GPS – Guide to Personal Solutions

913 W. Holmes Road Suite 143
Lansing, MI 48910

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Ronald Penfield, LMSW LMFT — *Alice S. Williams, LMSW* — *Stacy Piper-Harris LLPC, CSOTS*

INTAKE FORM

CLIENT: ______________________________ DOB: __________ AGE: _______

____
STREET ADDRESS — HOME PHONE

____
CITY — STATE — ZIP — WORK PHONE

Parent/Guardian (for minors only): ______________________________

Name of School (if applicable): ______________________________ Grade: __________

Client's Occupation: ______________________ Employer: ______________________

Client's SS#: ______________________________

In Emergency, Contact: ______________________ at ______________________

Primary Care Physician: ______________________ Phone: __________

INSURANCE INFORMATION Name of Insurance Company: ______________________
Policy Holder
(Subscriber): ______________________________ DOB: __________

Subscriber's Place
Of Employment: ______________________

Client's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: __________

Subscribers
Address: ____
Street — City — Zip — Phone

Contract # ______________________________ Group # ______________________

I authorize payment of medical benefits to the provider for services rendered, if applicable.
I further authorize release of information to the above designated insurance carrier.
Confidentiality procedures of the managed care and/or insurance company cannot be guaranteed by the psychotherapist. Information may be shared with collection department, outside collection agency, our attorney, credit bureau, law enforcement or IRS.

I have read the above and accept this policy as outlined.

Signature of Client: ______________________________ Date: __________

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Initial Client Questionnaire

Client name: ____________________________ Referred by _________________

Date of Birth: ____/_______/_________ Ethnicity: _____________

Relationship status (circle one) Married Single Divorced In partnership

How many times have you been married? _____

List marriages and dates:

How many children do you have? _____

List names and ages:

Who do you presently live with?

What are the major problems in your present household? (Living conditions, relationship problems, financial problems, social problems, etc.)

Are you spiritual or religious?

If so, what religious and spiritual values are important to you?

How did you hear about us? __________________________

What is the reason for your appointment today? (What are your symptoms, when did they start, how long do they last, how often do they happen?)

Current Symptoms:

	YES	NO
Have you been down, depressed, or hopeless in the past month?		
Are you bothered by little interest or pleasure in doing things?		
Has your appetite changed (eating more or less)?		
Has your sleep been disturbed (insomnia or over-sleeping)?		
Do you feel worthless or guilty?		
Do you have sudden or unexpected bouts of anxiety or nervousness?		
Do you often feel tense, worried, or stressed?		
Do you have acute onset of symptoms such as palpitations, shortness of breath, or trembling?		
Do you worry about a lot of different things?		
Do you avoid placed or situations because of anxiety or worry?		
Do you have recurrent, persistent or unwanted thoughts or do repetitive behaviors?		
Have you been through any significantly stressful periods on the past 6 months?		
In your lifetime, have you faced any potentially life-threatening events such as natural disaster, serious accident, physical or sexual assault/abuse, military combat or child abuse?		
Since you experienced any of these stressors, have you been easily startled?		
Angry or irritable?		
Emotionally numb or detached from your feelings?		
Prone to physical reactions when reminded of the event?		
Do you use prescription medicines or street drugs to relax, calm your nerves, or get high?		
Have you made an effort to cut down on your drinking or drug use?		
Have you been annoyed by people who criticize your drinking or drug use?		
Do you ever feel guilty about your drinking or drug use?		
Do you ever drink or use drugs to steady your nerves, get rid of a hangover, or relieve withdrawal symptoms?		

Therapy History

How many psychotherapists/counselors have you seen in past for this problem and related problems?

Are you presently in psychotherapy/ counseling with anyone? ☐ Yes / ☐ No
If Yes, Who?

What has been your past experience in psychotherapy/counseling so far?

Any previous psychological testing? _____ Do you have reports? ____

What were your symptoms?

Were you diagnosed with a mental illness? ☐ Yes / ☐ No When? ______________________

If yes, what was the diagnosis?

What is your opinion of psychiatric medications? Please list those you have tried or been on in the past:

How many psychiatrists have you seen previously for medication management? _____

What has been your experience with medication so far? ____________________

Have you been hospitalized for psychiatric problems? ☐ Yes / ☐ No. If yes, how many times? ___ . When was the last time? ____________________

Do you have a violent history? ☐ Yes / ☐ No

Have you attempted suicide in the past? ☐ Yes / ☐ No

Do you physically hurt yourself? ☐ Yes / ☐ No

Do you have thoughts of seriously harming yourself or others now? ☐ Yes / ☐ No

Are you an abuser of a victim of abuse? ☐ Yes / ☐ No
If yes, please explain:

Trauma History
Have you had significant trauma in your life? ☐ Yes / ☐ No
Were you abused or molested as a child? ☐ Yes / ☐ No

If Yes, please explain the nature of the trauma, when if occurred and the persons who were involved.

Family History of Psychiatric Illness:

Problem/Illness	In Which Family Member
Nervous breakdown	
Depression	
Bipolar disorder	
Anxiety/panic	
Drug abuse	
Alcohol abuse	
Suicide with a gun	
Suicide (other)	
Violent crime	
Survivor of abuse	
Abuser or Molester	

Medical Conditions and Medical History

Circle all problems present now or in past:

Allergies	Asthma	Chronic cough/bronchitis	Snoring
Chest pain	Heart problems	Palpitations	Mitral valve prolapse
Swelling of feet	High blood pressure	Thrombosis	On blood thinners
Problem with urination	Miscarriages	Sexual problems	Sexually Transmitted Diseases
Abortions	HIV	Weight gain	Weight loss
Diarrhea	Constipation	Liver problems	Heartburn/indigestion
Stroke	Headaches	Ringing in ears	Hearing aids
Vision problems	Thyroid problems	Infections	TB
Genetic Problems	Diabetes mellitus	High sensitivity to medications	Seizures
Nausea and vomiting	Arthritis/muscle pains	Numbness or tingling	Other problems:

Family History of Physical Illness:

Problem/Illness	In Which Family Member
Diabetes	
Heart disease	
Sudden-death	
Other major illness	

Environmental/food allergies? ☐ Yes / ☐ No; If yes, describe:

Who is your Primary Care Physician? ______________________

Other doctors seemed regularly: ________________

Please list your current medications, including any current psychiatric medication:

Family History

Did you have a happy childhood? ☐ Yes / ☐ No

Where you raised by your parents? ☐ Yes / ☐ No

How was your relationship with your parents growing up?

How is your relationship with your parents now?

How many brothers and sisters do you have?

If so, how many older/younger?

Substance Use History:

Substance	Age at First Use	Date/Age at Last Use	How often & How long you used
Alcohol			
Marijuana			
Methamphetamines			
Amphetamines			
Cocaine			
Benzodiazepines			
Barbiturates			
Hallucinogens			
Opiates (Prescription)			
Methadone			
Heroin			
PCP (Angel Dust)			
Inhalants			
Prescription Drugs			
Other illicit Substances			
Caffeine			
Tobacco (smoking/chewing)			

Have you ever had treatment for substance-abuse? ☐ Yes / ☐ No
Where and when? Inpatient?

Do you have any medication allergies? ☐ Yes / ☐ No; If yes, describe:

Social History

Do you have significant relationships outside your family? ☐ Yes / ☐ No
If so, with whom, and what kind of relationship?

Who is supportive of you at this time?

Have there been any deaths in your family or support system over the last five years?

Who and when?

Developmental History

Describe any developmental milestones or delays. (Crawling, walking, rolling over, smiling, sitting, standing etc.)

How much difficulty are you having presently in functioning at your work/ home life/school?

Legal History
Are you facing any legal difficulties at this time? ☐ Yes / ☐ No
If yes, please explain:

Have you ever been arrested? ☐ Yes / ☐ No
What year(s) and what was (were) the charge(s)?

Did you have probation, jail time or parole? List what and dates.

Education/Work History
Highest level of education? ________.

Recent jobs you have held:

Are you presently having problems functioning at your work/home life/school? ☐ Yes / ☐ No
If yes, please explain:

Strengths/Limitations
Please list what you believe to be your strengths and abilities.

Please list anything that is holding you back.

What are some of your needs?

Do you have any specific preferences for your care?
If yes, please describe:

Is there anything you are worried about regarding starting therapy?
If yes, please describe how we can better serve your needs.

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Acknowledgement of Notifications

I acknowledge the receipt of the Agency's **Client Responsibilities, Grievance Procedure and Consent for Treatment, Attendance Policy** and **GPS's Social Media Policy** and I understand and agree to comply with these policies. I understand that these policies will always be available to me on the Agency's website but that I may always request a hard copy if I am unable to access them.

I also acknowledge the receipt of the **HIPAA Notice of Privacy Practices** for my review. I understand that the HIPPA form will remain available on GPS's website but that I may always request a hard copy if I am unable to access it.

- ***I further understand it is my responsibility to know my insurance policy and what amount of deductible and copay I have. These are due at time of service. GPS makes a best effort to find these out before the first appointment but it has happened that*** insurance companies tell us wrong. IT IS ULTIMATELY THE CLIENT'S ***RESPONSIBILITY TO KNOW THEIR POLICY AND WHAT THEY WILL BE RESPONSIBLE FOR.***

I would like for the agency/therapist to email me, I understand there will be no information exchanged regarding my clinical care, only arrangement of appointments. ○ Yes ○ No

My email address is ____.

It is ok for the agency software to email me ○ Yes ○ No OR text me ○ Yes ○ No
An *appointment reminder* the day before my appointment.

Please use email address ________________________________ and/or text number

_______________________________________.

_______________________________________ _____________________
Client/Guardian Signature Date

____
Client/Guardian Printed Name

_______________________________________ _____________________
Witness Date

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Notification of Recipient Rights

On ________/_______/___________ I was given a copy of ***Your Rights,*** the booklet which serves as a summary of the rights of mental health services as guaranteed under Chapter 7 of the Michigan Mental Health Code. The procedure for filing a Recipient Rights complaint was explained to me in a manner in which I could understand and I had the opportunity to ask questions. I have also been notified of which person(s) to contact if I have questions about my rights or to report violations of my rights.

Consumer Signature Date Parent/Guardian Signature Date

----- (THIS SECTION FOR STAFF USE ONLY)--

☐ 1. The recipient (or parent/guardian on behalf of the recipient) appeared to understand his/her rights.

Staff Name (with title) Date of Rights Notification

☐ 2. The recipient (or parent/guardian on behalf of the recipient) did not appear to understand his/her rights.

☐ 3. The recipient or parent/guardian refused to sign.

☐ 4. Parent/guardian was not present to sign for the recipient.

☐ 5. Rights information not offered due to extenuating circumstances as described below.

If one or more boxes is checked for items 2, 3, 4, and 5 above, please explain each below. Use back of this form if more space is needed.

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Attendance Policy

Definitions of Problematic Attendance

- **No-Show** - Failing to attend a scheduled appointment without notifying the clinic
- **Late Notice Cancellation** - Canceling an appointment without a minimum of 24 hours notice to allow use time to fill the missed appointment slot
- **Arriving Too Late to Be Seen** - Arriving greater than 15 minutes late for a scheduled appointment. Being excessively late for an appointment creates problems for those who are scheduled after you.

______Initial **All the above will be treated the same.**

Most importantly, regular attendance at scheduled follow-up appointments is crucial for the success of your treatment.

- Additionally, missed appointments complicate access to the clinic for others and place our ability to continue to provide services in jeopardy.

GPS is a non-profit organization and while our goal is not financial gain, the clinic must pay for itself. Missed appointments cost our facilities thousands of dollars annually and ultimately may prevent us from providing services at their current levels in the future.

- We require a minimum of 24 hours notice prior to any canceled appointment.

This allows us time to fill the appointment slot to maximize access to our clinic.

- Failure to provide 24 hours notice prior to missing a scheduled appointment, no-showing for scheduled appointments, or arriving too late to be seen will be treated the same.
- We have a very strictly enforced policy that 2 no-shows, late notice cancellations, and/or late arrivals can be reason to terminate treatment.

We understand that occasionally unforeseen events prevent people from attending their appointments, which is why we allow for

- 1 no penalty missed appointment during a 6 month period.

We will make every effort to work with you to schedule appointment times/days that are easiest for you to attend and contact you with appointment reminders. In the event this occurs, however, no exceptions will be granted to this policy._______initial

Medicaid/Healthy Michigan
After a missed appointment as defined above, Healthy Michigan (Medicaid) clients will be removed from their current appointment time and moved to a waiting list with their therapist in order to be rescheduled at the earliest convenience of the therapist who manages their schedule. __________initial

Commercially Insured Clients
No Attendance fee for missed appointments as defined above $30___________initial

I understand it is my responsibility to contact my therapist directly (not at main number) at (ph) _______ ____________________________ in order to cancel or reschedule my appointment with minimum 24 hours notice or I will either be charged a no show fee (commercial insurance holders and self pay) or removed from my therapists current schedule and placed back on when there is an opening (Healthy Michigan).

I understand that GPS and my therapist set aside this time for me specifically and expect that I will attend regularly. Upon my second missed appointment as defined above I may be discharged from the clinic altogether at the discretion of my therapist and I may not be able to secure another appointment with anyone at GPS.

____________________________________ ____________________
Signature Date

____________________________________ ____________________
Therapist Date

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FEE AGREEMENT

Fees: The established fees for therapy services at the GPS are $175.00 for the intake session and $130.00 per session after that.

- **Client Fees are due at the time that services are provided unless other arrangements have been made in advance.**
- **If insurance information cannot be obtained at the time of intake, or the client does not have expected coverage, the client is responsible for the fee.**

Insurance Coverage/Information:

Insurance Provider ____________________ Annual Deductible ____________________

Insurance Co-Pay ____________________ Visits per calendar year ____________________

Fee for Service/Sliding Scale Fee/Cash Pay:

Annual Household income ____________________ Number of people in household ____________

Fee per session ____________________

- **Re-Assessment of Fees:** Fees are agreed upon at the time of Intake and reviewed periodically throughout services. This reassessment occurs with changes in insurance coverage and reimbursement and at least every 6 months.
- **Cancellation of Appointments:** Cancellations must be made at least 24 hours in advance of appointment time. Per our attendance policy, the charge for late or no cancellations will be **$30.00**. This rescheduling fee must be paid before the next appointment.
- **No-Show:** One no-show may result in termination of treatment. The charge for a no-show will be **$30.00**. This rescheduling fee must be paid before your next appointment.
- **Non-payment of fees will result in review of your case for possible discharge.**

BY SIGNING THIS AGREEMENT, I AGREE TO THE ABOVE FEES AND THAT THE FINANCIAL INFORMATION IS ACCURATE.

Client's Printed Name ____________________ Client's/Guardians Signature ____________________ Date ____________

____
Witness Signature Date