Dr. Mario Lehenbauer-Baum, Licensed Psychologist
Thrive in Life Counseling and Therapy LLC, 256 Seaboard Lane, Suite E-102, Franklin, Tennessee 37067
www.thriveinlifepsychology.com | office@thriveinlifepsychology.com | (615) 582-8602

CLIENT INTAKE FORM

Please note that any information provided on this form is protected as confidential information and will be part of your Clinical Record.

Contact and Insurance Information

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. Please note that as a general rule, Dr. Mario Lehenbauer-Baum will NOT use your e-mail/mail address or phone numbers for anything other than general inquiries, billing purposes or for scheduling/re-scheduling appointments. Please check all that applies:

Name:_____ **DOB:** _____ **Today's date**: _____

Insurance Provider:_____ **Insured's ID number**: _____

Referred By/How did you find our office? _____

Age: _____ **Gender**: _____ **Parent/Legal Guardian** (if under 18): _____

Employment Status and Employer(or school): _____

Home Address: _____
Can we use your home address to send bills/invoices: O YES O NO
If no, please indicate another address where you want us to send your bills:
Billing address: _____

Insured's name and address (only if different from client):_____
_____

Insured's date of birth: _____ **Insured's gender**: _____ **Relationship to Insured Person**: _____

I wish to be contacted in the following manner (please check all that applies):

__ **Home Telephone**: _____
__ OK to leave message with detailed information
__ Leave message with call back number only
__ OK to talk to someone else if someone else answers the phone, such as: _____

__ **Work Telephone**: _____
__ OK to leave message with detailed information
__ Leave message with call back number only
__ OK to talk to someone else if someone else answers the phone, such as: _____

__ **Cell Phone Number**: _____
__ OK to leave message with detailed information
__ Leave message with call back number only
__ OK to talk to someone else if someone else answers the phone, such as: _____

__ **Home Written Communication**
__ OK to mail to my home address stated above with Dr. Mario Lehenbauer-Baum in the return address
__ OK to mail to my home address with return address only, no name

__ **Work Written Communication**
__ OK to mail to my work address with Dr. Mario Lehenbauer-Baum in the return address
__ OK to mail to my work address with return address only, no name

__ **Email Address**:_____
__ OK to email bills/invoices to my email address
__ OK to use this email for scheduling/re-scheduling purposes

In case we need to reach out to an emergency contact, please list the name(s) and phone number(s):

Emergency contact name:_____ **Relationship to client:** _____

Emergency contact address:_____

Emergency contact phone:_____
Can we use the emergency contact phone to talk to the emergency contact? O YES O NO
Can we use the emergency contact phone to leave a message with detailed information? O YES O NO

Name of Primary Care Physician (if any) : _____

Phone number of Primary Care Physician (PCP) : _____

Please note that some clients want Dr. Mario Lehenbauer-Baum to share treatment and assessment information and/or updates with their primary care physician's office, but he does not do it automatically unless clients specifically want it. ***Do you want Dr. Mario Lehenbauer-Baum to contact your primary care physician and share confidential and protected health information (PHI) with your primary care physician?*** **O YES O NO**
If yes, Dr. Mario Lehenbauer-Baum will provide you with an additional form for your consent and authorization to share protected health information.

Please note that uses and disclosures may be permitted without prior consent in an emergency!

Please sign that you agree that we can contact you by using the address, email address and/or phone number provided above, and contact the emergency contact provided above.

_____	_____	_____
Client Signature, or parent(s) if Minor or Legal Charge	**Print Name**	**Date**
_____	_____	_____
Signature of Witness	**Dr. Mario Lehenbauer-Baum**	**Date**

General Intake Information

Have you ever received mental health services (psychotherapy, psychiatric services, etc.) before?
□ No □ Yes, previous therapist/practitioner: _____

Are you <u>currently</u> taking any prescription medication? □ No □ Yes, the following: _____
_____

Have you <u>ever</u> been prescribed psychiatric medication? □ No □ Yes, the following: _____
_____

How would you rate your current physical health? (1=poor and 10=exceptional): _____

Please list any physical health problems you are currently experiencing: _____
_____

How would you rate your current sleeping habits? (1=poor and 10=exceptional): _____

How many times/week do you exercise? _____ **What types of exercise?** _____

Are you currently experiencing:

Overwhelming Sadness: □ No □ Yes, since (month and/or year) _____
Grief or depression? □ No □ Yes, since (month and/or year) _____
Anxiety or phobias? □ No □ Yes, since (month and/or year) _____
Panics attacks? □ No □ Yes, since (month and/or year) _____
Chronic pain? □ No □ Yes, since (month and/or year) _____
Sleep problems? □ No □ Yes, since (month and/or year) _____
Difficulties eating/eating problems: □ No □ Yes, since (month and/or year) _____

Do you drink alcohol more than once a week? □ No □ Yes – please list how much: _____

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

Are you currently in a romantic relationship? □ No □ Yes, since (month and/or year) _____

How would you rate your relationship on a scale of 1-10: (1=poor and 10=exceptional): _____

Any there any recent life changes or stressful events? _____
_____

Family Mental Health History

Please identify your family history of any of the following issues and the family member's relationship to you (mother, father, grandmother, uncle, etc.):

Mental health issues	**Please mark**	**Family member(s)**
Alcohol/Substance Abuse	□ No □ Yes	_____
Anxiety	□ No □ Yes	_____
Depression	□ No □ Yes	_____
Domestic Violence	□ No □ Yes	_____
Eating Disorders	□ No □ Yes	_____
Obesity	□ No □ Yes	_____
Obsessive Compulsive Behavior	□ No □ Yes	_____
Schizophrenia	□ No □ Yes	_____
Suicide Attempts	□ No □ Yes	_____
Other: _____	□ No □ Yes	_____

Do you enjoy your school/work? Is there anything stressful about school or your current work?
_____

Do you consider yourself to be spiritual/religious? □ No □ Yes, please describe your faith:_____

What do you consider to be your three main strengths? _____

What do you consider to be your three main weaknesses? _____

What are your three major goals in coming to counseling? _____

Authorization for Use, Disclosure, Storage and Submission of Protected Health Information

If services are (partly or in full) covered by your health insurance, or employee benefit plan, please note that it requires Dr. Mario Lehenbauer-Baum to provide them with information relevant to the services that he provides to you (e.g., clinical diagnosis, Clinical Records, etc.). Psychologists are legally allowed to use or disclose your Protected Health Information and Clinical Records or any other information for payment, treatment, and health care operations purposes when your services are covered by health insurance or other providers.

Dr. Mario Lehenbauer-Baum uses billing software (for example, Office Ally www.officeally.com) to submit claims to health insurance providers, track claims and payments, to schedule appointments, and to record and store clinical and therapy notes. The billing software records and stores your protected health information data; please note that the billing software is compliant to HIPAA (Health Insurance Portability and Accountability Act of 1996).

By signing below, you understand and agree that Thrive in Life Counseling and Therapy LLC and Dr. Mario Lehenbauer-Baum have to store, maintain and submit protected health information and/or other necessary information to health insurance and other providers (e.g., Office Ally, other billing software providers, etc.) for treatment, payment, and health care operations purposes on/for all days you receive services.

Authorization and Signature

I authorize the release of my confidential protected health information and my Clinical/Medical Record(s) (e.g., progress notes), as described above, to be submitted and stored online and in physical locations for billing and practice management purposes, and to be used by billing agents and software, health insurance and other providers (e.g. for chart reviews). I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information. I understand that my protected health information needs to be re-disclosed for billing and practice management purposes every time I receive a service, and my signature indicates that I agree to my protected health information to be re-disclosed to billing software/agents, health insurance and other providers every time I receive a service.

If services are covered in full or partially by health insurance providers, I also understand that health insurance providers (or agencies affiliated with health insurance providers) may ask for copies of my clinical records; signature below also indicates that I agree to Dr. Mario Baum sending copies in whatever way necessary to health insurance providers without having to contact or inform me.

By signing below, I also understand and agree that Dr. Lehenbauer-Baum has to submit and store protected health information and/or other necessary information to billing agents, health insurance and other providers for payment, treatment, and health care operations purposes every time I see him. With my signature, I also indicate that I received a copy of this authorization form.

_____	_____	_____
Client Signature, or parent(s) if Minor or Legal Charge	**Print Name**	**Date**
_____	_____	_____
Signature of Witness	**Dr. Mario Lehenbauer-Baum**	**Date**

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Appointment, Fee and Cancellation policy

Fees:
The regular professional fee is $ 145 for an individual session and $ 165 for a couple's session (session length is 50 minutes). Psychological assessment/evaluation fees are usually around $ 1600 (the actual fee may be higher or lower, depending on the assessments' length and purpose; please verify with Dr. Lehenbauer-Baum).

In-network services:
Dr. Mario Lehenbauer-Baum is currently an in-network provider for Aetna and BlueCross/BlueShield. The session length for counseling sessions covered by BlueCross/BlueShield is 45 min., and it is 53 to 60 min. for counseling sessions covered by Aetna. Please note:

- You are responsible for updating any addresses, to provide information when/if you move to a different address, and when/if your health insurance coverage changes.
- If you change your health insurance provider, and Dr. Mario Lehenbauer-Baum is not in-network with your new insurance provider, you are responsible for the full professional fee of $ 145/session.
- Before the first session, you are also responsible to verify with your health insurance provider that Dr. Mario Lehenbauer-Baum is in-network with your specific plan. If your sessions are not covered, or the coverage changed in between, you are responsible for the full professional fee of $ 145/session.

Payments:
Dr. Mario Lehenbauer-Baum accepts payments with credit/debit cards, cash and checks. All professional fees, co-pays and/or any other payments will be collected at the end of every session (unless other arrangements have been made).

Appointment Cancellation and No-Show Fee Policy:
If you need to cancel or reschedule a session, please provide Dr. Baum with a **4 hours' notice**. **Please note that health insurance providers do not provide any reimbursements for missed or cancelled sessions**; if you miss a session without canceling **at least 4 hours** before, or you forget to show up, you take that time away from another client. **Therefore, the policy is to collect the regular professional fee of $ 145 as no-show fee** (regardless if other sessions were covered by health insurance providers!).

Appointment, Fee and Cancellation Policy Agreement

We appreciate your help in keeping the office schedule running timely and efficiently. By signing below, you understand the above appointment and cancellation policies and you agree to them.

_____	_____	_____
Client Signature, or parent(s) if Minor or Legal Charge	**Print Name**	**Date**
_____	_____	_____
Signature of Witness	**Dr. Mario Lehenbauer-Baum**	**Date**