3023 E. Copper Point Drive, Suite 108, Meridian, Idaho 83642
Telephone: (208) 888-5804; Fax: (208) 955-2703
www.idahothrive.org

SERVICE INTAKE - APPLICATION PACKET

Revised December 15, **2020**

Date: _____

COUNSELING OF IDAHO

GENERAL INFORMATION

Applicant Full Name: _____

Email: _____ Birthdate: _____ Age: _____

Physical Address: _____

_____

Mailing Address *(if different):* _____

_____

Home Phone: _____ Cell Phone: _____

May we leave a message on your phone? Y or N May we email you? Y or N

Gender: _____ Primary Language: _____

Primary Care Physician: _____

GUARDIAN INFORMATION *(if under 18 or not self)*

Legally Authorized (Entity or Person) Contact Information:

Name: _____ Relationship: _____

Address: _____

Phone: _____ Email: _____

Responsible Person(s) Contact Information (PCS Provider, Foster Care Provider, etc.):

Name: _____ Relationship: _____

Address: _____

Phone: _____ Email: _____

In case of emergency, please notify:

Primary contact:

Name: _____ Relationship: _____
Address: _____
_____
Phone: _____ Secondary Phone: _____

Secondary contact:

Name: _____ Relationship: _____
Address: _____
_____
Phone: _____ Secondary Phone: _____

ADDITIONAL INFORMATION

Primary &/or Secondary Diagnosis *(Attach documentation verifying DX if possible):*

Primary DX: _____

Secondary DX: _____

Current Living Arrangement: *(circle one)*

Family Residence	Institution or ICF-MR	Supported Living
Group Home	PCS Home	Foster Home
Correction Facility	Nursing Home	Assisted Living

Other: _____

Marital Status: *(circle one)*

Never Married/Single	Cohabitating	Engaged	Married
Separated	Divorced	Annulled	Widowed

****** IMPORTANT DOCUMENTATION ******

Please attach (or bring with you to your appointment) any relevant copies &/or cards.

- ✓ Medicaid/Medicare Card (if Medicaid Eligible – *required)
- ✓ Insurance Card (a copy on file required)
- ✓ Guardianship Documentation
- ✓ Medical Documentation (including primary diagnosis, if available)

COUNSELING SERVICES HISTORY

Have you received services from Thrive Counseling of Idaho at any time in the past? Yes or No
If so, please provide approximate dates of service: _____
If so, please provide the reason behind initial discharge or termination of services: _____
_____
_____

Have you received services from another mental health provider, counselor, or clinic? Yes or No
If yes, please provide the name of the provider: _____

CURRENT CONCERNS & ISSUES

Current Issues and/or Concerns *(please identify any and all current issues/concerns):*

Addiction	Depression	Drugs/Alcohol	Eating/Diet
Employment/Career	Family Issues	Financial	Health Issues
OCD	Relationships	Sexual Behavior	Sleeping Issues
Stress/Anxiety	Suicidal Thoughts	Thought to Harm Others	Victimization

Other *(please specify):* _____

Describe in your own words the primary problem, issue, or concern for seeking our services:
_____
_____
_____
_____

MEDICAL HISTORY

Has the patient had or does s/he currently suffer from **epilepsy or seizure disorders**? Yes or No

If so, what type? *(circle one)*

Absence	Atypical Absence	Myoclonic	Atonic	Tonic
Clonic	Tonic-Clonic	Simple Partial	Complex Partial	Secondarily Generalized
Focal Motor	Petite Mal	Grand Mal	Unknown	

How frequent does the applicant suffer from seizure activity_____
Date of most recent seizure activity: _____
Are seizures currently controlled by medication(s)? Yes or No

MEDICAL HISTORY *(cont.)*

Have you ever been hospitalized due to mental health issues? Yes or No
If yes, please provide information related to the hospitalization: _____

_____

_____

_____

_____

Do you suffer from any chronic medical conditions? If so, please list: _____

_____

_____

_____

Please list any known allergies: _____

_____

Please list any recurring illnesses or injuries: _____

_____

MEDICATION

Are you presently taking any prescription or nonprescription medication(s)? If so, please list:

Medication	Dosage	Frequency	Purpose
		AM/PM	
		AM/PM	
		AM/PM	
		AM/PM	
		AM/PM	
		AM/PM	
		AM/PM	
		AM/PM	
		AM/PM	

CONSENT DISCLOSURES

- **Informed Consent :** *Privacy Exclusions*
- **Informed Consent – Attendant:** *Services to be received – Expected Benefits and Risks*
- **Informed Consent:** *Right to Refusal of Services*
- **Informed Consent:** *Choice of Service Providers*
- **Informed Consent:** *Choice of Service Providers – Developmental and Cultural Sensitivity*
- **Informed Consent:** *Participant Rights*
- **Informed Consent:** *Participant Choice and Informed Consent*
- **Informed Consent:** *Inability to Provide Consent*
- **HIPPA Notice of Privacy Practices.** *Additionally, signing below indicates THRIVE Counseling provided you a copy of the agency HIPPA privacy statement as well. If you did not receive one, request one and it will be provided to you.*

Please be aware, THRIVE Counseling of Idaho does not provide 24-hour crisis services. Life threatening emergencies, medical emergencies, etc., need to be referred to crisis providers. Please call 911 in case of emergencies.

By signing below you are indicating the above information related to privacy exceptions and notices was reviewed with you by THRIVE personnel; that you have received the information in written terms and/or verbally; and, that you adequately understand and comprehend the information provided and agree to consent.

☐ **I requested and received a copy of the written terms.**

☐ **I decline the receipt of written consent terms.**

_____ _____

Participant Signature
Legal Guardian, Representative, or Foster Parent — Date

_____ _____

THRIVE Counseling of Idaho Representative — Date

ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PARTICIPANT-CLIENT MEDICAL OR HEALTH-RELATED INFORMATION

THRIVE COUNSELING OF IDAHO honors a participant's right to confidentiality of medical or health-related information as provided under federal and state law. Please read the following guidelines before signing this authorization.

No Obligation to Sign. You are under no obligation to sign this form, and you may refuse to do so. Except as permitted under applicable law, THRIVE may not refuse to provide you treatment or other health care services if you refuse to sign this form.

Revocation. You have the right to revoke this authorization, in writing, at any time before it expires. However, your written revocation will not affect any disclosures of your medical information that the person(s) and/or organization(s) listed on the reverse side of this form have already made, in reliance on this authorization, before the time you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and addressed to:

Thrive Counseling of Idaho
3023 E. Copper Point Drive, Meridian, Idaho 83642

Re-release. If the person(s) and/or organization(s) authorized by this form to receive your medical information are not health care providers or other people who are subject to federal health privacy laws, the medical information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release your medical information without your prior permission.

Right to Inspect. You have the right to inspect or copy the medical information whose disclosure you are authorizing, with certain exceptions provided under state and federal law. If you would like to inspect your records, contact THRIVE COUNSELING OF IDAHO for further information.

Signatures. Generally, if you are 18 years of age or older, you are the only person who is permitted to sign a form to authorize the disclosure of your medical information. If you are under the age of 18, your parent or guardian must sign this form for you. However, there are many situations in which this general rule does not apply. For more information regarding who is authorized to sign this form, contact THRIVE COUNSELING OF IDAHO representatives.

VERIFICATION OF INSURANCE BENEFITS

Client's Name: _____

Insured Member's Name: _____ **Birth Date:** _____

Member's Address: _____
Street City Zip

Insurance Company: _____ Healthy Connections? Y or N

Subscriber #: _____ **Group #:** _____

Deductible Amount: _____ Deductible Rollover Month (if known): _____

Maximum number of visits covered by your insurance per year: _____

The above Insurance Information was supplied by: _____

Responsibility for Payment/Payment Policy:

FINANCIAL RESPONSIBILITY AND PAYMENT POLICY - You are responsible for payment of all charges for mental health services provided by THRIVE, including any co-payments or deductibles. You are also required to provide an insurance card — this is necessary to validate coverage of benefits, You are ultimately responsible for any service provided that Is not covered by your policy, INSURANCE — You are responsible for any charges due to your insurance company. Your account with this office is your responsibility. It is your responsibility to notify us of any changes in your insurance plan. Any co-payments, deductibles, or services not covered by insurance are your financial responsibility. Any service denied because of a change in benefits becomes your responsibility.

Thrive Counseling of Idaho's hourly professional fee is $115.00 per hour. If full payment Is made at the time of service, the rate will range between $85 and $115 depending on your therapist. Any written documentation requested to be produced by our professionals will be billed to the client at $21.25 per fifteen (15) minute increment.

With this consent, I acknowledge I am fully responsible for payment of services rendered by THRIVE. I acknowledge that I am fully responsible for understanding my insurance benefits, coverage and whether or not mental health benefits were part of the medical benefits provided through my insurance company.

_____ _____
Participant or Responsible Party Signature Date

_____
Printed Name

GENERALIZED ANXIETY DISORDER SCREENER

Take this very quick self-screener to get an idea of how much anxiety you are currently experiencing. Come back and repeat the screener as often as you want to see if you are becoming more or less anxious over the days and weeks ahead.

It is important to understand that this screener is only an indicator and should not be taken as the final diagnosis. If you are feeling overwhelmed by feelings of anxiety, speak with your counselor during your visit and/or contact your physician.

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(circle one)

Feeling nervous, anxious or on edge:

Not at all *Several days* *More than half the days* *Nearly every day*

Not being able to stop or control worrying:

Not at all *Several days* *More than half the days* *Nearly every day*

Worrying too much about different things:

Not at all *Several days* *More than half the days* *Nearly every day*

Trouble relaxing:

Not at all *Several days* *More than half the days* *Nearly every day*

Being so restless that it is hard to sit still:

Not at all *Several days* *More than half the days* *Nearly every day*

Becoming easily annoyed or irritable:

Not at all *Several days* *More than half the days* *Nearly every day*

Feeling afraid as if something awful might happen:

Not at all *Several days* *More than half the days* *Nearly every day*

https://forms.liveandworkwell.com/member/forms/screener anxiety.asp?siteId=3648&clientName=Optum%201daho%20Behavioral%20Health%20Plan

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	Over half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

(Healthcare professional: For interpretation of TOTAL, TOTAL: please refer to accompanying scoring card).

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐

Thank you for choosing Thrive Counseling of Idaho as your provider of counseling services!

We are committed to providing you with quality and affordable mental health care. Because some of our clients have had questions regarding our client and insurance responsibilities for services rendered, we have developed this payment policy. Please review it carefully, ask us any questions you might have, then sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans. If you are not insured by a plan that we do business with, payment in full is expected at the time of each visit. If you are insured by a plan that we do business with but do not have an up-to-date insurance card, payment in full is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance provider with any questions you have regarding your coverage.

   If we are an out-of-network provider, we will charge the client full payment at the time of the visit. In some cases, the client will receive payment from their insurance provider. Some insurers will not provide payment in the full amount the client was charged by Thrive. The client is responsible for any difference between the charges billed to the client by Thrive and the amount your individual insurance provider chooses to pay.

2. **Co-payments and Deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance provider. Failure on our part to collect co-payments and deductibles can be considered fraud. Help us in upholding the law by paying your co-pay at each visit.

3. **Non-Covered Services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered, not considered reasonable, or not necessary by insurers. You must pay for these services in full at the time of your visit.

4. **Proof of Insurance.** All clients must complete our application packet before seeing the clinician. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims Submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company. We are not party to that contract.

6. **Coverage Changes.** If your insurance changes, please notify us before your next appointment so that we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed or invoiced to you.

7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and you immediate family members may be discharged from this practice. If this occurs, you will be notified by regular and certified mail that you have 30 days to find alternate medical care. During that 30 day period, our physician will only be available to treat you on an emergency basis.

8. **Missed Appointments.** Our policy is to charge for missed appointments not cancelled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Our standard missed appointment charge is $50.00. Please help us serve you better by keeping your scheduled appointments.

9. **Cancellations.** Our policy is to charge a $50.00 fee for cancellations made less than 24 hours before the time of your appointment.

10. **Fees.** Thrive Counseling of Idaho's professional fees are as follows:

    - **$115.00/hour** (A typical session includes 50-55 minutes of direct contact between clinician and client and 5-10 minutes for clinician to document the session.)
    - If full payment is made at the time of the visit, a $30 credit is applied and the client pays only **$85.00/hour** for MOST of our counselors. Ask what your counselor's cash pay policy is before your visit.
    - If full payment is not rendered at the time of the visit, **a payment plan may be arranged** between the client and Thrive. In this case, each hour will be charged the standard **$115.00**.
    - Any written documentation requested to be produced by our professionals will be billed to the client directly at **$21.25** per fifteen (15) minute increment required for fulfillment.

Our practice is committed to providing the best treatment for our clients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. If, however, you have any questions or concerns regarding this policy, please let us know.

I have read and understand the payment policy and agree to abide by its guidelines:

_____	_____
Signature of Client or Responsible Party	*Date*

Primary Care Physician

THRIVE COUNSELING OF IDAHO

3023 E. Copper Point Drive, Meridian, Idaho 83642 (T): (208) 914-8924; (F): (208) 955-2703

Release of Records Exchange

REQUEST FOR AND AUTHORIZATION TO RELEASE RECORDS OR HEALTH INFORMATION

By my signature below**, I,** _____ authorize Thrive Counseling of Idaho, Inc. to ***release***; and/or, ***obtain*** personal health information to/from:

Provider Name: _____

Address: _____

Telephone: _____

Facsimile: _____

And have access to; or, release the following records: _____

☒ Current Medical Information and/or Medical Records
☒ Evaluation, Assessment, or Diagnostic Reports or Documentation
☒ Treatment Plan(s); or, Update, Addendums to Treatment Plan(s)
☐ Other (please specify): _____
☐ IEP or school-related reports
☒ Progress-Session Notations

For the following **PARTICIPANT**:_____ **D.O.B** _____

For the purpose(s) OR need: For Treatment Purposes; as well as, maintain current, accurate documentation in participant record

AUTHORIZATION STATEMENT:

I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by Thrive Counseling of Idaho. Re-disclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, this written authorization will have an expiration date of one (1) calendar year from the authorized signature below.

THRIVE may only use or disclose your personal health information for purposes as required by law or regulations and will continue to protect your personally identifiable health information as described in the Informed Consent form(s) provided.

With my signature below, I understand what this document states and authorize release of my personal health information as stated above. I understand I will be given a signed copy of this Authorization for my records, if requested.

_____ _____
Participant Signature (if applicable) Month/Date/Year

_____
Print Participant Name

_____ _____
Signature of Legally Authorized Representative (if applicable) Month/Date/Year

_____
Print Legally Authorized Representative Name

_____ _____
Representative, Thrive Counseling of Idaho Month/Date/Year