Alaska Brain and Spine

Dr. Joshua Costello

**EMPOWERING YOU TO LIVE THE BEST LIFE POSSIBLE**

4001 Geist Rd, suite 12, Fairbanks, AK 99709 [www.alaskabrainandspine.com](http://www.alaskabrainandspine.com/)

Phone (907) 374-1981

Fax (907) 374-1983

Todays Date:

First First: Last: MI:\_\_\_\_

Address: \_\_\_\_ City: State:\_\_\_ Zip:\_\_\_\_\_\_

SSN: Birthdate:

Sex: Male [ ] Female [ ] Transgender [ ]

Home Phone: Cell: OK to leave message?

Circle all that apply: Single Married Partnered Separated Divorced Widowed

Employed Retired Not employed FT student PT student Child Other [ ] Minor | If minor, legal guardian name: How did you hear about Alaska Brain and Spine: Primary Doctor Name and Phone Number: Person(s) allowed to receive my medical information: My E-mail address is: **EMPLOYMENT INFORMATION (does not apply for minor)**

Employer Name: Occupation: Employer Phone: Employer Address: **EMERGENCY CONTACT**

Contact Name: Relation to patient: Contact phone: Address:

# EMAIL CONSENT

Alaska Brain and Spine offers you the ability to communicate with us via email. However, due to HIPPA regulations we need the consent from you before we are able to send or receive any emails including but not limited to; chart notes, ledgers, appointments, intake and history information, imaging/lab results, etc.

By signing below states that I understand, most email services (Hotmail, Gmail, Yahoo) do not utilize encrypted email and Alaska Brain and Spine is not liable. I give my consent to communicate by email with Alaska Brain and Spine. (Leave blank if you do not wish to ever receive health information via email)

Signature Date Printed name

# INSURANCE & BILLING INFORMATION

1. **Primary Insurance Company**: ID#: Policy Holder’s name: Group Number:

Address if different from patient:

Birthdate: SSN: Relationship to Patient:

1. **Secondary Insurance Company**: ID#: Policy Holder’s name: Group Number:

Address if different from patient:

Birthdate: SSN: Relationship to Patient:

**We recommend that you research your insurance benefits and eligibility.**

* + Insurance coverage is not a guarantee of payment.
	+ I understand that Alaska Brain and Spine is not “In-network” with my insurance company and that I am responsible for verifying my out-of-network benefits.
	+ I understand that copays/coinsurance/deductibles and/or patient balances are due at the time of service.
	+ We will bill your insurance based on the information you provide us. You are responsible for informing our office of any changes/updates to insurance information.
	+ You are ultimately responsible for payment of services rendered. If we do not hear from the insurance within 60 days of submission the balance will become patient responsibility.
	+ After claims process through insurance patient will receive a statement and payment is due at that time. If payment has not been received within 60 days your account may be sent to a collection agency. In the event your account is sent to collections this may result in discharge from care.
	+ I hereby authorize Alaska Brain and Spine to release my information to my insurance company and my insurance company to release information to Alaska Brain and Spine. I hereby assign benefits to be paid directly to Alaska Brain and Spine for this date and any future visits I may have.

### Payment in full is required at the time of service in the following circumstances:

* + - You do not have insurance coverage
		- You have not met your deductible
		- Any services rendered or treatment related supplies not covered by insurance
		- You have Federal Blue Cross Blue Shield
		- You are at maxed benefits with your insurance company
		- Any supplements/products

By signing below I acknowledge I have read and understand the above and I accept responsibility to pay for all services rendered which my insurance does not cover.

Patient Signature (or Responsible Party) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name Relationship to Patient

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**Insurance Prior Authorization**

Your health insurance may require prior authorization for certain services either through their own offices or a third party administrator.

Alaska Brain and Spine will make every effort to inform the patient/parent when this prior authorization is required. Insurance requirements can differ with carriers and plans. We will send for a prior authorization after your initial visit.

Please be aware that this process could take up to 2 weeks. If the prior authorization department deems the services are not medically necessary, your insurance will not cover these services. We will inform the patient/parent of the denial as soon as we receive this information. We will give the patient/parent the option to receive further services. If patient consents to these services, the patient/parent will be responsible for payment in full at the time of service. We will try to bill your secondary insurance as a courtesy but please be aware that they may deny these services also.

As treatment continues, it may be necessary to obtain an additional authorization for services if approved originally. We are informing you that the insurance could deem further services as not medically necessary in which case the above process will be followed.

By signing below, I am acknowledging the understanding of the above information. I have had the opportunity to ask questions regarding fees and payment.

Patient:

Printed

Signature:

Patient/Parent/Guardian

Date:

Staff Signature: Date:

# Cancellation and No Show Policy

Alaska Brain and Spine is a multidisciplinary clinic. We provide services for chiropractic care, physical therapy, massage therapy, naturopathy, counseling, acupuncture and pilates. We have various types of appointments for our providers. Chiropractic has four types of appointments: 20 min, 40 min, 60 min Intensive and a New Patient. Physical Therapy

has 60 min appointments. Naturopathy has New Patient and 30 min appointments. Counseling has New Patient, 60 min and 30 min sessions. Our massage appointments are either 60 min or 90 min. Our clinic has a wait list for initial and follow up appointments. A late cancellation or a “no-show” denies us the time necessary to schedule these wait-listed patients. We respect our patient’s time greatly and strive to deliver the best care possible in a timely manner. The policy below enables us to utilize all available appointment times for patients in need of medical

care.

# We require that you call at least 24 hours in advance to cancel your scheduled appointment. If this time frame is not met it will be considered a “same day cancellation”.

**Failure to do so will result in a late cancellation fee outlined below.**

**A “No-Show” is someone who misses an appointment without canceling it. Failure to be present at the time of your scheduled appointment will result in a “no-show” fee outlined below.**

**Fees for Late/Same Day Cancellations and No-Shows**

## New Patient visit $250.00

40 Min Appointment

30 Min Appointment

$150.00

 $125.00

20 Min Appointment $75.00

Counseling Initial $175.00

Counseling Follow-up 45-60min $97.50

Physical Therapy Appointment $200.00 Massage Therapy Appointment $150.00

Thank you for your cooperation. Sincerely,

Providers and Staff of Alaska Brain and Spine

**Patient or Legal Guardian Signature Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed Patient or Legal Guardian Name**

# PRIVACY POLICY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

# USES AND DISCLOSER OF YOUR MEDICAL INFORMATION

**FOR TREATMENT:** We may use medical information about you to provide you with medical treatment or services.

**FOR PAYMENT:** We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and may be collected from you, an insurance company, or a third party.

**FOR HEALTH CARE OPERATIONS:** We may use and disclose health information about you for operations of our health care practice.

**FOR INDIVIDUALS INVOLVED IN YOUR CARE AND PAYMENT FOR YOUR CARE:** We may release medical

information about you to a friend or family member who is involved in your medical care.

**AS REQUIRED BY LAW:** We will disclose medical information about you when required to do so by federal, state, or local law.

# YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

**YOUR RIGHT TO INSPECT AND COPY:** To inspect and copy your medical information, you must submit your request in writing. We may deny your request to inspect and copy, in limited circumstances. If you are denied access to medical information, you may request in writing, that the denial be reviewed.

**YOUR RIGHT TO AMEND:** If you feel the medical information, we have about you is incorrect or incomplete, you may request an amendment in writing. Your request may be denied if you do not include a reason to support the request.

**YOUR RIGHT TO AN ACCOUNTING OF DISCLOSURES:** You have the right to request in writing, a list of any disclosures of your medical information we have made, except for disclosures for treatment, payment, and health care operations, as previously described.

**YOUR RIGHT TO REQUEST RESTRICTIONS:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations.

**Your Right to Request Confidential Communications:** You have the right to request in writing that we communicate with you about medical matters in a certain way or at a certain location.

**YOUR RIGHT TO A PAPER COPY OF THESE FORMS:** You have the right to a paper copy of this notice at any time. **CHANGES TO THIS NOTICE:** We reserve the right to change this notice and will post the current notice in our facility. **COMPLAINTS:** If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services.

**OTHER USES OF MEDICAL INFORMATION:** Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

**By my signature below I acknowledge receipt of a copy of the Notice of Privacy Practices.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Adult Counseling Intake Form\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_

Are you currently in a romantic relationship? □Yes □No

If yes, for how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, on a scale of 1-10 (10=great), how would you rate the quality of your romantic relationship? \_\_\_\_\_\_

Do you have children? □No □Yes

If yes, how many?: \_\_\_\_\_ Ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEALTH INFORMATION

How is your physical health currently? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Primary Care doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Name) (Phone)

Please list any chronic health problems or concerns (e.g. asthma, hypertension, diabetes, headaches, stomach pain, seizures, etc.):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hours per night you normally sleep \_\_\_\_\_\_\_

Are you having any problems with your sleep habits? □ No □ Yes

 If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ Can’t fall asleep □ Can’t stay asleep

Do you exercise regularly? □ No □ Yes

If yes, how many times per week do you exercise? \_\_\_\_\_\_ For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, what do you do?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you having any difficulty with appetite or eating habits? □ No □ Yes

If yes, check where applicable: □ Eating less □ Eating more □ Bingeing □ Purging

Have you experienced significant weight change in the last 2 months? □ No □ Yes

Do you regularly use alcohol? □ No □ Yes

If yes, what is your frequency?

□ once a month □ once a week □ daily □ daily, 3 or more □ intoxicated daily

How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Rarely □ Never

Do you smoke cigarettes or chewing tobacco? □ No □ Yes

If yes, how often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink caffeinated drinks? □ No □ Yes

If yes, # of sodas per day\_\_\_\_\_\_ cups of coffee per day\_\_\_\_\_\_\_

Have you ever had a head injury? □ No □ Yes

If yes, when and what happened?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

THERAPY INFORMATION:

What prompted you to seek therapy at the current time?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What are your overall goals for therapy?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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In the last year, have you experienced any significant life changes or stressors?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you had previous therapy? □No □Yes

If yes, why and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, who did you see for therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PSYCHIATRIC INFORMATION

Are you currently taking prescribed psychiatric medications (antidepressants or others)? □Yes □No

If Yes, please list names and doses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If No, have you been previously prescribed psychiatric medication? □Yes □No

If Yes, please list names and dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you hopeful about your future? □Yes □No

Are you having current suicidal thoughts? □ Frequently □ Sometimes □ Rarely □ Never

 If yes, have you recently done anything to intentionally hurt yourself? □Yes □No

Have you had suicidal thoughts in the past? □ Frequently □ Sometimes □ Rarely □ Never

If so, when did you have these thoughts?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you ever act on them? □Yes □No

Are you having current homicidal thoughts (i.e., thoughts of hurting someone else)? □Yes □No

Have you previously had homicidal thoughts? □Yes □No

If yes, when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you **currently** experiencing: Rating Scale 1-10 (10 =worst)

 *Only rate the areas to which you say “yes”*

Depressed Mood or Sadness yes no \_\_\_\_\_\_

Irritability/Anger yes no \_\_\_\_\_\_

Mood Swings yes no \_\_\_\_\_\_

Rapid Speech yes no \_\_\_\_\_\_

Racing Thoughts yes no \_\_\_\_\_\_

Anxiety yes no \_\_\_\_\_\_

Constant Worry yes no \_\_\_\_\_\_

Panic Attacks yes no \_\_\_\_\_\_

Phobias yes no \_\_\_\_\_\_

Sleep Disturbances yes no \_\_\_\_\_\_

Hallucinations yes no \_\_\_\_\_\_

Paranoia yes no \_\_\_\_\_\_

Poor Concentration yes no \_\_\_\_\_\_

Alcohol/Substance Abuse yes no \_\_\_\_\_\_

Frequent Body Complaints ( e.g., headaches) yes no \_\_\_\_\_\_

Eating Disorder yes no \_\_\_\_\_\_

Body Image Problems yes no \_\_\_\_\_\_

Repetitive Thoughts (e.g., Obsessions) yes no \_\_\_\_\_\_

Repetitive Behaviors (e.g., counting ) yes no \_\_\_\_\_\_

Poor Impulse Control (e.g., ↑ spending) yes no \_\_\_\_\_\_

Self Mutilation yes no \_\_\_\_\_\_

Sexual Abuse yes no \_\_\_\_\_\_

Physical Abuse yes no \_\_\_\_\_\_

Emotional Abuse yes no \_\_\_\_\_\_

Have you experienced in the **past**: Rating Scale 1-10 (10 =worst)

 *Only rate the areas to which you said “yes”*

Depressed Mood or Sadness yes no \_\_\_\_\_\_

Irritability/Anger yes no \_\_\_\_\_\_

Mood Swings yes no \_\_\_\_\_\_

Rapid Speech yes no \_\_\_\_\_\_

Racing Thoughts yes no \_\_\_\_\_\_

Anxiety yes no \_\_\_\_\_\_

Constant Worry yes no \_\_\_\_\_\_

Panic Attacks yes no \_\_\_\_\_\_

Phobias yes no \_\_\_\_\_\_

Sleep Disturbances yes no \_\_\_\_\_\_

Hallucinations yes no \_\_\_\_\_\_

Paranoia yes no \_\_\_\_\_\_

Poor Concentration yes no \_\_\_\_\_\_

Alcohol/Substance Abuse yes no \_\_\_\_\_\_

Frequent Body Complaints ( e.g., headaches) yes no \_\_\_\_\_\_

Eating Disorder yes no \_\_\_\_\_\_

Body Image Problems yes no \_\_\_\_\_\_

Repetitive Thoughts (e.g., Obsessions) yes no \_\_\_\_\_\_

Repetitive Behaviors (e.g., counting ) yes no \_\_\_\_\_\_

Poor Impulse Control (e.g., ↑ spending) yes no \_\_\_\_\_\_

Self Mutilation yes no \_\_\_\_\_\_

Sexual Abuse yes no \_\_\_\_\_\_

Physical Abuse yes no \_\_\_\_\_\_

Emotional Abuse yes no \_\_\_\_\_\_

OCCUPATIONAL, FINANCIAL, EDUCATIONAL, & LEGAL INFORMATION:

Are you employed? □ No □ Yes

If yes, who is your current employer/position? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, are you happy at your current position? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any work-related stressors, if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have financial concerns? □ No □ Yes

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently in the military? □ No □ Yes Previously? □ No □ Yes

Highest level of education:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any legal concerns? □ No □ Yes

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY HISTORY:

Are your parents: □ still together

 □ divorced, when\_\_\_\_\_\_\_\_\_\_\_\_

 □ remarried

 □ unmarried

 □ deceased, if yes whom\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ age at death\_\_\_\_\_\_

Number of siblings:\_\_\_\_\_\_\_ Ages:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have good family support? □ No □ Yes From whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty Family Member(s)

Depression yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bipolar Disorder yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anxiety Disorders yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Panic Attacks yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Schizophrenia yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol/Substance Abuse yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eating Disorders yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Learning Disabilities yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Trauma History yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suicide Attempts yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychiatric Hospitalizations yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OTHER INFORMATION:

What role, if any, do religion and/or spirituality play in your life?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you satisfied with your social situation/interpersonal relationships? □ No □ Yes

 If no, explain why:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What do you consider to be your strengths? What do you like most about yourself?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What are effective coping strategies you use when stressed?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is there anything that I did not ask about here that would be important for me to know about you?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Informed Consent**

These document is intended to inform you of policies and your rights.

**Risk, Benefits and Responsibility of Counseling**

There may be both risks and benefits associated with participation in counseling. Counseling may facilitate an ability to relate to others, enhance academic and work performance, improve relationships with self and others, expand an individual’s ability to deal with everyday stress, and provide a clearer understanding of self, values and goals. Although counseling can be beneficial to many people, it may not be helpful for everyone. It is the client’s responsibility to actively participate in the therapeutic process and treatment.

**Emergency Situations**

In case of emergency outside of normal business hours please call:

• 911 for immediate emergency care or visit the F.M.H. emergency room

• the Crisis Hot Line at 452-4357

• the Fairbanks Community Behavioral Health Center On-Call Service at 452-1575

**Limitations of Confidentiality**

Client information shared is confidential, except in the following circumstances:

• Information required by your insurance company such as diagnosis and dates of services, etc. will be shared with our billing provider to collect payments

• Mandated reporting of abuse of children or adults

• Threats of suicide or homicide

• Cases where you have signed a release of information

• Information necessary for consultation with other providers at Alaska Brain and Spine

• Information released as outlined in the HIPAA Notice of Privacy Practice

• Those required by law

• Your treatment may be discussed with other counseling professionals for the purpose of consultation. If that occurs, your confidentiality will be maintained

• In the event of an emergency, hospitalization, and with your permission, we may use or disclose your protected information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition. In case of an emergency and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to my professional judgment.

**Court Testimony**

If I am required to participate in court proceedings on your behalf, I will charge $300 per hour for court appearances/testimony with a $600 minimum. This is due to the inevitability of me needing to consult with an attorney myself as well as needing to reschedule clients for court appearance. This fee will be assessed if I am scheduled for court on your behalf, and it is not contingent upon my actual participation or testimony. This fee is based on current client fees and is not an expert witness fee. You are responsible for these fees at the time of service. Insurance will not cover this fee. Travel and waiting time will be included in the hourly rate. Please discuss with me in advance any court related services you may require.

**Contact outside of scheduled sessions**

If for some reason, therapist/client contact is requested and provided in person, over the phone, through email outside of scheduled session time, it will be billed at regular session rates.

**By signing below, you acknowledge and accept conditions as outlined above in this Informed Consent:**

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Client’s Signature Date

**Professional Disclosure Statement**

Elizabeth Sewell, M.Ed., LPC, CDC-I

*Formal Education*

Bachelor of Science in Human Services, concentration in criminal justice at the Valley City State University

Masters of Education in Community Counseling at the University of Alaska Fairbanks

*Areas of Specialization and Competence*

I have experience working with a variety of client concerns, including anxiety, behavioral concerns, depression, domestic violence, family conflict, grief, healthy relationships, parenting skills and trauma.

*Fee Schedule*

*Initial Evaluation 60-80 minutes ($350)*

Individual Counseling, 30 minutes ($180)

Individual Counseling, 45 minutes ($195)

Individual Counseling, 60 minutes ($195)

\*As a courtesy to you, Alaska Brain and Spine will bill your insurance.

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Client’s Signature Date

This information is required by the Board of Professional Counselors which regulates all licensed professional counselors. The board can be contacted at P.O. Box 110806 Juneau, AK 99811-0806 or Phone: (907) 465-2551