Joanne Medellin, MS, LMFT
8016 State Line Rd. #115
Leawood, KS 66208
(816) 508-7843

REGISTRATION FORM

(Please print)

Client 1:

Name: _____ Date: _____

Date of Birth: _____ Current Age: _____

Address: _____

Cell phone: _____ Home Phone: _____ E-mail Address: _____

Place of Employment: _____ Occupation/Title:_____

Emergency Contact (name and phone):_____

Primary Care Physician: _____ Phone Number:_____ Fax Number _____

Referred by: _____

Permission to text for scheduling purposes: Yes _____ No _____

Permission to email regarding scheduling or updates from my therapist: Yes _____ No _____

Permission to leave a voicemail on cell phone: Yes _____ No _____

Client 2:

Name: _____ Date: _____

Date of Birth: _____ Current Age: _____

Address: _____

Cell phone: _____ Home Phone: _____ E-mail Address: _____

Place of Employment: _____ Occupation/Title:_____

Emergency Contact (name and phone):_____

Primary Care Physician: _____ Phone Number:_____ Fax Number _____

Referred by: _____

Permission to text for scheduling purposes: Yes _____ No _____

Permission to email regarding scheduling or updates from my therapist: Yes _____ No _____

Permission to leave a voicemail on cell phone: Yes _____ No _____

Household Members

Full Name M/F Relationship Date of Birth Age

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

Cancellations/Fees

A 24-hour notice is required for all cancellations. Otherwise, **normal session fee will be charged** for the missed appointment. Insurance companies do not pay for missed appointments; therefore this charge will be the patient or guardians responsibility.

Fees	
Payments using credit/debit	**$3.00***
FMLA/Letters to physicians, employers, schools	**$20.00***
Reports/Court testimony (includes all required time)	**$150.00/hour***

***fees not covered by insurance**

_____ _____

Client/Guardian signature Client/Guardian signature

Authorization to treat

I give my consent to my therapist to provide assessment and therapeutic services to me/my child, within the scope of his/her license. I understand that my therapist will work with me to develop a treatment plan and treatment will be formulated to resolve my problem(s) as quickly as possible. I agree to cooperate with my therapist in the treatment process to carry out therapeutic homework assignments and to follow through with any medical treatment, as prescribed by my physician. I further agree to keep my, or my child's scheduled appointments and understand that failure to do so more than two times may result in my care being terminated.

By signing below, I agree to payment and arrangements set forth, affirm that all my questions have been satisfactorily answered, and I give informed consent for myself/my child's treatment. I understand that I will be furnished a copy of the consent whenever I request it.

_____ _____ _____

Client Signature/Responsibility Party Client Signature/Responsibility Party Date

Authorization to treat minor child

Name of Child _____ Date of Birth _____

I warrant that I am a custodial parent of the above named minor child. I hereby give permission for him/her to receive counseling. I acknowledge that I am aware of the mandating reporting laws in the state of Missouri. I am also aware that I can withdraw the permission to treat my child at any time. I will assume responsibility to notify my child's other parent that counseling has been initiated and will take sole responsibility in arranging for the payment for all counseling services for my child.

_____ _____ _____

Client Signature/Responsible Party Client Signature/Responsible Party Date

Professional Disclosure Information (HIPAA)

Your signature below indicates that you have read our HIPPA agreement and agree to its terms and serves as acknowledgement that you have received our HIPPA notification form. Not abiding by these policies may lead to termination of our work together and/or referral to another professional.

_____ _____ _____

Client Signature/Responsibility Party Client Signature/Responsibility Party Date

Supervision Release

Your signature below indicates that you understand your therapist is under supervision by Janet Byars, LCMFT, KS . This supervisor will have full access to your client file. I give my permission for my therapist to share information regarding my case during clinical supervision.

_____ _____ _____

Client Signature/Responsibility Party Client Signature/Responsibility Party Date

Waiver of Medical/Psychiatric Consultation

I understand that under the provisions of KSA 65-6404 (b) (3) my therapist is required to consult with my primary care physician or a psychiatrist to determine if there may be a medical condition or medication that may be causing or contributing to any signs of a mental disorder that she or he may have observed while working with me or my minor child(ren) listed below. In the event that I or my minor child(ren) do not have a primary care physician or psychiatrist, I acknowledge that my therapist has/have recommended that I seek medical consultation.

By signing below I am indicating that I waive my right to such consultation and that I am aware that this waiver will become part of my clinical record.

_____ _____

Name of minor child Name of minor child

_____ _____ _____

Client Signature/Responsibility Party Client Signature/Responsibility Party Date

Client Rights

YOU HAVE THE RIGHT:

1. To be treated with consideration and respect.
2. To expect quality services provided by concerned, competent staff.
3. To a clear statement of purposes, goals, techniques, rules of procedure and limitations, as well as potential dangers of the services to be performed, plus all other information related to or likely to effect the on-going counseling relationship.
4. To obtain information about the case record and to have the information explained clearly and directly.
5. To full knowledgeable and responsible participation in the on-going treatment plan.
6. To expect complete confidentiality and that no information will be released without written consent.
7. To see and discuss charges and payment records.
8. To refuse any recommended services and be advised of the consequences of this action

CONFIDENTIALITY OF INFORMATION:

Laws insuring your right to privacy protects matters discussed with your therapist. In most cases, your therapist is prohibited from disclosing information about your care without your written consent and then only to the extent you authorize. Cases where information may be disclosed without your consent include:

1. When child abuse is know or suspected (reporting is required by law.
2. When the abuse of an elderly or depended person is known or suspected (required by law)
3. If you commit a crime against a staff member of another person in the premises,
4. If there is a situation that is potentially life threatening.
5. When the court subpoenas the records.

SECURITY OF RECORDS:

Your treatment of record related and related financial records are kept in a locked file cabinet. Records will not be made available to others without signed authorization to release information and payment for the records prior to releasing them. Special rules relating to the release of treatment records containing information regarding drug and alcohol abuse: CFR 42, PART 2 prohibits disclosure of such information without written consent of the client and only to the extent specifically authorized. This information cannot be disclosed to another source without written consent. A general release for medical or other information is not sufficient. Use of information in records for criminal investigation and prosecution is strictly prohibited.

RETENTION OF RECORDS:

Treatment records are retained for a period of seven years following the termination of treatment for adults and until ages 28 in the case of minors. At the end of that period the records are destroyed in a manner that assures the confidentiality of the information unless the client requests otherwise, in writing, prior to the destruction of records.

INFORMATION REGARDING PSYCHOTHERAPY:

1. Psychotherapy may involve remembering unpleasant events and can arouse intense emotions of fear and anger; feelings of anxiety, depression, frustration, loneliness and helplessness may be experienced. Also feelings of relief, energy, power, self-acceptance, and well being may also occur
2. Psychotherapy is not always effective and may, in some cases; result in deterioration rather than improvement of a clients psychological functioning. Psychotherapy has been shown effective in about 75% of cases.
3. There are numerous forms of psychotherapy, which vary, not only underlying theory and methods employed, but also in terms of time commitment and cost. We will attempt to provide treatment that is realistic in both areas.
4. Current research has failed to demonstrate that any one form of psychotherapy is necessarily more effective than any other.
5. Depending upon a client's condition, there may be available alternatives to psychotherapy, such as medication or behavior modification; we will make these recommendations if they are appropriate, based upon our assessment.

_____	_____	_____
Client Signature/Responsibility Party	Client Signature/Responsibility Party	Date

Joanne Medellin, MS, LMFT
8014 State Line Rd. #112
Leawood, KS 66208
(816) 508-7843

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION: I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

• Make sure that protected health information ("PHI") that identifies you is kept private. • Give you this notice of my legal duties and privacy practices with respect to health information. • Follow the terms of the notice that is currently in effect. • I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is: a. For my use in treating you. b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy. c. For my use in defending myself in legal proceedings instituted by you. d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA. e. Required by law and the use or disclosure is limited to the requirements of such law. f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes. g. Required by a coroner who is performing duties authorized by law. h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.

3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AURTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.

2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.

3. For health oversight activities, including audits and investigations.

4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.

5. For law enforcement purposes, including reporting crimes occurring on my premises.

6. To coroners or medical examiners, when such individuals are performing duties authorized by law.

7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.

8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.

10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.

2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.

4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.

5. The Right to Get a List of the Disclosures I Have Made.You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.

7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on July 17, 2014

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing the appropriate box in your Intake Packet, you are acknowledging you have received and read this Notice.

Joanne Medellin, MS, LMFT
INDIVIDUAL CONCERNS

Name	Date

Check any of the following terms that apply to you (S = Self) or any of your family members (F = Family).

S	F		S	F		S	F	
☐	☐	Nervousness	☐	☐	Health Problems	☐	☐	Marital Problems
☐	☐	Shyness	☐	☐	Stomach Problems	☐	☐	Divorce
☐	☐	Anger	☐	☐	Bowel Problems	☐	☐	Separation
☐	☐	Loneliness	☐	☐	Depression	☐	☐	Affair
☐	☐	Frustration	☐	☐	Headaches	☐	☐	Problems w/ ex-spouse
☐	☐	Temper	☐	☐	Memory Problems/Loss	☐	☐	Stress
☐	☐	Weight Gain/Loss	☐	☐	Balance Problems	☐	☐	Alcohol Usage
☐	☐	No Ambition	☐	☐	Seizures	☐	☐	Drug Usage
☐	☐	Sleeping Problems	☐	☐	Problems with Attention	☐	☐	Sexual Problems
☐	☐	Tiredness	☐	☐	Problems w/Self-Control	☐	☐	Gambling Problems
☐	☐	Self-Control	☐	☐	Hear/see things others do not	☐	☐	Grief
☐	☐	Insecurity	☐	☐	Repetitive behaviors to reduce stress	☐	☐	Learning/Academic Problems
☐	☐	Fears	☐	☐	Chronic Pain	☐	☐	Stuttering Problems
☐	☐	Panic Attacks	☐	☐	Eating Problems	☐	☐	Legal Problems
☐	☐	Isolation	☐	☐	Suicidal Thoughts	☐	☐	Work Problems
☐	☐	Can't Concentrate	☐	☐	Pressure to keep talking	☐	☐	Problems w/Children
☐	☐	Difficulties in Decision-making	☐	☐	Excessive Risk-Taking Behavior	☐	☐	Problems w/ Parents
☐	☐	Lost interest or pleasure	☐	☐	Racing Thoughts	☐	☐	School Problems
☐	☐	Lack of Energy/fatigue	☐	☐	Nightmares	☐	☐	Problems w/ Friends
☐	☐	Excessive Anxiety or Worry	☐	☐	Aggressive Behavior towards others	☐	☐	Frequent Lying/Deceitfulness
☐	☐	Witness/ Experience life threatening event or serious injury						

If you have noticed any <u>recent changes</u> in the following areas, <u>please circle those changes.</u>

vision	hearing	coordination	balance	strength	speech	memory
energy	sleeping	menstrual cycle	elimination	eating	sexual activity	thinking

List any medical problems you have: _____

_____

_____

List all medications you are taking:

_____

_____

List any counseling you or a member of your family are receiving or have received:

Therapist Address When Family Member(s)

_____

Have you ever been physically, sexually, emotionally abused? No Yes
If yes, briefly describe: _____

Have you ever been hospitalized for mental or nervous problems? No Yes
If yes, when and where? _____

Have you ever attempted suicide? No Yes
If yes, where and when? _____

Are you suicidal now? No Yes

How often do you drink alcohol? _____

Have you ever been arrested for driving under the influence (DUI)? No Yes
If yes, how many times? _____

Do you use drugs? No Yes
If yes, what drugs do you use and how often? _____

Have you ever been arrested? No Yes
If yes, how many times and for what? _____

Are you currently involved or do you expect to be involved in any court-related matters? No Yes
If yes, please describe: _____

What is it in your marriage, family or individual life that brings you to therapy?

What kinds of stressors are you experiencing right now?

What important things about your marriage or family would it be helpful for your therapist to know? (i.e. illnesses, handicaps, deaths, divorces, school/job changes, suicide)

Do you have any concerns about violence or abuse in your family? Alcohol or drug usage? Please describe.