MATERNAL COUNSELING
SERVICES

Thank you for downloading the Intake Questionnaire and Paperwork Packet for Maternal Counseling Services. It is courageous that you have asked for help and we look forward to helping you. This packet includes the following

1. The Paperwork Packet for Maternal Counseling Services

    - ✓ Informed consent and personal disclosure
    - ✓ Notice of Privacy Practices
    - ✓ Consent for Communication by Email, Text Message, and Other Non-Secure Means.
    - ✓ Please print and read over the paperwork packet. We will sign in your intake appointment.

2. The Intake Questionnaire

    - ✓ Please complete and email to your counselor, or print and bring to your first session.
    - ✓ We will review this document in your first session.

It should take you no more than 10-20 minutes to review and complete the entire packet.

We look forward to assisting you in your goals toward mental wellness. If you have questions prior to your appointment, please email help@maternalcounselingservices.com

Sincerely,

Ciji C. Gamble, MA, LPC, NCC
Maternal Counseling Services

Maternal Counseling Services, PLLC

help@maternalcounselingservices.com
269-903-4535

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Please be aware that there are two forms of communication that are related to clinical documentation, progress notes, which constitute your clinical record, and psychotherapy notes. Progress notes include your reasons for seeking therapy, your diagnosis, the goals for treatment, your progress toward those goals, your medical and social history, your treatment history, any past treatment records received from other providers, reports of any professional consultations, your billing records, and any reports sent to insurance carriers. You may examine and/or receive a copy of your clinical record. Psychotherapy notes are not regarded as a part of the clinical record and are the practitioner's notes that may help analyze the content of the conversations in session, which aid the counselor in understanding the client in the context of the problems shared. Psychotherapy notes are not available to the client and cannot be sent anyone else without the client's signed authorization.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective October 27, 2016

This Notice of Privacy Practices applies to the following organizations.

This notice applies to Maternal Counseling Services, PLLC and its clients

Please sign and date that you have received and reviewed the Notice of Privacy Practices

Signature

Date

Communication by Email, Text Message, and Other Non-Secure Means

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with Ciji C. Gamble, MA, LPC, NCC of Maternal Counseling Services, there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate with your Maternal Counseling Services therapist
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

If there are people in your life that you don't want accessing these communications, please talk with your Maternal Counseling Services therapist about ways to keep your communications safe and confidential.

Consent For Transmission Of Protected Health Information By Non-Secure Means

I, _____ AUTHORIZE: Maternal Counseling Services, PLLC and Ciji C. Gamble, MA, LPC, NCC

(name of client) (name of clinician)

1611 W. Centre Ave Suite 200, Portage, MI 49024

(street address)

TO TRANSMIT THE FOLLOWING PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT:

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment
- Completed forms, including forms that may contain sensitive, confidential information
- Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment
- My health record, in part or in whole, or summaries of material from my health record
- Other information. Describe: _____

BY THE FOLLOWING NON-SECURE MEDIA:

- Unsecured email.
- SMS text message (i.e. traditional text messaging) or other type of "text message."
- Google Voice Text, Phone and Voicemail
- Other media. Describe: _____.

TERMINATION

This authorization will terminate at discharge of services.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

_____ _____

(Signature of client) Date

MATERNAL COUNSELING
SERVICES
1611 W. CENTRE AVE. SUITE 200
PORTAGE, MI 49024

Intake Form

Patient Information

First Name: _____ Middle Initial: _____ Last Name : _____

Preferred Nickname : _____ Date of Birth (m/d/yyyy) : _____

Street Address : _____ City : _____ State : _____ Zip : _____

Mobile Phone : _____ Home Phone : _____
May Maternal Counseling Services, PLLC and your counselor leave voice message on your number(s)? ◯ Y/N ◉
May Maternal Counseling Services, PLLC and your counselor send text messages to your mobile number? ◉ Y/N ◯

Email Address : _____
May Maternal Counseling Services, PLLC and your counselor email you at this email address? ◯ Y/N ◯
Please be aware that the use of email and text messages are considered non-secure means of communication.
If you have questions please view the Practice Paperwork Packet

Gender: O Male O Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Ethnicity: _____ Religious Affiliation *(if applicable)*: _____

Emergency Contact

First Name: _____ Middle Initial: _____ Last Name : _____

Relationship: ☐ Parent ☐ Spouse ☐ Legal Guardian ☐ Other

Date of Birth (m/d/yyyy) : _____

Street Address : _____ City : _____ State : _____ Zip : _____

Mobile Phone : _____ Home Phone : _____

Primary Care Physician or OB/GYN

Note: If within a year of being postpartum, please provide your OB/GYN

Name: _____

Practice Name : _____

Street Address : _____ City : _____ State : _____ Zip : _____

Office Phone : _____ Fax Number : _____

Insurance (if applicable)

Insurance Company & Plan Name : _____

Insurer's ID : _____ Group ID : _____

Relationship to Insured ☐ Parent ☐ Spouse ☐ Legal Guardian ☐ Self

If you are a dependent or not the primary person insured please list the insurer's name and date of birth

_____

Who referred you to counseling or how did you find Maternal Counseling Services?

Presenting Problem

What is your reason for seeking counseling?

What symptoms are you experiencing?

☐ Irritability	☐ Fatigue	☐ Trouble concentrating	☐ Depressed mood
☐ Excessive sleep	☐ Low motivation	☐ Isolation from others	☐ Low self-esteem
☐ Difficulty Sleeping	☐ Restlessness	☐ Fear	☐ Hopelessness
☐ Tearful or crying spells	☐ Anxiety/Nervousness	☐ Loss of interest in activities	☐ Social Withdrawal
☐ Panic	☐ Racing Thoughts	☐ Bad Dreams/Nightmares	☐ Mood Swings

How long have these symptoms been occurring and when did they start?

Have you ever been to counseling? Y/N
If yes, please specify date and reason.

Have you ever been to hospitalized for mental illness? Y/N
If yes, please specify date and reason

Have you ever had suicidal or homicidal thoughts? Y/N
If yes, please specify which, when the last thoughts occurred and when the first developed.

Have you ever had a suicide attempt? Y/N
If yes, please list the date of the attempt and the plan used.

Have you ever experienced physical, sexual, emotional or religious abuse? Y/N
If so by whom and when:

Do you or anyone in your family have history of the following? Please check if self and list family member

- ○ Addiction (☐ Self/Family_____)
- ○ Anxiety (☐ Self/Family_____)
- ○ Phobias (☐ Self/Family_____)
- ○ Anger (☐ Self/Family_____)
- ○ Thyroid Issues (☐ Self/Family_____)
- ○ Obsessions –recurring thoughts (☐ Self/Family_____)
- ○ Compulsions – repetitive behaviors (☐ Self/Family_____)
- ○ Depression (☐ Self/Family_____)
- ○ Panic Attacks (☐ Self/Family_____)
- ○ Premenstrual Dysphoric Disorder (☐ Self/Family_____)
- ○ Bipolar Depression (☐ Self/Family_____)

Please list current medications, dosage and prescribing physician.

_____

_____

Do you consume or use any of the following?
If yes, please select the circle and detail type, amount and frequency.

☐ Alcohol_____ ☐ Tobacco_____

☐ Recreational Drugs_____ ☐ Caffeine_____

Family & Social Support

Name	M/F	Age	Living in the Household? Y/N	State of the Relationship (Great, Good, Fair, Poor)
Patient's Parent (s)				
1.				
2.				
Patient's Siblings				
1.				
2.				
3.				
4.				
5.				
Patient's Significant Other (if applicable, and may include those separated or divorced)				
1.				
2.				
Patient's children (if applicable)				
1.				
2.				
3.				
4.				
5.				

Do you feel as if you have emotional support? Y/N
If yes, by whom?

Are you coping with any developmental delays, physical limitations or abilities?

What is your highest level of education?

Military Experience?

Yes No Sig. Other Active or Inactive Duty

Have you ever been involved in the legal system? Y/N
If yes, please detail.

Pregnancy & Postpartum History
Please complete the applicable items if you are currently pregnant or if you are within 18 months of being postpartum.

Do you have a history of infertility? Y/N
If yes, please detail the interventions used as well as time from attempting to conception.

Have you had any pregnancy terminations, miscarriages, birth loss or pregnancy loss? Y/N
If yes, please detail.

Did you enjoy being pregnant? Y/N

Was your pregnancy planned? Y/N

What are your feeding plans?
Nursing Formula Exclusively Pumping Other_____

Did you or your infant experience medical complications during pregnancy, labor or during the postpartum period? Y/N
If yes, please detail.

Please share your birth story. (C-section, Vaginal delivery, Induced, Overdue, etc...)

Thank you for taking the time to complete the adult intake form. This will allow for a seamless intake session with your counselor. Please either save and email to help@maternalcounselingservices.com or you may print and bring to your first session.