

# *Your Space Counseling, LLC*

1621 Tongass Avenue, Suite 305

Ketchikan, AK 99901

907-247-5000

907-247-5001-Fax

*info@lynchtherapy.com*

Thank you very much for considering Your Space Counseling for your mental health needs.

Please fill out the following information. Answer the questions as best you can. Any areas that are confusing can be addressed when we meet.

Our first meeting will last between one to two hours.

Once therapy begins, I will arrange weekly appointments. I make every effort to accommodate your schedule; however, there may be some times during the day that are unavailable. Afternoons tend to get booked quickly. After we agree on a day and time, I will hold this appointment for you. I charge \$150 for missed appointments that are not due to illness or emergency.

I am happy to answer any questions you may have. Please do not hesitate to contact me.

*Sincerely,*

*Roseann Lynch LPC, NCC, RPT, CDC I*

*Nationally Certified Counselor, Licensed Professional Counselor, Registered Play Therapist, Chemical Dependency Counselor I*

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Ketchikan, AK 99901  
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## Today's Date:

*Legal Name of Client:*

*D.O.B.*

*Mailing Address:*

*Home Phone:*

*Cell Phone:*

*Email Address:*

*Referred by:*

*Emergency Contact:*

*Phone:*

*Name of Insurance Carrier:*

*Phone:*

*Name of Insured:*

*D.O.B.*

*Insured's SS #:*

*Insurance ID #:*

*Insurance Address:*

*Insurance Phone Number:*

*Relationship to Insured:*

*Insurance Group #:*

*What problem would you like help with?*

*When did this problem first begin?*

*What has been tried to solve this problem?*

*Please list medical conditions:*

<i>Medication:</i>	<i>dosage:</i>	<i>Medication:</i>	<i>dosage:</i>
<i>Medication:</i>	<i>dosage:</i>	<i>Medication:</i>	<i>dosage:</i>

*Physician's Name:*

*Please list previous mental health treatment:*

*Please list any significant accidents:*

*Would you like help with drug problems?*       *Yes*       *No*

*Would you like help with alcohol problems?*       *Yes*       *No*

*Have you ever attempted suicide?*       *Yes*       *No*

*If you answered yes, when did you make an attempt?*

*Do you have suicidal thoughts now?*       *Yes*       *No*

*Is there anything else you would like me to know about you?*

*If you need to cancel or reschedule an appointment, please give **24 business hours** advance notice, **OTHERWISE YOU WILL BE BILLED AT THE HOURLY RATE.***

Mental Health counseling is a medical service and as such, there is no guarantee that your insurance company will cover all recommended services.

I agree that I am financially responsible for all unpaid balances, collection fees, interest earned fees and attorney fees should this account be sent to a collection service. **Fees:** Intake-\$275, Individual Therapy-\$150, Family Therapy-\$180, Couples Counseling- \$180,Interactive Therapy-\$175.

**\*\*Unpaid balances** will be sent to Cornerstone Collections.

*In the event your check is returned for insufficient funds, you will be charged the bank fee not to exceed \$35.*

**Signature(s)** \_\_\_\_\_ **Date** \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS:** *I have read and received a copy of the, Notice of Privacy Practices and Client Rights document.*

**Signature(s)** \_\_\_\_\_ **Date** \_\_\_\_\_

*I sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask.*

### **Activity Patterns**

Are you having difficulty falling asleep?       YES     NO  
Are you waking early and unable to fall back asleep?       YES     NO  
What is your typical weight?      \_\_\_\_\_

### **Physical Anxiety** (4)

Which of these have you experienced in the last two weeks?

<input type="checkbox"/> pounding heart	<input type="checkbox"/> excessive sweating	<input type="checkbox"/> trembling/shaking
<input type="checkbox"/> chills or hot flushes	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> feeling of choking
<input type="checkbox"/> chest pain or discomfort	<input type="checkbox"/> nausea or stomach ache	<input type="checkbox"/> dizzy or lightheaded
<input type="checkbox"/> tingling fingers or face	<input type="checkbox"/> fear of losing control	<input type="checkbox"/> fear of dying
<input type="checkbox"/> feeling detached from yourself		

### **General Anxiety** (3)

Which of these have been a problem for you in the last two weeks?

<input type="checkbox"/> poor concentration or your mind goes blank	<input type="checkbox"/> easily fatigued	<input type="checkbox"/> muscle tension	
<input type="checkbox"/> restless sleep	<input type="checkbox"/> uncontrollable worries	<input type="checkbox"/> feeling restless, keyed up, edgy	<input type="checkbox"/> irritable

### **Other Physical Symptoms**

Which of these have been a problem over the past week?

<input type="checkbox"/> headache	<input type="checkbox"/> joint pain	<input type="checkbox"/> frequent urination
<input type="checkbox"/> neckache	<input type="checkbox"/> abdominal pain	
<input type="checkbox"/> back pain	<input type="checkbox"/> diarrhea	

### **Focus Problems** (6)

Which of these have you experienced over the past two weeks?

<input type="checkbox"/> attention to details or careless mistakes	<input type="checkbox"/> maintaining attention	<input type="checkbox"/> listening to others
<input type="checkbox"/> finishing projects	<input type="checkbox"/> organizing tasks	<input type="checkbox"/> doing work or homework
<input type="checkbox"/> losing things	<input type="checkbox"/> too distractible	<input type="checkbox"/> too forgetful

### **Activity Symptoms** (6)

Which of these have you experienced over the past two weeks?

<input type="checkbox"/> fidgeting/squirming	<input type="checkbox"/> problems sitting still	<input type="checkbox"/> restless feelings	<input type="checkbox"/> difficulty quieting down
<input type="checkbox"/> on the go	<input type="checkbox"/> talking excessively	<input type="checkbox"/> blurting out answers	<input type="checkbox"/> interrupting others
<input type="checkbox"/> problems waiting your turn			

### **Emotions**

Which have you felt in the past two weeks?

on top of the world!     sad     hopeless     anxious     irritable     angry  
 lonely     empty

### **Low Feelings** (5)

Which of these have you experienced in the past two weeks?

depressed most of the time     loss of interest or pleasure in most activities     change in weight  
 sleeping too little     sleeping too much     slow down     restless  
 low energy/fatigue     feeling guilty     feeling worthless     difficulty concentrating  
 recurrent thoughts of death

### **Atypical Low Feelings** (3)

Which of these have you experienced in the past two weeks?

good news cheers you up     hungry and gaining weight     want to sleep too much  
 feel paralyzed and unmotivated     sensitive to rejection

### **Emotional Activation** (1)

feeling quite irritable     feeling super good     feeling unrestrained

### **Behavioral Activation** (3/4)

In the last two years, which of these have you felt for a week or more?

feeling like you could “lick” the world     talking more than usual or interrupting others  
 needing less sleep     rapid or racing thoughts     easily distracted     impulsive actions  
 agitated or over focused on activities

### **Other Activated Conditions**

In the last two years, which of these have you felt for a *week or more*?

feeling tremendous energy     not sleeping for days     intense work/social life  
 spending too much money     feeling lots more sociable     more sexually aware  
 can't finish projects     working 12 hrs a day     working all night  
 need constant distraction     feeling overwhelmed     can't cope  
 jumping out of your skin     morning panic     overactive thoughts  
 not feeling right in your body     worrying about disease     taking sudden trips

### **Adult Experiences**

Which if these have you *ever* experienced as an adult (when not intoxicated)?

ringing in your ears     knowing others' thoughts     sense of leaving your body  
 having visions     amnesia episodes     hear noises OR voices others can't hear

### **Social Anxiety**

Are you often:

excessively anxious in social situations     afraid of being embarrassed in front of others?  
 If so, do these feelings interfere with your life?     Yes     No

### **Past Behavior**

Which of these have you *ever* done on purpose as an adult?

binge eating     using laxatives to diet     suicide attempt(s)

What type of alcohol do you like to drink? \_\_\_\_\_.  
How much do you drink? \_\_\_\_\_.  
What type of drug/s do you like to use? \_\_\_\_\_.  
How much do you use drugs? \_\_\_\_\_.  
How much do you use alcohol? \_\_\_\_\_.

Have you ever tried to stop drinking or using drugs?  Yes  No If yes, for how long?

What helped you to stop drinking or using drugs?

Has any of the following occurred after you tried to stop drinking/using drugs? Circle all that apply:

**Easily irritated depressed fatigued shakes confusion can't think clearly anxious nervous  
jumpy headaches face/hand sweating clammy skin nauseau/vomiting hands shaking involuntary  
body movements confusion hallucinations feverish black outs memory loss  
Emotions going up and down**

What are some goals you would like to work on in therapy?

- 1.
- 2.
- 3.

## CLIENT RIGHTS

### **Right to request how I contact you**

It is my normal practice to communicate with you at your home address and daytime phone number you gave me when you scheduled your appointment, about health matters, such as appointment reminders etc. Sometimes I may leave messages on your voicemail. You have the right to request that I communicate with you in a different way.

### **Right to release your medical records**

You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that I acted in reliance on such authorization.

### **Right to inspect and copy your medical and billing records.**

You have the right to inspect and obtain a copy of your information contained in my medical records. To request access to your billing or health information, contact me. Under limited circumstance I may deny your request to inspect and copy. If you ask for a copy of any information, I may charge a reasonable fee for the costs of copying, mailing and supplies.

### **Right to add information or amend your medical records.**

If you feel that information contained in your medical record is incorrect or incomplete, you may ask me to add information to amend the record. I will make a decision on your request within 60 days, or some cases within 90 days. Under certain circumstance, I may deny your request to add or amend information. If I deny your request, you have a right to file a statement that you disagree. Your statement and my response will be added to your record. To request an amendment, you must contact me. I will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

### **Right to an accounting of disclosures.**

You may request an accounting of any disclosures, if any, I have made related to your medical information, except for information I used for treatment, payment, or health care operational purposes or that I shared with you or your family, or information that you gave me specific consent to release. It also excludes information I was required to release. To receive information regarding disclosure made for a specific time period no longer than six years after today's date, please submit your request in writing to me. I will notify you of the cost involved in preparing this list.

### **Right to request restrictions on uses and disclosures of your health information.**

You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to me. However, I am not required to agree to such a request.

### **Right to complain.**

If you believe your privacy rights have been violated, please contact me personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. You will not be retaliated against for filing such a complaint.

### **Right to receive changes in policy.**

You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from me.

## **HIPPA NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**Effective date: April 14, 2010**

Your Space Counseling has been and will always be totally committed to maintaining client's confidentiality. I will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

This notice describes my policies related to the use and disclosure of your healthcare information.

**Use and disclosures of your health information for the purposes of providing services:** Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allows me to use and disclose your health information for these purposes.

**TREATMENT:** I may need to use or disclose health information about you to provide, manage or coordinate your care or related services; which could include consultants and potential referral sources.

**PAYMENT:** Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. I may bill the person in your family who pays for your insurance.

**HEALTHCARE OPERATIONS:** I may need to use information about you to review your treatment procedures and business activity. Information may be used for certification, compliance and licensing activities.

**Other uses or disclosures of your information which does not require your consent** There are some instances where I may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse: then by Alaska State Law, I am obligated to report this to the Office of Children's Services. I may also disclose information without your consent if you provide information that informs me that you are in danger of harming yourself or others and is someone is harming you, information to remind you of /or to reschedule appointments or treatment alternatives, information shared with law enforcement if a crime is committed on my premises or against myself or as required by law such as a subpoena or court order.

## **Informed Consent**

Thank you for choosing Your Space Counseling. Your first appointment will take approximately 60-90 minutes. Each individual therapy session will occur for 45-60 minutes. Marriage or Family sessions are generally 50- 90 minutes. I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of my policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and I will try my best to give you all the information you need.

### **Information about me:**

I am Roseann Lynch. I have earned a Bachelor of Science Degree in Teaching from the University of New York: York College, a Masters Degree in Counselor Education from the University of New York: Queens College and an Advanced Graduate Certificate in Marriage, Family and Couples Counseling from Regent University. I am licensed by the State of Alaska as a Licensed Professional Counselor. I have experience working with infants, children, adolescents, families, couples and adults. I have credentials as a Nationally Certified Counselor, Registered Play Therapist and Chemical Dependency Counselor- 1. I utilize Cognitive Behavioral Therapy, Eye Movement Desensitization and Reprocessing Therapy, Sensorimotor Psychotherapy Sand Tray Therapy and Child Centered Play Therapy during individual, group, couples and family therapy sessions; although other treatment approaches may be used depending on the person or condition.

### **EMERGENCY SITUATIONS:**

*In the event I become incapacitated or deceased, Patti Hauser, Licensed Clinical Social Worker and Chemical Dependency Counselor 2 will contact you.*

*If an emergency situation for which you feel immediate attention is necessary and I am unable to return a call within 15 minutes, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. Your Space Counseling will follow up with those emergency services with standard counseling and support to the client or the client's family.*

**FINANCIAL/INSURANCE ISSUES:** *As a courtesy I will bill your insurance company, HMO, responsible party or third party payer for you. I ask that every client authorize payment of medical benefits directly to Your Space Counseling. Mental Health Billing Services (MHBS) will bill your insurance company for services I provide. There may be times when your insurance does not cover a service or your deductible has not been met. When this happens, MHBS will send you a bill for payment. If you have questions regarding your coverage, please contact your insurance company and if you have questions regarding a bill, please contact: MHBS at 907-258-6427.*

**\*\*Unpaid balances** can incur the risk of being sent to Cornerstone Collections. **Fees:** Intake-\$275, Individual Therapy-\$150-180, Family Therapy and Couples Counseling- \$180, Interactive Therapy-\$175.

**\*\*Same Day Cancellations:** will be charged \$150 for adults and \$75 for children under the age of 18.

