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 1
Nationally Certified Counselor, Licensed Professional Counselor, Registered Play Therapist, Chemical Dependency Counselor 1
Eye Movement Desensitization and Reprocessing CertifiedTherapist

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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:

Medication: ***dosage:*** ***Medication:*** ***dosage:***
Medication: ***dosage:*** ***Medication:*** ***dosage:***

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.

The following questions are focused on symptoms you may experience. Please answer as best you can.

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?

__pounding heart __excessive sweating __trembling/shaking
__chills or hot flushes __shortness of breath __feeling of choking
__chest pain or discomfort __nausea or stomach ache __dizzy or lightheaded
__tingling fingers or face __fear of losing control __fear of dying
__feeling detached from yourself

General Anxiety (3)

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

__poor concentration or your mind goes blank __easily fatigued __muscle tension
__restless sleep __uncontrollable worries __feeling restless, keyed up, edgy
__irritable

Other Physical Symptoms

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

__headache __joint pain __frequent urination
__neckache __abdominal pain
__back pain __diarrhea

Focus Problems (6)

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

__attention to details or careless mistakes __maintaining attention __listening to others
__finishing projects __organizing tasks __doing work or homework
__losing things __too distractible __too forgetful

Activity Symptoms (6)

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

__fidgeting/squirming __problems sitting still __restless feelings __difficulty quieting down
__on the go __talking excessively __blurting out answers

__interrupting others
__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 goals for yourself would you like to work on?

1.

2.

3.

The following are questions regarding your relationship. Please answer as best you can.

1. What would you say is the most important thing you want to see change due to coming to couples counseling?

2. What is a strength for the two of you as a couple?

3. Have any of these things happened in your relationship? (circle one)			
a. Physical pushing, shoving, pinning or hitting	Yes, this happened in the past year	Never	Not in the past year
b. Not letting me do things I wanted to do (see friends, go on a trip, individual activities…)	Yes, this happened in the past year	Never	Not in the past year
c. Being jealous of relationships	Yes, this happened in the past year	Never	Not in the past year
d. Using a weapon, knife, gun or threatening to	Yes, this happened in the past year	Never	Not in the past year
e. Yelling, screaming, cursing or verbal attack	Yes, this happened in the past year	Never	Not in the past year

4. Is there any history of infidelity in your relationship?

None	**Yes, emotional affair only**	**Yes, physically romantic affair**	**Yes, there is a current relationship with someone else**

Clinical Couples Assessment of Relationship Elements (CARE)

Please rate your relationship on the following seven areas from 1- couldn't be worse to 7- couldn't be better.

Think about your relationship in terms of the last **2 weeks.**

	Couldn't be worse			Not bad not good			Couldn't be better
Communication	1	2	3	4	5	6	7
Resolution of differences	1	2	3	4	5	6	7
Freedom from blaming your partner when things go wrong	1	2	3	4	5	6	7
Willingness to admit to having hurt your partner and ask your partner for forgiveness	1	2	3	4	5	6	7
Ability to forgive your partner after a hurt	1	2	3	4	5	6	7
Intimacy & Closeness	1	2	3	4	5	6	7
Central Values & priorities of what is important in life	1	2	3	4	5	6	7
My thoughts about our relationship being positive and hopeful	1	2	3	4	5	6	7
Commitment to my partner for the long term	1	2	3	4	5	6	7

Created by Worthington et al, 1997 & Ripley (2009)

Relationship Efficacy Measure

How do you feel about your ability to handles problems in your relationship? Please answer each question.

		Strongly Disagree						Strongly Agree
1.	**I have little control over the conflicts that occur between my partner and I.**	1	2	3	4	5	6	7
2.	**There is no way I can solve some of the problems in my relationship.**	1	2	3	4	5	6	7
	When I put my mind to it I can resolve just about any disagreement that comes up between my partner and I.	1	2	3	4	5	6	7
1.	**I often feel helpless in dealing with the problems that come up in my relationship.**	1	2	3	4	5	6	7
2.	**Sometimes I feel that I have no say over issues that cause conflict between us.**	1	2	3	4	5	6	7
3.	**I am able to do the things needed to settle our conflicts.**	1	2	3	4	5	6	7
4.	**There is little I can do to resolve many of the important conflicts between my partner and I.**	1	2	3	4	5	6	7

Dyadic Trust

Circle the number that indicates where, on a scale of 1 to 5, you would agree with these eight statements.

	Strongly Disagree		Neutral		Strongly Agree
1. My partner is primarily interested in his (her) own welfare.	1	2	3	4	5
2. There are times when my partner cannot be trusted.	1	2	3	4	5
3. My partner is perfectly honest and truthful with me.	1	2	3	4	5
4. I feel that I can trust my partner completely.	1	2	3	4	5
5. My partner is truly sincere in his (her) promises.	1	2	3	4	5
6. I feel that my partner does not show me enough consideration.	1	2	3	4	5
7. My partner treats me fairly and justly.	1	2	3	4	5
8. I feel that my partner can be counted on to help me.	1	2	3	4	5

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 scheduling appointments. 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 INFORMATIION. 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 50 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 am also certified in Eye Movement Desensitzation and Reprocessing (EMDR). 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.

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 will be sent to Cornerstone Collections. Fees: Intake-$275, Individual Therapy-$150, Family Therapy and Couples Counseling- $180, Interactive Therapy-$175. Cancellation fee: $150, when the cancellation is not due to***