAT#: _____ Number of Sessions: _____

Name of EAP: ☐ Reliant Behavioral Health ☐ OPTUM/United Behavioral Health ☐ Aetna EAP ☐ BPA

☐ ComPsych ☐ Magellan ☐ Cigna EAP ☐ Other: _____

Insurance Information

Primary Insurance: _____

Policy/ID # _____

Group # _____

Subscriber: _____

Subscriber DOB: _____

Client's relationship to subscriber:

☐ Self ☐ Spouse ☐ Child ☐ Other

Marital Information

☐Single ☐Living with Partner ☐Married ☐Separated ☐Divorced ☐Widowed Length of Time: _____

Referral Source

How did you hear of my clinic (or from whom)? _____

Relationship to referral source: _____

Health Information

Primary Care Physician: _____ Phone: _____

Date of last visit: _____ **By initialing here I consent to Gregory M. Deitchler, LMFT, LPC coordinating care with my primary care physician if necessary for my treatment** _____

Primary Care Psychiatrist: _____ Phone:_____

Date of last visit: _____ **By initialing here I consent to Gregory M. Deitchler, LMFT, LPC coordinating care with my primary care psychiatrist if necessary for my treatment** _____

Are you currently taking any medications or homeopathic: YES □ NO □

Name of Medication	Dosage	Frequency	Purpose	Prescribing Doctor

Health History

Please list past and current medical conditions (major illness/injuries/surgeries/etc.)

What	When	Treatment

Alcohol/Substance Usage

Preferred Substance: □Alcohol □Tobacco □Narcotics □Prescription □Other:_____

Date of last use:_____

Type and amount of usage:_____

Age usage began:_____ How often do you use/consume? _____

Have you ever had any legal problems related to your use/consumption? YES □ NO □

Have you ever had any relationship problems related to your use/consumption? YES □ NO □

Has your use/consumption ever become a problem? YES □ NO □

Interest/Hobbies

Do you participate in any cultural activities related to your social or ethnical background? YES □ NO □

Please list your hobbies or interests: _____

_____

Spirituality

Do you practice a faith or religion? YES □ NO □ If so, please identify: _____

Would you like faith to be a part of treatment? YES □ NO □

If yes, please describe what this might look like: _____

_____

Have you or are you currently contemplating harming yourself? YES □ NO □ Past □ present □

Have you or are you currently contemplating ending your life? YES □ NO □ past □ present □

Has anyone in your immediate family attempted or completed suicide? YES □ NO □ past □ present □

Current Concerns

What brought you in for treatment? _____

_____

What are your expectations for treatment? _____

_____

What is one thing that you want me to know about you today? _____

_____

PRESENTING PROBLEMS/FEELINGS/EXPERIENCES (Check all that apply)

- ☐ Aggressive Behavior
- ☐ Alcohol Abuse/Dependency
- ☐ Anger
- ☐ Anxiety
- ☐ Change in Appetite
- ☐ Compulsions
- ☐ Cutting/Injuring
- ☐ Delusions/Hallucinations
- ☐ Depression
- ☐ Easily Annoyed
- ☐ Easily Distracted
- ☐ Eating Disorder
- ☐ Emotional Abuse
- ☐ Excessive Worry
- ☐ Family Issues
- ☐ Fatigue
- ☐ Fearful
- ☐ Financial
- ☐ Friendship
- ☐ Grief/Loss
- ☐ Guilt/Worthlessness
- ☐ Headaches
- ☐ Hearing Things
- ☐ Hopeless
- ☐ Impulsivity
- ☐ Insomnia
- ☐ Intimacy
- ☐ Irritable
- ☐ Life Decision
- ☐ Loss of Pleasure
- ☐ Mania
- ☐ Medical/Organic Condition
- ☐ Mood Instability
- ☐ Muscle Tension
- ☐ Pain
- ☐ Panic
- ☐ Paranoia
- ☐ Parenting
- ☐ Physical Abuse
- ☐ Poor Concentration
- ☐ Racing Thoughts
- ☐ Relationships
- ☐ Restless
- ☐ Sadness
- ☐ School
- ☐ Seeing Things
- ☐ Self-Destructive Behavior
- ☐ Sex Compulsion/Dependency
- ☐ Sexual Abuse
- ☐ Sexuality
- ☐ Sleeping Too Little
- ☐ Sleeping too much
- ☐ Spirituality
- ☐ Stomachaches
- ☐ Stress
- ☐ Substance Abuse/Dependency
- ☐ Suicidal Ideation
- ☐ Tearful
- ☐ Trauma
- ☐ Uncertain
- ☐ Work
- ☐ Other: _____

Please identify and rate the top six feelings/experiences that are most troubling for you currently (1= most severe, 6= least severe)

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Approximately how long have these been bothering you? _____

Please indicate approximately how much distress do you believe these problems are causing in your life:

- ☐Mild (less than once a week)
- ☐Moderate (1-2 times per week)
- ☐Severe (4-5 times per week)
- ☐Impairing (daily)

PROMISING HORIZONS

Counseling & Assessment

Gregory M. Deitchler, M. A.; L.M.F.T., L.P.C., C.S.C.

I received my Bachelor's degree in Psychology from Boise State University in May of 1996. I have been working in the Mental Health field since that time. I graduated from a 60 credit accredited Counseling program at Boise State in May of 2000. I am a member of the American Counseling Association (ACA) and am bound by the ethical guidelines and standards of the ACA. I am also a member of the International Association of Marriage and Family Counselors, and I am also bound by and practice under their ethical guidelines and standards. I am licensed in the State of Idaho as a Licensed Marriage and Family Therapist, and as a Licensed Professional Counselor.

My Counseling Style and Our Partnership:

In my counseling practice I work with individuals, couples, and families. My theoretical orientation is rooted in reality theory, which basically takes an account of where you are now and where you plan to go in the future. I believe in a brief solution-focused style that will enable us as a team to work systematically to get at the problem at hand, or the symptoms that have brought you to counseling. We will touch on the past, as it is relevant; however, I like to focus on what the future has in store for you. My theoretical model is a strong foundation in cognitive behavioral therapy and working to get to the source of the problem. At any time throughout our session(s) you have the right to stop the session or to move it in another direction.

Fees and Cancellation Policy:

My counseling hours start at 9am on weekdays and appointments can be arranged on Saturdays. Counseling sessions are 60 min. in length. The initial session is $150.00, with subsequent 60 min. sessions at $125.00 per session, or on occasion a shorter session of 35-45 min. which are billed at $100.00 per session. Payment is required at the time of the visit, unless other payment arrangements have been made. Any court appearances or testifying will be at a $300.00 per hour rate including document prep and/or travel time. If you plan on canceling an appointment it must be 24 hours in advance or you will be charged a $50.00 "No-Show" fee for the appointment time.

Confidentiality:

Consultation is an important part of my practice. I consult with colleagues about generalized cases on a weekly basis. I feel that this helps me serve my clientele better. Outside this private group of professionals, any information that is obtained about you during the counseling sessions will not be revealed to anyone except where disclosure is required by law: 1st, Where this is reasonable suspicion of abuse to children or the elderly persons. 2nd, where you present a serious danger to yourself or others. Licensure does not imply endorsement by the counselor licensing board or the effectiveness of treatment. In order to protect your privacy, we will only release information after your review and approval, and a release has been signed in my office.

I have read and understand the Promising Horizons Counseling and Assessment Informed Consent.

Client Signature_____Counselor Signature_____

Parent/Guardian Signature (if client is under 18) _____

AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

I request that **Gregory M. Deitchler, MA, LMFT, LPC** provide professional service to,

□ myself_____ □ and/or_____ ,

who is my _____ .

- I agree to pay the counselors stated fees as listed in Informed Consent document.
- I agree that this financial relationship with this counselor will continue as long as the counselor provides services or until I inform him, in person or by certified mail that I wish to end this professional relationship.
- I agree to meet with my counselor at least once before stopping therapy.
- I agree to pay for service provided to me or stated client up until the time that I have fulfilled my
- financial responsibility.
- I agree that I am responsible for the charges of service provided by this counselor, although other persons or insurance companies may make payment on my or clients behalf.

_____ _____ _____

Client/Guardian Signature Relationship Date

I, the counselor, have discussed the issues above with the client and/or the person representing the client. My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____ _____

Counselor Counselor Signature Date

PAYMENT INFORMATION

Acceptable forms of payment: Cash, Check, Credit, and Debit

Please make checks payable to: Promising Horizons, LLC

You will be responsible for any applicable co-pays, cost-shares, co-insurance, deductibles, or self-pay amounts. Our "No Show" fee of $50.00 will remain in effect for all appointment types. We ask that you leave a credit or debit card on file with us to process your co-pays and co-insurance after your visits. This will be processed the day of your appointment.

- We notify our billing department of your attendance or if you have "No showed."
- Your applicable co-pay/cost-share/coinsurance/deductible/session fee/"no-show" fee is charged to your card on file.
- You are sent a receipt if you request one.

□ **I ACCEPT** THE TERMS OF GREGORY M. DEITCHLER LMFT LPC CREDIT CARD REQUIREMENT FOR COPAYS AND DEDUCTIBLES AND WISH TO USE MY DEBIT/CREDIT CARD TO PAY FOR THE SERVICES RENDERED. I AGREE TO ALLOW PROMISING HORIZONS, LLC TO RUN MY CARD ON FILE FOR APPOINTMENT FEES.

_____

Client/Guardian signature

For ongoing credit and debit payments: **Charges will show as "Medical Billing" on your bank/credit card statement**

Name as it appears on Card: _____

Card#: _____Expiration Date: _____ Billing ZIP code: _____

□ I DO NOT WISH TO USE ANY CREDIT/DEBIT CARD INFORMATION AND DO NOT GIVE GREGORY M. DEITCHLER LMFT LPC OR PROMISING HORIZONS, LLC PERMISSION TO KEEP ANY RECORD OF PAYMENT INFORMATION ON FILE FOR FUTURE USE.

ASSIGNMENT OF BENEFITS / RELEASE OF MEDICAL INFORMATION

I hereby authorize and request that payment of benefits by my primary insurance company, and my secondary insurance (if any) be made directly to Promising Horizons, LLC for services furnished to me or my dependent. I understand that my insurance company may only cover a portion of the total bill. I further understand that I may be responsible for all charges not covered by this assignment. In addition, I authorize Promising Horizons, LLC to disclose any and all written information from the insurance company and/or its designated representatives. Such disclosure shall be for reimbursement purposes for those services received.

I hereby release Promising Horizons, LLC, its officers, agents, employees and any clinical staff associated with my case, from all liability that may arise as a result of disclosure of information to the insurance company(s) or their designated representatives. By signing this assignment of benefits and release of information I acknowledge:

1. I am aware and understand that this authorization will not be used unless the insurance company(s) or their designated representatives request records of information for reimbursement purposes; or seek to take action reference payment for treatment services.
2. I agree to participate and assist Promising Horizons, LLC or its designated representatives with any appeal process necessary to collect payments for services rendered.
3. I am aware and have been advised of the provisions of Federal and State Statues, rules and regulations and provide for my right to confidentiality of these records.
4. I understand that this assignment and authorization is subject to revocation at anytime except to the extent that action has been taken in reliance thereof. In any event, this authorization will expire once reimbursement for services rendered is complete.
5. Promising Horizons, LLC is appointed by me to act as my representative and on my behalf in any proceeding that may be necessary to seek payment from my insurance carrier. This includes receiving a copy of my insurance plan's documents.
6. Should an overpayment take place, a refund check will be mailed to the authorized party that is due the overpayment.

I acknowledge receipt of a completed and signed copy of this assignment and release form.

_____ _____

Client Name Client Signature Date

_____ _____

Counselor Name Counselor Signature Date

HIPPA Compliance Form

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information.

Our Legal Duties
State and Federal laws require that we keep your medical records private. Such laws require that we provide you with this notice informing you of our privacy of information policies, your rights, and our duties. We are required to abide these policies until replaced or revised. We have the right to revise our privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to us in an evaluation, intake, or counseling session are covered by the law as private information. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information
Information about you may be used by the personnel associated with this clinic for diagnosis, treatment planning, treatment, and continuity of care. We may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with this clinic such as billing, quality enhancement, training, audits, and accreditation.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of this clinic not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person or persons, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Public Safety
Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

Abuse
If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, we may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

Prenatal Exposure to Controlled Substances
Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death
In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Professional Misconduct
Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings
Health care professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Other Provisions
When payment for services are the responsibility of the client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the time-frame, and the name of the clinic or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within the clinic or by outside sources specializing in (and held accountable for) such procedures.

In the event in which the clinic or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify us in writing where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only. If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information we will say that it is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

Your Rights

You have the right to request to review or receive your medical files. The procedures for obtaining a copy of your medical information is as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is $1.00 per page, plus postage.

You have the right to cancel a release of information by providing us a written notice. If you desire to have your information sent to a location different than our address on file, you must provide this information in writing.

You have the right to restrict which information might be disclosed to others. However, if we do not agree with these restrictions, we are not bound to abide by them.

You have the right to request that information about you be communicated by other means or to another location. This request must be made to us in writing.

You have the right to disagree with the medical records in our files. You may request that this information be changed. Although we might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

You have the right to know what information in your record has been provided to whom. Request this in writing.

If you desire a written copy of this notice you may obtain it by requesting it from the Clinic Director at this location.

Complaints

If you have any complaints or questions regarding these procedures, please contact the clinic. We will get back to you in a timely manner. You may also submit a complaint to the U.S. Dept. of Health and Human Services and/or the Idaho Bureau of Occupational Licenses. If you file a complaint we will not retaliate in any way.

Direct all correspondence to: Gregory M. Deitchler,
Promising Horizons Clinical Director
3061 S. Meridian Rd. Suite 100
Meridian, ID 83642

I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.

Client's name (please print): _____

Signature: _____ Date: _____/_____/_____

Signed by: __client __guardian __personal representative

CONSENT FOR TREATMENT AND ACKNOWLEDGMENT

I, hereby acknowledge that I have received, read and been given an opportunity to ask questions regarding the following Promising Horizons, LLC business documents. I understand that if I have any questions or concerns regarding these business documents, I may contact my clinician.

- ☐ Your Counselor's Informed Consent and Procedures
- ☐ Agreement to Pay
- ☐ Cancellation/No Show Policy
- ☐ Insurance Assignment of Benefits
- ☐ HIPAA-Notice of Privacy

I, voluntarily consent to participate in the intake, assessment and treatment process. I also acknowledge the following:

1. I have been given the opportunity for discussion of any concerns that I have regarding treatment.
2. I will be informed and take part in my treatment and goal planning.
3. I have been given no guarantee of treatment outcomes.
4. I have been informed of any and all fees associated with my treatment.
5. Promising Horizons, LLC will use and disclose personal health information for treatment and to receive payment for services provided.

Printed Name of Client	Signature of Client	Date
Printed Name of Parent/Guardian	Signature of Parent/Guardian	Date
Printed Name of Counselor	Signature of Counselor	Date