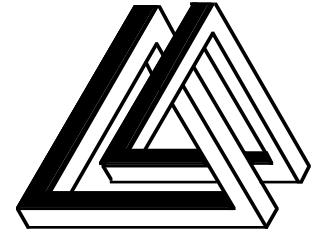


FAMILY THERAPY INSTITUTE MIDWEST INC

Recognized Experts in Family Therapy

2601 W 6th St, Suite C
Lawrence, KS 66049



Adult Information Form

Client Name	<input type="text"/>	<input type="text"/>	<input type="text"/>
	First	Middle	Last
Address	<input type="text"/>		Is Address?: <input type="radio"/> Home <input type="radio"/> Other
City	<input type="text"/>	State	<input type="text"/>
		Zip	<input type="text"/>
Home ☎	<input type="text"/>	Office ☎	<input type="text"/>
		Mobile ☎	<input type="text"/>
			<input type="radio"/> ATT <input type="radio"/> Sprint <input type="radio"/> T-mobile <input type="radio"/> Verizon
Email	<input type="text"/>		
	Please DO NOT include phone numbers or email addresses at which you do not want to be reached under any circumstances.		
DOB	<input type="text"/>	Age	<input type="text"/>
		SSN#	<input type="text"/>
Family Role	<input type="text"/>	Sex	<input type="radio"/> Male <input type="radio"/> Female
M Status	<input type="text"/>	Income	<input type="text"/>
		Years of Education	<input type="text"/>
Employer or School	<input type="text"/>	Work/ School Status	<input type="text"/>
Referred By	<input type="text"/>	Emergency Contact*	<input type="text"/>

*Please provide a name and phone number for someone who could be contacted in case of a serious health emergency. By providing this number you are authorizing FTI Midwest to contact this person under these un-

Where Did you Find Contact Information on Family Therapy Institute Midwest?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> AT&T Yellow Pages | <input type="checkbox"/> Yellowbook | <input type="checkbox"/> School Personnel | <input type="checkbox"/> Internet |
| <input type="checkbox"/> My Insurance Company | <input type="checkbox"/> Doctor's Referral | <input type="checkbox"/> Poster | <input type="checkbox"/> A Local Agency |
| <input type="checkbox"/> Court or Attorney | <input type="checkbox"/> Newspaper Column | <input type="checkbox"/> Friend's Referral | <input type="checkbox"/> Another Therapist |

Insurance/Medicaid Information

Clients who qualify by diagnosis, and wish to do so, may choose to have their treatment reimbursed by a medical insurance carrier. You may do this by receiving a bill and forwarding it to your insurance company, or by having us bill the company directly. In either case it is likely to be necessary for us to have some contact with the company to provide information necessary for billing. By signing this form you are agreeing to allow us to provide whatever information is legally allowed to assure reimbursement for services we may render. Typically this will include diagnosis, but sometimes insurance companies ask for treatment plans, and goals and objectives. Insurance companies are bound by Federal laws guiding confidentiality, but FTI Midwest cannot be responsible for any records once they are released to your company. To learn more about your insurance company's policies on these matters, please contact them directly. PLEASE NOTE: While we do take Medicaid, WE DO NOT ACCEPT MEDICARE AS PRIMARY OR SECONDARY INSURANCE. EVEN IF A CLIENT HAS ANOTHER INSURANCE POLICY OR MEDICAID, IF THEY ALSO HAVE MEDICARE WE CANNOT SEE THEM because we will not be reimbursed and the client cannot pay us directly.

Relationship of client to policyholder: Self Spouse Child Other

Does more than one insurance company cover this client? Yes* No

*If "yes" you must complete a second form with insurance information. Please ask your therapist for this form.

If you are the insurance policy holder, you may put "same" in any box that you have already filled out above. If you are not the policyholder you must complete all of the following information for us to bill the insurance company service to the above client.

Policy Holder
 First Middle Last

Address **Is Address?:** Home Other

City **State** **Zip**

Home ☎ **Office** ☎ **Other** ☎

Please do not include phone numbers at which you do not want to be reached under any circumstances

DOB **Age** **SSN#**

M Status **Sex** Male Female

Employer or School **Work/ School Status**

Insurance Co Name **Ins ID Number** **Group Number**

Insurance Co Address **Insurance Co Phone** ☎

I have read the above statement or had it explained to me and my questions have been answered. I agree to release FTI Midwest to provide all information necessary to my insurance carrier in order to process my claim and, if FTI-Midwest is billing my company directly, have all benefits assigned to FTI-Midwest.

 Client

 Date

Clinical Information

For us to give the best service possible, we must have the following information. Please answer all of the questions below. If you do not know how to answer a question, put a “?” in the blank and your intake counselor will discuss it with you.

1. Have there been divorces, separations, deaths, or serious illness in your family recently? No Yes

Briefly explain: _____

2. Have you ever had any children removed from your home? No Yes

3. School Information

Last school attended: _____

Year of last attendance: _____ Highest grade: _____

4. Medical Information

Your doctor: _____

Date of last physical exam or treatment: _____

Are you being treated for any medical or surgical conditions? No Yes

Have you ever had an injury to the head requiring medical treatment? No Yes

Do you have allergies, or bad reactions to medications or other substances?
 No Yes (List:) _____

Current Medications

Name	Indication	Dose/Frequency	Start Date	Prescriber

5. Counseling and Psychiatric Information

Treatment Dates	Diagnosis	Inpatient	Outpatient	Medications	Clinician/Facility

Have you ever been diagnosed with Bipolar (manic-depressive) disorder, Schizophrenia,, Schizo affective disorder or other psychotic disorder? No Yes

Are you having difficulty performing your duties as a parent, employee, husband, wife, etc..... No Yes

Do you get social security disability benefits or have they been applied for? No Yes

Have you ever thought of hurting yourself? No Yes

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

Have you ever thought of hurting someone else? No Yes

Have you ever harmed or attempted to harm someone else? No Yes

6. Substance Use/Abuse History

Substance Used	Age @ Onset	Current Use Pattern (Frequency/Amount)	Method	Last Used (Time/Amount)

- Have you ever felt the need to cut down on your drinking or drug use? No Yes
- Have you ever been annoyed by criticism of your drinking or drug use? No Yes
- Have you ever felt guilty about your drinking or drug use? No Yes
- Have you ever had a morning “eye-opener” (used drugs or alcohol first thing in the morning to get started or relieve withdrawal)? No Yes

7. Your Family (the family you raised)

Children's Name(s)	DOB/Age	Living with (Other than parent)	Medical Problems	Mental Health/ Substance Abuse Tx.

8. Your Family of Origin (the family that raised you)

Name	Age	Current Location	Health Status	Mental Health/SA Hx.
Mother				
Father				

Adult Checklist of Concerns

<input type="checkbox"/> Abuse-physical <input type="checkbox"/> Abuse-sexual <input type="checkbox"/> Abuse-emotional <input type="checkbox"/> Abuse-neglect <input type="checkbox"/> Aggression, violence <input type="checkbox"/> Alcohol use <input type="checkbox"/> Anger, hostility, arguing, irritability <input type="checkbox"/> Anxiety, nervousness <input type="checkbox"/> Attention, concentration, distractibility <input type="checkbox"/> Career concerns, goals, and choices <input type="checkbox"/> Childhood issues (your own childhood) <input type="checkbox"/> Children, child management, child care, parenting <input type="checkbox"/> Codependence <input type="checkbox"/> Confusion <input type="checkbox"/> Compulsions <input type="checkbox"/> Cruelty to Animals <input type="checkbox"/> Custody of children <input type="checkbox"/> Decision making, indecision, mixed feelings, putting off decisions <input type="checkbox"/> Delusions (false ideas) <input type="checkbox"/> Dependence <input type="checkbox"/> Depression, low mood, sadness, crying <input type="checkbox"/> Divorce, separation <input type="checkbox"/> Drug use-prescription medications, over-the-counter medications, street drugs <input type="checkbox"/> Eating problems-overeating, undereating, appetite, vomiting (see also "Weight and diet issues") <input type="checkbox"/> Emptiness <input type="checkbox"/> Failure <input type="checkbox"/> Fatigue, tiredness, low energy <input type="checkbox"/> Fears, phobias <input type="checkbox"/> Financial or money troubles, debt, impulsive spending, low income <input type="checkbox"/> Friendships <input type="checkbox"/> Gambling <input type="checkbox"/> Grieving, mourning, deaths, losses, divorce <input type="checkbox"/> Guilt <input type="checkbox"/> Headaches, other kinds of pains <input type="checkbox"/> Health, illness, medical concerns, physical problems <input type="checkbox"/> Inferiority feelings <input type="checkbox"/> Interpersonal conflicts <input type="checkbox"/> Impulsiveness, loss of control, outbursts	<input type="checkbox"/> Irresponsibility <input type="checkbox"/> Judgment problems, risk taking <input type="checkbox"/> Legal matters, charges, suits <input type="checkbox"/> Loneliness <input type="checkbox"/> Marital conflict, distance/coldness, infidelity/affairs, re-marriage <input type="checkbox"/> Memory problems <input type="checkbox"/> Menstrual problems, PMS, menopause <input type="checkbox"/> Mood swings <input type="checkbox"/> Motivation, laziness <input type="checkbox"/> Nervousness, tension <input type="checkbox"/> Obsessions, compulsions (thoughts or actions that repeat themselves) <input type="checkbox"/> Oversensitivity to rejection <input type="checkbox"/> Panic or anxiety attacks <input type="checkbox"/> Perfectionism <input type="checkbox"/> Pessimism <input type="checkbox"/> Procrastination, work inhibitions, laziness <input type="checkbox"/> Relationship problems <input type="checkbox"/> School problems (see also "Career concerns . . .") <input type="checkbox"/> Self-centeredness <input type="checkbox"/> Self-esteem <input type="checkbox"/> Self-neglect, poor self-care <input type="checkbox"/> Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse") <input type="checkbox"/> Shyness, oversensitivity to criticism <input type="checkbox"/> Sleep problems-too much, too little, insomnia, nightmares <input type="checkbox"/> Smoking and tobacco use <input type="checkbox"/> Stress, relaxation, stress management, stress disorders, tension <input type="checkbox"/> Suspiciousness <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Temper problems, self-control, low frustration tolerance <input type="checkbox"/> Thought disorganization and confusion <input type="checkbox"/> Threats, violence <input type="checkbox"/> Weight and diet issues <input type="checkbox"/> Withdrawal, isolating <input type="checkbox"/> Work problems, employment, workaholicism/overworking, can't keep a job
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If you have any other concerns not noted above, please feel free to list them here:

Adult Consent to Treatment

For us to consider providing services to you, you must *read and sign* this consent form. This *is not* a contract. It just allows us to see you. You may withdraw this consent to treatment at any time and ask that your file be closed. You should also know that this is not an agreement by FTI Midwest to provide services to you. You may wish to talk with your therapist about your consent to treatment during intake session. He or she will answer your questions.

Understanding Psychotherapy. Psychotherapy and psychiatric services are designed to help you change. Sometimes this kind of change is difficult because it raises feelings, thoughts, and worries that you try to keep inside. The benefits may include improved behavior, relationships, and mood. You may learn to communicate better with those around you. You should know that this is not a precise science. In many cases we are successful in helping people to change. In some cases we are not. FTI Midwest cannot guarantee the success of any treatment.

FTI Midwest is owned and operated by persons of several professions, psychology, social work, and nursing. Each does psychotherapy with clients. None of our professionals is a medical doctor, though Mary Lu Egidy and Elaine Rolfs are Advanced Registered Nurse Practitioners (ARNP) and thus able to do psychiatric intakes and prescribe medications under the contracted oversight of Manuel Morales, MD a physician licensed by the Kansas Healing Arts Board.

Grievance Procedure. At times clients in psychotherapy may find themselves in conflict with their therapist about some aspect of treatment. This may come from a misunderstanding between client and therapist, or a genuine disagreement in how treatment should proceed. We attempt to resolve any conflicts in a manner that is suitable to our clients, while maintaining important treatment standards. If you reach a point of conflict in your treatment, you should first attempt resolution with your assigned therapist. If this does not solve the conflict and you are also seeing another therapist or nurse practitioner at FTI, you should speak with them about the issue. They will attempt to resolve the conflict. If you are not seeing another provider at FTI, please contact Heather Falley, practice manager. She will assign the grievance to a staff member who is not involved with your family. If the conflict cannot be resolved in this manner, we may suggest seeking services elsewhere. If the conflict cannot be resolved by the FTI grievance procedure, *Medicaid clients* may also contact Kansas Health Solutions, the Medicaid coordinating agency. Their number is 866-547-6457 or go to kansashealthsolutions.org. This information will also be provided to you by the front office at a later date should you need to use it.

Second Opinions and Service Referral. Clients are entitled to a second opinion at either this agency or another. A second opinion may be helpful when you do not agree with an FTI diagnosis or treatment finding. FTI Midwest does not usually make specific recommendations about where or when to seek a second opinion. At times however, FTI Midwest may find that we do not have adequate training, experience, or services to properly address your needs. In this case we may recommend other resource that are more suitable. This is especially true for adults, who may require services that we do not offer or that we cannot easily access. Medicaid clients may contact Kansas Health Solutions (see information above) for referrals.

Confidentiality. All services provided are *strictly confidential*. We cannot release any information about your case to anyone outside FTI Midwest without your written consent. In order to help you we do share information between staff at FTI Midwest. For example, your therapist may talk to a colleague in our organization in order to understand your case better. Releases of information are available on our website. You may download them, fill them out and bring the to your next appointment.

Breaking Confidentiality. *There are three exceptions to confidentiality.* By law all therapists must break confidentiality: (1) if a client is threatening to hurt himself/herself or someone else in order to protect the client or the other person; (2) if we suspect that a child is being abused; and (3) if a court of law subpoenas (demands to see) the records. If this happens, we will attempt to invoke *privileged communication* (a legal protection of your right to therapeutic

confidentiality) if you or your attorney asks us to do so. However, under some circumstances, the court can override privileged communication and order us to disclose these records.

Email or Fax Contact. At your discretion you may contact your therapist via email for the same purpose you would initiate phone contact. However, for therapy you are advised against using unsolicited fax transmissions as they are not monitored as closely. FTI does not consider email contact to be therapy and does not bill it as such. It is instead considered administrative and supportive contact. By initiating email contact you are accepting this understanding and agreeing to act accordingly. For evaluations, both email and fax contact are acceptable but are considered part of the evaluation. By initiating this contact you are accepting this understanding and agreeing that the email may be used in your evaluation.

You are advised that email communication is protected by federal law, but should not be considered secure. It is possible that someone on the Internet might read your communication or our communication back to you. By initiating this sort of contact you are waiving this level of confidentiality unless you specify in your email a limitation of the expected response (e.g., "please don't reply"). Fax communication for evaluations is secure within our office and within the limits of electronic security in general (e.g., someone could be wiretapping phone lines but this would also be a federal offense). If you are especially concerned about this issue, please discuss it with your therapist at intake.

Text Messaging. Some therapists have found that text messaging can be a very helpful tool in keeping in touch. Please provide your text information OR advise the front office if you DO NOT want to be contacted by text messaging.

Crisis Intervention. As a family therapy practice, FTI Midwest specializes in working with children and teenagers. We also serve couples (married and unmarried). We serve some individual adults who fit into our scope of practice. However, our crisis services for adults are very limited. If you expect to need crisis intervention – or have used psychiatric crisis intervention in previous therapies – you need to be aware that FTI Midwest is unlikely to meet your needs. Please talk with your therapist about what is available for adult crisis management and community alternatives. After-hours calls may be placed to your therapists cell phone for bona fide crises. For life-threatening emergencies you should report to the LMH emergency room.

Working with your Physician. It is often in your clinical best interest for FTI staff to work with your physician. This is especially true when you are being seen here for medication. By signing this document you are agreeing to have us contact your physician as necessary to coordinate treatment. If you do not wish to have us contact your physician please mark this box:

I AM WITHOLDING PERMISSION FOR FTI MIDWEST TO CONTACT MY PHYSICIAN REGARDING MY CASE

Payment Agreement (Please read this carefully)

Obligation. By signing this document, you are agreeing to pay for the services you receive at FTI Midwest. We pride ourselves on making our services affordable for families and we will work closely with you to keep your account current. We offer interest-free payment plans for those clients who place a credit card or checking account number on file at our office. However, we also retain a bill collection agency for outstanding accounts that become delinquent. By signing this document you are releasing us to refer your account to collections in the event that you do not make timely payment. Please read each of the follow paragraphs to assure your understanding of our billing procedure and ask your intake therapist if you have any questions about these procedures.

Insurance: If you have insurance, we will submit claims on your behalf if you authorize us to do so on the insurance form (page 2). However, you must pay all costs insurance does not cover including copayments, coinsurance, deductible and no-show fees (see below). Under Kansas law, most in-state insurance companies must pay 100% of the first \$100 of services, and 80% of the second \$100. Thereafter, insurance companies may pay as much as 90% and as little as 50%. Some require you to meet your healthcare deductible. Some companies (Cigna, Coventry, Humana, etc.) have set rates that they have contracted with us to pay after the first session. You are responsible for verifying your coverage by calling the number on your insurance card. Some companies REQUIRE YOU TO CALL to get an authorization number before your first session. If you do not make this call, you may end up with a bill that your insurance company will not reimburse. For some diagnoses some insurance companies require you to pay into your healthcare deductible. You are encouraged to discuss this with your therapist. Deductible costs must be paid in full or on a payment plan as discussed below.

Billing Arrangements. In order to keep serving our clients FTI Midwest must keep billing costs to a minimum, while helping you keep your costs for our services affordable. Typically FTI Midwest expects and receives payment at time of service. However, we also offer payment plans that allow zero percent financing for costs not covered by insurance. To qualify for a monthly payment plan you must place on file at FTI Midwest either **a valid credit card or checking account number** for monthly withdrawal and authorize us to bill that account each month until outstanding charges are paid off. If your bank fails to honor this account or you withdraw your authorization without providing another method of payment, your account will be considered delinquent and a collection action undertaken. If an unexpected balance is incurred (e.g., a healthcare deductible), you must sign up for one of these payment methods or your account will become delinquent 60 days after settlement with the insurance company. We DO NOT make monthly payment plans under any other system.

Guarantors. If you are 18+ years old and have a parent or other individual guaranteeing your bill, we must have their billing information and they must agree to one of these arrangements. Please ask the front desk for a guarantee form to be sent to your parent. By signing this form you are releasing us to contact your guarantor for the purpose of payment – but not release of medical record. Be aware that if the guarantor does not pay your bill, you will be ultimately responsible for it's payment and subject to collections.

EVERYONE MUST READ AND CHECK ONE OF THE FOLLOWING BILLING OPTIONS:

- Self Pay:** I do not have or do not wish to use my insurance. I am paying all fees in full by cash, check or credit card at time of service. I understand that no payment plans are available for self-pay clients.
- EAP:** I have contracted EAP through my place of employment and have requested services be provided at FTI Midwest. I agree to cover all charges not paid through my EAP including charges incurred if my EAP refuses to pay for these services for any reason. If I continue at FTI Midwest after exhausting my EAP services, I understand that additional charges will apply which may or may not be paid by my insurance company. I agree to pay any costs not paid by insurance as described in the next section.

The contact phone number for my EAP service provider is: _____.

The authorization number for my session(s): _____.

- Health Insurance:** I have active health insurance, have contacted my insurance company for authorization (if necessary) and believe they will pay for these services. I agree to pay all costs not covered by insurance includ-

ing refused claims, deductible, copay, no-show fees, or coinsurance by one of the following methods. I understand that FTI Midwest no longer issues monthly statements, but that I may request a statement for my records. I have selected the following payment method for balances not covered by insurance (**you must select one of the following access services at FTI Midwest**):

- Payment in Full at Time of Service.** I agree to pay all costs due when I come for each appointment including deductible, copayment, no-show fees. If I am not sure of my copayment, I will make a minimum payment of \$20 until the actual amount is determined and will then make up any difference or receive a refund at my next appointment. I agree to payoff any remaining balance within 60 days of my last appointment at FTI Midwest or my account will be considered delinquent.
- Monthly Credit Card or Checking Account Deduction For BALANCE DUE or FLAT-RATE*.** I agree to pay all incurred charges each month by placing a valid credit card or checking account number on file with this office. That number will be kept in a secure file and used for any amounts not paid by insurance after insurance has cleared. *Please complete the auto-withdrawal agreement forms on the next page to set up your payment plan. NO PAYMENT PLANS WILL BE OFFERED WITHOUT AUTO-WITHDRAWAL.*

EVERYONE MUST CHECK AND AGREE TO BOTH OF THE FOLLOWING:

- I understand that all missed appointments and late cancellations incur a charge of \$50. This fee may be changed with notice posted on the monitor in the FTI Midwest lobby. A missed appointment is any appointment not cancelled. A late cancel is any appointment not cancelled with 24 hours notice. Fees for missed or late-cancelled appointments due to legitimate emergencies may be waived. FTI Midwest may offer reminders to clients, but failure to send a reminder does not release me from paying a no-show fee.
- I understand that I must pay all costs not paid by my insurance carrier. If I am over the age of 18, and have a parent or other party (guarantor) paying my bill, I understand that I remain *primarily responsible*. This means that if that person does not pay outstanding charges, I remain liable for them. I also understand that I am subject to collection action if my account becomes past due and I have not placed a credit card or checking account number on file to make regular payments. By signing this document I am releasing FTI Midwest to provide necessary information to it's designated collection agency. I also understand that if I move or relocate without making arrangements with FTI for future billing, I am subject to immediate collection action. I also understand that if my check is returned, fees up to 25% of the face value of the check will be added to any delinquent account placed for collection.

I have read the above statement or had it explained to me and my questions have been answered. I consent to receive services from FTI Midwest if they are offered under these terms. I realize that these are the core issues of informed consent and that others may come up during my therapy. If that happens, I am free to talk to my therapist about these issues.

Client

Date of Birth

Today's Date

Witness

Today's Date

AUTHORIZATION AGREEMENT FOR ELECTRONIC DEBIT

Checking Account Authorization

I hereby authorize Family Therapy Institute Midwest Inc. to initiate a debit to my Checking Account indicated below at the depository financial institution named below. If this item is returned unpaid, I authorize an additional returned check fee of the maximum amount as allowed by the state to be charged to this account. Please attach a voided copy of your personal check to this authorization form, since your check will identify the routing transit number and normally your account number.

Bank: _____

Branch: _____ Address: _____

Name on Account: _____

Routing Number: _____ Account Number: _____

Date for monthly withdrawal: _____

Amount Approved:

Total balance due up to a: \$ _____ maximum charge each month.

Exactly: \$ _____ each month until balance due is paid in full.

This authorization is to remain in full force and effect until my account is closed or until Family Therapy Institute Midwest Inc. has received written notification from me of its termination, in such time and such manner as to afford Family Therapy Institute Midwest Inc. and my bank a reasonable opportunity to act on it. I understand that if I cancel this agreement without making another payment arrangement my account will be considered delinquent and may be referred for collection action.

Authorized Signature: _____ Date Signed: _____

Credit Card Authorization

I hereby authorize Family Therapy Institute Midwest Inc. to initiate a debit to the following credit card:

Visa Mastercard

-- -- --

Expiration Date: / Back of Card Security Code:

Date for monthly withdrawal: _____

Amount Approved:

Total balance due up to a: \$ _____ maximum charge each month.

Exactly: \$ _____ each month until balance due is paid in full.

This authorization is to remain in full force and effect until my account is closed or until Family Therapy Institute Midwest Inc. has received written notification from me of its termination, in such time and such manner as to afford Family Therapy Institute Midwest Inc. a reasonable opportunity to act on it. I understand that if I cancel this agreement without making another payment arrangement my account will be considered delinquent and may be referred for collection action

Authorized Signature: _____ Date Signed: _____

Notice of Family Therapy Institute Midwest's Inc. (FTIM) Policies and Practices to Protect the Privacy of Your Health Information

I and/or my legal guardian have been offered an office copy of the FTI Midwest privacy policy or I have declined to review said policy. I agree to direct any questions or concerns about said policy to FTI Midwest staff for clarification. Upon reviewing or declining to review the policy:

- I wish to receive a copy of the FTI Midwest Privacy Policy.
- I DO NOT wish to receive a copy of FTI Midwest Privacy Policy.

Client signature

Date

Parent or legal guardian signature

Date

Relationship to client

Witness

Date