

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: _____

If health insurance is used: 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: YES 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: _____

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 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 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

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: _____

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? YES NO

Can we use the emergency contact phone to leave a message with detailed information? YES 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?** YES 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 currently taking any prescription medication? No Yes, the following: _____

Have you ever 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?** _____

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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	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Anxiety	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Depression	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Domestic Violence	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Eating Disorders	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Obesity	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Obsessive Compulsive Behavior	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Schizophrenia	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Suicide Attempts	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Other: _____	<input type="checkbox"/> No <input type="checkbox"/> 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? _____

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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

CLIENT INTAKE FORM

Effective date: 09/24/2019

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Appointment, Fee and Cancellation policy

Fees:

The regular professional fee is \$ 150 for an individual session and \$ 170 for a couple’s session (session length is 50 minutes). Psychological assessment/evaluation fees are usually between \$ 1200 and \$ 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 (September 2019) in-network with Aetna and BlueCross/BlueShield. The regular session length for 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 \$ 150/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 \$ 150/session (even if you were under the impression that sessions were covered). There is no reimbursement for psychological services that you already received and paid for.

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 \$ 150 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