THANK YOU FOR CHOOSING OUR OFFICE

The following are the forms you will need to review and complete prior to your first appointment with Laura Shockley, LCPC. All these forms are fillable via the computer. We will need these forms returned before your appointment so once you fill them out, please either print and mail them to our office, or fax them to us at 208-323-9604 or save them on your computer and email them to us at newpatients@sage-healthcare.com

1. **Policy and Practices**
2. **Financial Agreement Form**
3. **Notice of Privacy Practices**
4. **Acknowledgment/Message Permission Form**
5. **Client Intake Questionnaire Form**
6. **Release of Information Form**

If you have insurance you wish us to bill, please call us with your insurance information. If you have any questions about your first appointment or in general, the answer may possibly be found on our website under "*Frequently Asked Questions*" or please call our office at 208-323-1125.

Laura Shockley Counseling, LLC
Laura Shockley, LCPC
413 N Allumbaugh Street, Suite 101
Boise, ID 83704
(208) 323-1125

Information about your Therapist
I have been a therapist since 2001. I hold a Masters Degree in Counseling with an undergraduate degree in Criminal Justice, Elementary and Secondary Education. I also have my clinical license so my title is Licensed Clinical Practicing Counselor and I am licensed to practice counseling in the state of Idaho. I work mainly with individuals but do see couples and families as well. I also work with adolescents addressing a wide variety of issues. My practice is based on personal integrity and commitment to my client.

Psychological Treatment
Therapy is a large commitment of time, money, and energy so your therapist should be carefully chosen. It is of utmost importance that you feel comfortable, safe and trusting with your counselor. Depending on the experiences that have led you to seek treatment, it may take some time to feel safe and trusting so, if at any point you decide you are not connecting with me, please know I will assist you in finding another qualified therapist and with your consent, I will provide him or her with the essential information needed to better meet your individual issues.

Psychotherapy is a collaborative relationship and requires your active involvement in the process of change. The foundation of my therapy is based on the idea that past events and relationships are strongly connected to our current behaviors based on beliefs about ourselves. Although we can not change our past, we can re-process through it, so negative events that left us with our negative beliefs can be re-examined. We must first understand what drives our behavior before we can begin moving toward changing it. Offering your views and responses when they are important to you is one of the ways you will be an active partner in this process. This is why it is important for me to establish a safe, trusting environment so you feel comfortable to open up and express what you are thinking and feeling. I firmly believe that a strong foundation needs to be built in order for real change to occur. You will be the one in control of deciding the speed at which this change will happen, depending on where you are emotionally. Therefore, when I assign “homework” it isn’t necessarily whether you do or don’t do what I suggest, rather it is about why you did or didn’t do it. Processing through the thoughts and feelings that drive your behavior is what is important. During therapy you will undoubtedly experience negative feelings. Acknowledging and processing through them might be frightening and uncomfortable so at anytime you experience distress, please communicate that to me. Despite this, you should know that psychotherapy has been repeatedly scientifically demonstrated to be beneficial for most people.

Financial Policies
Full payment or co-payment is due at the time of service. The office will accept cash, check, or Visa/MasterCard.
Your insurance policy is a contact between you and your insurance company. I am not a party to that contract. I will, however, bill all primary insurance as a service to my clients. If your insurance has not paid your account in full within sixty days of billing, I will require the balance to be paid in full. My patient accounts department will however, make every effort to help you resolve any problems which your insurance company may have with paying your claim.

In addition to our regularly scheduled appointments, it is my practice to charge for other professional services you may require such as report writing, letter writing, and telephone conversations lasting longer than 15 minutes, attendance at meetings or consultations with other professionals. That your have authorized, preparation of records or treatment summaries, or completions of other services you have requested of me.
If a check is returned for insufficient funds, a $25 returned check fee will be charged to your account.

Emergency Situations
For emergencies after hours, please call Intermountain Hospital at 277-8400 or go to your nearest emergency room.

Cancellation and No Show Policy
If you need to change or cancel an appointment, please do so as soon as possible. If cancellation does not occur at least 24 hours prior to your appointment or you miss your appointment, you will be charged after your first missed appointment or late cancel appointment. I know occasional, unforeseen events occur that are unavoidable that result in a "late cancellation". However, upon two no shows, late cancellations, or a combination of the two, services may be suspended if there is no communication about rescheduling. You will be charged $75.00 after one late cancel and/or a missed appointment. (Your insurance company will not cover this type of fee.)

Your Rights as a Client

1. You have the right to ask questions about any procedures used during therapy. If you wish, I will explain the approach and methods use.
2. Your have the right to end therapy at any time without any moral, legal, or financial obligation other than those already accrued. However, prior to termination, I suggest that a meeting be scheduled to discuss further recommendations.
3. One of your most important rights involves confidentiality. Within certain limits, information revealed by you during therapy will be kept confidential and will not be revealed to any other person or agency without your written permission. At times, therapy will involve the participation of more than one family member and/or significant person(s), therefore I do not guarantee confidentiality between participants in the therapy session.

4. There are also certain situations in which I am required by law to reveal information obtained during therapy to other persons or agencies **without your permission.** Also, I am not required to inform you of my actions in this regard. These situations are as follows:
    a) If you threaten bodily harm or death to another person, I may be required by law to inform the intended victim and appropriate law enforcement agency.
    b) If you threaten bodily harm or death to yourself, I may inform the law enforcement agencies and others (such as a spouse, friend or an inpatient psychiatric, institution) who could aide in prohibiting you from carrying out your threats.
    c) If the court of law issues a legitimate subpoena, I may be required to provide the information described n the subpoena.
    d) If you reveal information relative to child abuse or neglect, I am required by law to report this to the appropriate authority.
    e) I you are in therapy or being tested by order of a court of law, the results of the treatment or test ordered may be revealed to the court.

Limitations of the Therapy Contract

A. I am not a physician and cannot prescribe medication or give recommendations about physical problems. Nevertheless, depending on the nature of the presenting problems, I may require you to consult with a physician before proceeding with therapy.
B. I can not guarantee that each person's goals in therapy will be met completely. Seeking resolve issues between family members and other persons can lead to discomfort, as well as relationship changes that may not be originally intended.

Signature Section

I have read, understood, and agree to the contents and terms of this document.

X_____ Date_____

X_____Date_____

FINANCIAL AGREEMENT

Provider**: Laura Shockley, LCPC**

CLIENT INFORMATION Preferred Pronouns: ☐ she/her/hers ☐ He/him/his ☐ They/them/theirs ☐ Other: Please specify:_____

Legal Patient Name_____DOB_____SS#_____

Address_____City_____State_____ Zip_____

Phone #_____Can we leave messages at this number: Yes____☐__No____☐

Gender Assigned at Birth: F____☐__M____☐ Other_____Decline to Answer____☐____Marital Status: S____☐ D____☐ W____☐ Other_____

Current Gender: F____☐__M____☐ Other_____Decline to Answer____☐____Preferred Name: _____

Employer:_____Work Phone#_____

Address_____City_____State_____ Zip_____

SPOUSE/PARTNER INFORMATION: Name**:** _____DOB_____SS#_____

Employer:_____Work Phone#_____

FINANCIAL RESPONSIBLE (If other than Client)

Name_____DOB_____SS#_____

Address_____City_____State_____ Zip_____

Ph#_____Employer: _____Work#_____

EMERGENCY CONTACT: Name_____DOB_____SS#_____

Address_____City_____State_____ Zip_____Ph#_____

INSURANCE INFORMATION

Primary Insurance_____ Policyholder Name_____

Policyholder ID#_____ Group #_____ Employer_____

Secondary Insurance_____ Policyholder Name_____

Policyholder ID#_____ Group #_____ Employer_____

OFFICE POLICY: Payment is due at the time of service. You are responsible for all fees regardless of insurance coverage. We charge $25.00 for all returned checks. As a courtesy, we will submit claims to the above-named insurance company. Benefits quoted by your insurance company are not a guarantee of payment. If your insurance company has not paid your claim within 60 days, the payment of the claim will be your responsibility. We do not bill for the following: student insurance, retroactive Medicaid, victims and workers' compensation, or third parties listed in divorce decrees. All minors must be accompanied by a parent or legal guardian. If your insurance company requires an authorization or referral for your visit, you are responsible to obtain and maintain the authorization or referral. Our providers do not do disability paperwork or FMLA until you have been an established patient for at least 6 months.

ASSIGNMENT OF BENEFITS: I request that payment of authorized insurance benefits be made on my behalf to Sage Health Care or the provider of my choice for any services furnished to me by that provider. I authorize the holder of medical information about me or any information needed to determine these benefits to be released to the insurance company(s) listed above.

Policyholder Signature or Responsible Party_____Date_____

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.

We are required by law to maintain the privacy of your health information, to notify you of our legal duties and privacy practices with respect to your health information and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your protected health information. Our duties and your rights are set forth more fully in 45 C.F.R. part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. USES AND DISCLOSURES OF INFORMATION THAT WE MAY MAKE WITHOUT WRITTEN AUTHORIZATION

We may use or disclose protected health information for the following purposes without your written authorization. These examples are not meant to be exhaustive.

TREATMENT: We may use or disclose your protected health information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.

PAYMENT: We may use or disclose protected health information so that we, or other health care providers, may obtain payment for treatment provided to you. For example, we may disclose information from your medical records to your health insurance company to obtain pre-authorization for treatment or submit a claim for payment.

HEALTHCARE OPERATIONS: We may use or disclose protected health information for certain health care operations that are necessary to run our practice and ensure that our patients receive quality care. For example, we may use information from your medical records to review the performance or qualifications of physicians and staff; train staff; or make business decisions affecting our practice.

Other Uses or Disclosures: We may use or disclose your health information for certain other allowed by 45 CFR part 164.512 or other applicable laws and regulations, including the following:

- To avoid a serious threat to your health or safety or the health or safety of others.
- As required by state or federal law such as reporting abuse, neglect or certain other events.
- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the military or correctional institutions.
- For research purposes if certain conditions are satisfied.
- To our third party business associates who perform activities involving protected health information for us, e.g., billing or transcription services. Our contracts with the business associates require them to protect your health information.

2. USES AND DISCLOSURES OR INFORMATION THAT WE MAY MAKE UNLESS YOU OBJECT

Unless you instruct us otherwise, we may use and disclose protected health information in the following instances without your written authorization:

FACILITY DIRECTORIES: Unless you object, we will include your name, your location in our facility, your general condition, and your religious affiliation in our facility directory. We may disclose the foregoing information to clergy and, except religious affiliation, to people who ask for you by name.

PERSONS INVOLVED IN YOUR HEALTH CARE: Unless you object, we may disclose protected health information to a member of your family, or other person identified by you who is involved in your health care or the payment for your health care. We will limit the disclosure to the protected health information relevant to that person's involvement in your health care or payment.

NOTIFICATION: Unless you object, we may use or disclose protected health information to notify a family member or other person responsible for your care of your location and condition. Among other things, we may disclose protected health information to a disaster relief agency to help notify family members.

3. USES AND DISCLOSURES OF INFORMATION THAT WE MAY MAKE WITH YOUR WRITTEN AUTHORIZATION

Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes; or if we seek to sell your information. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. YOUR RIGHTS CONCERNING YOUR PROTECTED HEALTH INFORMATION

You have the following rights concerning your protected health information. To exercise any of these rights, you must submit a written request to the Privacy Contact identified below.

- You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are *not* required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.
- We normally contact you by telephone or mail at your home address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.
- You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others.
- You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record of if we determine that the record is accurate and complete.
- You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period.
- You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. CHANGES TO THIS NOTICE

We reserve the right to change the terms of this Notice at any time, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or Privacy Officer.

6. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.

7. Contact Information.

If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact:

Privacy Officer: Brenda Schwartz
Phone: 208-954-5579
Address: 413 N Allumbaugh Street, suite 101 Boise, ID 83704
Email: brenda.schwartz@sage-healthcare.com

8. Effective Date. This Notice is effective Sept 13, 2021

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy Practices

_____ _____

Signature Date

Relationship to Patient if signed by someone other than patient:

Parent ☐ Guardian ☐ Other:_____

Permission to Leave Messages

By signing below, I give the staff at Sage Health Care, PLLC permission to leave detailed appointment information on my answering machine at the phone number(s) that I have provided to their office. I understand that I have the right to revoke this authorization at any time.

_____ _____

Patient Signature or legal Guardian Date

_____ _____

Printed Name Date

Laura Shockley Counseling, LLC

CLIENT INTAKE QUESTIONNAIRE

(Confidential)

Please fill out whatever is applicable to you. If you need more space for any answer, please use the back of the sheet. Also, note that during the first couple of sessions, I will address the questions below with you, so if you are more comfortable leaving any blank until you have met with me, please know that is an option. (I use this as a resource to refer to when I am completing your initial evaluation and want you to have the opportunity to write in your information if it is helpful to you).

Today's Date:_____

NAME_____ **GENDER**_____**DOB:**____/____/_____

REFERRAL SOURCE_____**RELATIONSHIP**_____

DESCRIBE YOUR CURRENT PROBLEMS AS YOU SEE THEM AND WHAT YOU WOULD LIKE TO ACCOMPLISH IN COUNSELING:_____

_____

_____

_____

_____

HOW LONG HAS THIS BEEN GOING ON?

_____

Do you have a support system? ☐ Yes ☐ No; If yes, who would you include?_____

_____

PREVIOUS PSYCHIATRIC TREATMENT

COUNSELING/THERAPY

THERAPIST_____ DATES_____

THERAPIST_____ DATES_____

THERAPIST_____ DATES_____.

MEDICATION MANAGEMENT (psychiatrist or PCP prescribing psychiatric medication)

PROVIDER_____ DATES_____

PROVIDER_____ DATES_____

PROVIDER_____ DATES_____

PAST PSYCHIATRIC MEDICATIONS (Please list why you stopped taking it)

_____

_____

HAVE YOU EVER BEEN PSYCHIATRICALLY HOSPITALIZED? ☐ Yes ☐ No

IF YES, WHERE AND WHEN _____

_____

HAVE YOU EVER ATTEMPTED SUICIDE? ☐ Yes ☐ No

IF YES, PLEASE EXPLAIN _____

_____

MEDICAL/SURGICAL HISTORY

DO YOU SEE ANY MEDICAL SPECIALISTS? ☐ Yes ☐ No

If yes, please list provider's name and what you see them for:

_____

_____

_____

_____

CURRENT MEDICATIONS may list here or provide list (including OTC, Herbal medications, and Natural Remedies)

NAME _____ DOSE/REGQUENCY_____

NAME _____ DOSE/REGQUENCY_____

NAME _____ DOSE/REGQUENCY_____

NAME _____ DOSE/REGQUENCY_____

NAME _____ DOSE/REGQUENCY_____

NAME _____ DOSE/REGQUENCY_____

NAME _____ DOSE/REGQUENCY_____

NAME _____ DOSE/REGQUENCY_____

NAME _____ DOSE/REGQUENCY_____

NAME _____ DOSE/REGQUENCY_____

Medical History: Please provider any information that might be relevant to your counseling treatment.

_____

_____

_____

_____

CHRONIC PAIN: ☐ Yes ☐ No Where? _____

Average pain level (0-10; 0 = no pain, 10 = worst ever) _____

How long have you suffered with chronic pain? _____

SUBSTANCE USE HISTORY

Please indicate substances currently used (over the past 30 days); how much at one time, how many times per day/week, and/or history of use; age of first use, time since last use, and length of time used.

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

FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

Alcohol Abuse	☐ Yes ☐ No	_____
Substance Abuse	☐ Yes ☐ No	_____
Anxiety	☐ Yes ☐ No	_____
Depression	☐ Yes ☐ No	_____
Bipolar disorder	☐ Yes ☐ No	_____
Domestic Violence	☐ Yes ☐ No	_____
Eating Disorders	☐ Yes ☐ No	_____
OCD (behaviors)	☐ Yes ☐ No	_____
Schizophrenia/Psychosis	☐ Yes ☐ No	_____
ADHD	☐ Yes ☐ No	_____
Suicide Attempts	☐ Yes ☐ No	_____
Psychiatric Hospitalization	☐ Yes ☐ No	_____

TRAUMATIC EVENTS

Please list any events you would consider traumatic to you.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name:_____**DOB**_____

I hereby authorize Laura Shockley, LCPC and her office staff to use and or disclose my individually identifiable Protected Health Information ("PHI") in the manner described below. I understand that the person or entity receiving my PHI, may re-disclose my PHI, and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such redisclosure by the person or entity receiving my PHI. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form.

☐ Obtain information from: AND/OR ☐ Disclose information to:

Name and Address:_____

_____Phone #:_____

Category and Time Period of PHI

Please initial the Category of PHI you wish to release

☐ Initial Evaluation ☐ Claims/Billing Information ☐ Lab Results

☐ Progress Notes ☐ Therapy notes ☐ Entire Medical Record

☐ other_____

Time period of healthcare treatment records you wish to be included:

☐ Anytime ☐ Healthcare provided between (date)_____ and (date) _____

Limit of PHI

I understand that this authorization extends to all of any part of the records/information designated above which may include treatment for physical and mental illness, alcohol/drug abuse; HIV/AIDS test results or diagnosis. I understand that if I wish to limit the use and disclosure of my PHI, I would have indicated below by initialing the appropriate category of PHI I *DO NOT* wish to be released.

_____ HIV/AIDS test results or diagnosis _____Alcohol/drug abuse _____ Other_____

Please limit the use and disclosure of my PHI to only include the following dates:_____

[Example: laboratory results from July 1998; mental health records from January 2001 to present"]

Purpose of PHI

☐ Continuity of Care ☐ Aftercare Planning

☐ Contact with Referring Supervisor ☐ Referral

☐ Family Involvement ☐ Other_____

I understand that this authorization will expire on the following date or event:_____
If no specific date or event is stated, this authorization will expire one (1) year from the date of this authorization. I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying the above provider in writing. I understand that my revocation or modification of this authorization will not effect any actions taken by the provider mentioned above in reliance on this authorization before the provider mentioned receives my request for revocation or modification. I must sign my written request and send it to: 413 N Allumbaugh Street, Suite 101, Boise, ID 83704

Signed:_____Date:_____

If not signed by the patient, please indicate authority or relationship:_____

Note to Agency/Person receiving information: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42CFR Part 2.1) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.