

William M. Adcock LCSW Counseling Intake

Confidential

The information asked for below is to help us understand you, your situation and to enable us to be of help to you. Please fill out this form as completely as you can.
All information will be held in strict confidence.

Date: _____

Name _____ Age _____ Birthdate _____

Address _____ Email _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

May we leave a message at these numbers? _____

Highest educational grade completed _____ Diploma or degree: _____

Present Household (names and ages) Children (names and ages)

Family income: _____

Have you experienced the death of spouse and if so, when? _____

Divorce(s) _____

Marital Status _____ Name of Spouse/Partner _____

How Long Have You Been Together with spouse/partner? _____

Closest Friend/Relative _____ Phone _____

Address _____ City _____ State _____ Zip _____

Military Information

Have you ever been in the military service? _____ Dates: _____

Which service? _____ Did you serve in combat? _____

Employment Information

Where do you work? _____

What is your job there? _____ How long? _____

If less than 6 months, previous employer: _____

What was your job there? _____ How long? _____

Religious Information (Optional)

Did you attend church in childhood? _____ If so, which church? _____

Do you attend now? _____ Where? _____

Are you a Christian? _____ Do you have personal religious practices and, if so, what are they? _____

Are there religious practices in your home and, if so, what are they? _____

There are times when prior medical and psychological records will be requested.

Please make sure that all information given below is correct.

Have you lost or gained weight in the last 6 months? _____ How much? _____

Are you dieting _____ If so what plan are you following? _____

Do You Smoke? _____ How Much? _____ Do You Drink? _____ How Much? _____

Do You Take Recreational Drugs _____ If yes, what kind? _____ How often? _____

Last Medical Examination _____ Reason _____

Are You Now Under a Doctor's Care? _____ If yes, Doctor's name: _____

Reason for Doctor's Care: _____

Are You Taking Any Medication? _____ If yes, what kind? _____

Reason for Medication: _____

Have You Ever Been Hospitalized for a Physical Illness? Describe: _____

Have you ever been Hospitalized for a Mental Illness, Personality Disorder, Anxiety Disorder, etc?

Describe: _____

Referral Information

How did you learn about the counselor at Forks? _____

If referred, by whom? _____ Title/relationship _____

Any Previous Therapy/Counseling? _____ If Yes, Name of Counselors: _____

When and Number of Sessions: _____

Reason for Therapy/Counseling: _____

What concerns do you bring to these counseling sessions? _____

Check Any of the Following That May Apply to You:

<input type="checkbox"/>	Headache	<input type="checkbox"/>	Inferiority Feelings	<input type="checkbox"/>	Shy With People
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Feel Tense	<input type="checkbox"/>	Can't Make Friends
<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	Feel Panicky	<input type="checkbox"/>	Afraid Of People
<input type="checkbox"/>	No Appetite	<input type="checkbox"/>	Fears and Phobias	<input type="checkbox"/>	Home Conditions Bad
<input type="checkbox"/>	Over-Eating	<input type="checkbox"/>	Obsessions	<input type="checkbox"/>	Unable To Have A Good Time
<input type="checkbox"/>	Stomach Trouble	<input type="checkbox"/>	Depressed	<input type="checkbox"/>	Always Worried About Something
<input type="checkbox"/>	Bowel Disturbances	<input type="checkbox"/>	Suicidal Ideas	<input type="checkbox"/>	Don't Like Weekends/Vacations
<input type="checkbox"/>	Always Tired	<input type="checkbox"/>	Take Tranquilizers	<input type="checkbox"/>	Can't Make Decisions
<input type="checkbox"/>	Always Sleepy	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Over-Ambitious
<input type="checkbox"/>	Unable To Relax	<input type="checkbox"/>	Dangerous Drugs	<input type="checkbox"/>	Financial Problems
<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	Allergy	<input type="checkbox"/>	Gambling
<input type="checkbox"/>	Recurrent Dreams	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Job Problems
<input type="checkbox"/>	Nightmares	<input type="checkbox"/>	Homosexuality	<input type="checkbox"/>	Can't Keep A Job
<input type="checkbox"/>	Hallucinations	<input type="checkbox"/>	Sexual Problems	<input type="checkbox"/>	Other

INFORMED CONSENT FOR COUNSELING

WHAT IS COUNSELING?

Counseling involves the development of a therapeutic relationship between a counselor and a client. While counseling cannot guarantee results, it is a process intended to help the client deal with mental, emotional, and behavioral problems and develop personal awareness and insight into oneself and others. Although many clients feel that they are able to make better decisions about their life following counseling, some clients experience changes that could produce disruption and turmoil in their lives. Should this happen the client is encouraged to discuss this with their counselor. Clients are free to terminate counseling at any time.

WHAT HAPPENS FIRST?

Your initial appointment with a counselor is called an intake session. During this session, the counselor will ask you detailed questions about your personal history, life situation, and your present concerns. You will also be asked to read and sign the informed consent, a notice of privacy practices and complete an intake form. If you have any questions or concerns about either form you are encouraged to discuss this with your counselor. Follow-up appointments may be scheduled unless the counselor believes that you would be better served by seeking counseling in the community.

LIMITS OF SERVICES

Counseling at Forks of Elkhorn Baptist Church is made by appointment during regular office hours and at other times when scheduled in advance and in collaboration with the counselor.

COST AND LENGTH OF COUNSELING

Pastoral Care is provided by all ministers of Forks of Elkhorn Baptist Church as needed and as the schedule permits. **There is no charge for these services.**

Clinical Issues are handled by mental health professionals, such as psychologists, licensed clinical social workers, certified social workers under supervision, mental health counselors and other licensed mental health professionals. Usually these professionals are working in conjunction with medical professionals to meet both physical and emotional needs of clients. While our counselor, is certified to provide these services, ethical dilemmas may prevent him from entering into a therapeutic relationship with members of the church. In most cases, a dual relationship is considered an ethical conflict. If it is determined there is an issue relating to dual relationships, a decision about referral to another counselor will be made. If you are referred to another counselor for clinical purposes and cannot afford it, we can exhaust avenues for helping with the cost of these services.

For those seeking counseling who are NOT members of Forks of Elkhorn Baptist Church, There is a charge for these services and appointments will be scheduled after regular office hours. Fees for nonmembers and inactive members (not attended in the last six months) are on a sliding scale which is currently no more than \$75 per session and no less that \$50 per session; however, the counselor may waive or lower the fee based on your personal financial situation. **We cannot bill insurance for this service.** Each session will last for no more than 50 minutes. Sessions will continue until the counselor and/or the client determine that further sessions are no longer necessary.

IS EVERYTHING CONFIDENTIAL?

Information is kept confidential except when the counselor is compelled to release information as mandated by state law. Circumstances that would require a counselor to release confidential information include but are not exclusive to:

1. The written consent of the client, or in the case of death or disability, the person's personal representative, other person authorized to sue, or the beneficiary of an insurance policy on the person's life, health, or physical condition.
2. Disclosure of information that concerns potential harm to the client or others.
3. Review of the file by the counselor's supervisor.
4. If the client is a minor, and the information acquired by the counselor indicates that the client was the victim or subject of a crime, the counseling consultant may testify upon any examination, trial, or other proceedings in which the commission of the crime is the subject of the inquiry.
5. If the client waives the privilege by bringing charges against the counselor.
6. In response to a subpoena from a court of law, only records related to a complaint or report under Kentucky Statutes.
7. The counselor has reasonable cause to believe that a child, adult dependent, or a developmentally disabled person has suffered abuse or neglect.

COUNSELOR INFORMATION

William (Bill) M. Adcock, is a graduate of the University of Tennessee with a Bachelor of Science in Music Education, and a Master of Science in Social Work (Clinical Track). In addition he holds a Masters in Music (Church Music and Music Education) from the Southern Baptist Theological Seminary in Louisville, Kentucky.

Bill is a Certified Social Worker working towards licensure as a Licensed Clinical Social Worker (LCSW) in the Commonwealth of Kentucky. The Supervisor of Record is George Dunn, LCSW with Shelby Counseling Associates in Louisville, Kentucky. Additional supervisors are Isaac G. Manis, (LCSW) Associate professor, University Department of Psychiatry in Lexington, Kentucky and Joe D. States, (LCSW), Veterans Administration Hospital, Department of Psychological Services, Lexington, Kentucky. Bill, George, Isaac and Joe practice within the guidelines prescribed by the laws and regulations pertaining to the practice of social work in the Commonwealth of Kentucky. A copy of the law can be provided upon request.

I have read and understood my rights and responsibilities as a client who is receiving counseling services at the Forks of Elkhorn Baptist Church. I am in receipt of a copy of this informed consent.

Client's Name (print) Date

Client's Signature

Counselor's Name (print) Date

Counselor's Signature

PRIVACY STATEMENT

This notice describes how mental health information about you may be used and disclosed and how you may obtain access to this information. Please review it carefully

All care is overseen and supervised by a licensed mental health professional. All information describing your mental health treatment and related health care services ("mental health information") is person and we are committed to protecting the privacy of the personal and mental health information you disclose to us. We are required by law to maintain the confidentiality of information that identifies you and the care you receive. When we disclose information to other persons and companies to perform services for us, we require them to protect your privacy, too. This Notice also applies to your psychologist, counselor, psychiatrist and other health care professionals who provide care to you. We must also provide certain protections for information related to your medical diagnosis and treatment, including HIV/AIDS, and information about alcohol and other substance abuse. We are required to give you this Notice about our privacy practices, your rights and our legal responsibilities.

WE MAY USE AND DISCLOSE YOUR MENTAL HEALTH INFORMATION

For TREATMENT, For example, we may give information about your psychological condition to other health care providers to facilitate your treatment, referrals for consultations.

For PAYMENT, For example, we may contact your insurer to verify what benefits you are eligible for, to obtain prior authorization, and to receive payment from your insurance carrier.

For HEALTHCARE OPERATIONS, For example, we give information to medical services providers to review the quality of care provided, for performance, improvement or for the training of health professionals

For APPOINTMENTS AND SERVICES to remind you of an appointment, or tell you about treatment alternatives or health related benefits or services.

To INDIVIDUALS INVOLVED IN YOUR CARE such as your parents, if you are a minor, or your conservator

WITH YOUR WRITTEN AUTHORIZATION.

We may use or disclose mental health information for purposes not described in this Notice only with your written authorization.

WE MAY USE YOUR MENTAL HEALTH INFORMATION FOR OTHER PURPOSES WITHOUT YOUR WRITTEN AUTHORIZATION

As REQUIRED BY LAW when required or authorized by other laws such as the reporting of child abuse, elder abuse or dependent adult abuse

For HEALTH OVERSIGHT ACTIVITIES to governmental, licensing, auditing, and accrediting agencies as authorized or required by law including audits; civil, administrative or criminal investigations, licensure or disciplinary actions; and monitoring of compliance with law.

In JUDICIAL PROCEEDINGS in response to court/administrative orders, subpoenas, discovery requests or other legal process

To PUBLIC HEALTH AUTHORITIES to prevent or control communicable disease, injury or disability, or ensure the safety of drugs and medical devices

To LAW ENFORCEMENT for example, to assist in an involuntary hospitalization process

To THE STATE LEGISLATIVE SENATE OR ASSEMBLY RULES COMMITTEES for legislative investigations

For RESEARCH PURPOSES subject to a special review process and the confidentiality requirements of state and federal law

To PREVENT A SERIOUS THREAT TO HEALTH OR SAFETY of an individual, we may notify the person, tell someone who could prevent the harm or tell law enforcement officials

To PROTECT CERTAIN ELECTIVE OFFICERS including the President, by notifying law enforcement officers of potential harm

YOU HAVE THE FOLLOWING RIGHTS:

1. To receive a copy of this Notice when you obtain care
 2. To Request Restrictions. You have the right to request a restriction or limitation on the mental health information we disclose about you for treatment, payment or health care operation. You must put your request in writing. We are not required to agree with your request. If we do agree with the request, we will comply with your request except to the extent that disclosure has already occurred or if you are in need of emergency treatment and the information is needed to provide the emergency treatment
 3. To Inspect and Request a Copy of your Mental Health Record except in limited circumstances. A fee will be charged to copy your record. You must put your request for a copy of your records in writing. If you are denied access to your mental health record for certain reasons, we will tell you why and what your rights are to challenge that denial
 4. To Request an Amendment and/or Addendum to your Mental Health Record. If you believe that information is incorrect or incomplete, you may ask us to amend the information or add an addendum (addition to the record) of no longer than 250 words for each inaccuracy. Your request for amendment and/or addendum must be in writing and give a reason for the request. We may deny your request for an amendment if the information was not created by us, is not a part of the information which you would be permitted to inspect and copy, or if the information is already accurate and complete. Even if we accept your request, we do not delete any information already in your records
 5. To Receive an Accounting of Certain Disclosures we have made of your mental health information. You must put your request for an accounting in writing
 6. To Request That We Contact You by Alternate Means (e.g. fax versus mail) or at alternate locations. Your request must be in writing, and we must honor reasonable request
- CHANGES TO THIS NOTICE:** We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective

for information we already have about you as well as any information we receive in the future

If you believe your privacy rights have been violated you may file a complaint with the Secretary of the Department of Health and Human Services for the Commonwealth of Kentucky or any HIPPA Officer

YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT

Effective date: June 1, 2006

Revised: March 18, 2009