BLUE SKY COUNSELING ASSOCIATES, LLC
DBA ALAMOGORDO COUNSELING ASSOCIATES

1301 OREGON AVE.
ALAMOGORDO, NM 88310
PHONE: (575) 443-6166
FAX: (575) 437-0755

**Client Intake Form**

Name:_____ Date:_____

SSN:_____ Marital Status:_____

Physical Address:_____ Date of Birth (Age):_____(____)

_____ Gender:_____

Mailing Address:_____ Ethnicity:_____

_____ Referral Source:_____

_____ Occupation:_____

Phone Number:_____

Guardian Name and Phone:_____

Emergency Contact(s):_____

_____

_____

*Present your current insurance card(s) OR provide the following*

**Primary Insurance Information** **PCP:_____**

Responsible Party: Self Spouse Parent

Name of Insurance:_____Copay:_____

Member ID#:_____Group ID#:_____Deductible:_____

If not self:

Subscriber's Name:_____

SSN:_____ DOB:_____

**Secondary Insurance Information**

Responsible Party: Self Spouse Parent

Name of Insurance:_____Copay:_____

Member ID#:_____Group ID#:_____Deductible:_____

If not self:

Subscriber's Name:_____

SSN:_____ DOB:_____

**No Insurance / Private Pay_____**

BLUE SKY COUNSELING ASSOCIATES, LLC
DBA ALAMOGORDO COUNSELING ASSOCIATES

1301 OREGON AVE.
ALAMOGORDO, NM 88310
PHONE: (575) 443-6166

**Current Medications if any:**

_____

_____

_____

**Persons living in home:**

| **Name** | **Age** | **Relationship** |
|---|---|---|

_____

_____

_____

_____

If client is 13 or under and parents divorced:

Custodial parent/Guardian: _____ Relationship: _____

Non-custodial parent name and phone # _____

If shared custody does this parent consent to child's counseling? _____

Issues you would like to address in counseling? _____

_____

_____

Would you like Faith based counseling? _____

Faith practiced: _____

BLUE SKY COUNSELING ASSOCIATES, LLC
DBA ALAMOGORDO COUNSELING ASSOCIATES

1301 OREGON AVE.
ALAMOGORDO, NM 88310
PHONE: (575) 443-6166
FAX: (575) 437-0755

Client substance use:

Have you ever felt you needed to cut down on your alcohol or drug use? ____

Have people annoyed you by criticizing your alcohol or drug use? _____

Have you ever felt guilty about drinking or using drugs? _____

Have you ever felt you needed a drink or to use drugs first thing in the morning? ___

Have you ever been in legal trouble for alcohol or drug use? _____

Has anyone asked you to cease drinking or using drugs_____?

**Certification Statement**

I do certify that the information given above is true and correct to the best of my knowledge. The primary use of this information is to provide, plan and coordinate health care. I understand that I am responsible for all charges incurred for services my dependents or I receive. Payment is due when services are rendered. After 90 days, past due accounts may be turned over to a collection agency and I will be responsible for collection fees in addition to the account balance. I have read, understand and agree to the attached disclosures and give my "Informed Consent." Unless approved for a lower rate, I understand that the hourly rate for counseling is $175.00 for the initial appointment and $140.00 for additional appointments. No-shows, cancellations or rescheduling less than a 24-hour in advance will be subject to a $50.00 no-show fee and after the second occasion, may result in you being requested to seek services elsewhere.

Client/Guardian's Signature_____ Date_____

**Disclosure of Information/Consent for Treatment of a Minor** (Reference 32A-6A)

A child fourteen years of age or older is presumed to have capacity to consent to treatment without consent of the child's legal custodian, including consent for individual psychotherapy, group psychotherapy, guidance counseling, case management, behavioral therapy, family therapy, counseling, substance abuse treatment or other forms of verbal treatment that do not include aversive interventions.

A child under fourteen years of age may initiate and consent to an initial assessment with a clinician and for medically necessary early intervention service limited to verbal therapy. The purpose of the initial assessment is to allow a clinician to interview the child and determine what, if any, action needs to be taken to ensure appropriate mental health or habilitation services are provided to the child. The clinician may conduct an initial assessment and provide medically necessary early intervention service limited to verbal therapy with or without the consent of the legal custodian if such service will not extend beyond two calendar weeks.

1301 Oregon Ave.
Alamogordo, NM 88310
Phone: (575) 443-6166
Fax: (575) 437-0755

A clinician or other mental health and developmental disabilities professional shall promote the healthy involvement of a child's legal custodians and family members in developing and implementing the child's treatment plan, including appropriate participation in treatment for children fourteen years of age or older. However, nothing in this section shall limit the rights of a child fourteen years of age or older to consent to services and to consent to disclosure of mental health records.

Except as otherwise provided in the Children's Mental Health and Developmental Disabilities Act, a person shall not, without the authorization of the child, disclose or transmit any confidential information from which a person well-acquainted with the child might recognize the child as the described person or any code, number or other means that could be used to match the child with confidential information regarding the child. When the child is under fourteen years of age, the child's legal custodian is authorized to consent to disclosure on behalf of the child.

## Common Exceptions to Confidentiality

You are entitled to confidentiality with your provider. This includes all information contained on your intake forms and any that you bring to subsequent counseling sessions. All communications regarding personal information will be held in strict confidence except as permitted by law (Refer to Notice of Privacy Practices for further information). In most other cases, an Authorization for Release of Information must be signed by you before any information is released. The following are some of the most frequent exceptions to confidentiality that you should be aware of:

1) Under New Mexico law, a release of information is not required "When such disclosure is necessary to protect against a clear and substantial risk of imminent serious physical injury or death inflicted by the client on himself or another." (NM Statute 43-1-19)

2) New Mexico law requires that child abuse and neglect be reported. "Every person, including but not limited to a licensed physician, a resident or an intern examining, attending or treating a child, a law enforcement officer, a judge presiding during any proceeding, a registered nurse, a visiting nurse, a schoolteacher or a school official or social worker acting in an official capacity that knows or has a reasonable suspicion that a child is an abused or neglected child shall report the matter immediately to: (1) a local law enforcement agency; or (2) the county Social Services Department or the Human services Department in the county where the child resides. (NM Statute 32A-4-3). In these situations, New Mexico statutes do not provide privileged communication between provider and client. Information from your file and/or your provider's testimony could be introduced in any legal action.

3) If you (the client) are receiving services from Blue Sky Counseling Associates, LLC, and initiate legal action against Blue Sky Counseling Associates, LLC, its therapist, staff or business associate, a release of information is not required for defense from the action.

4) If consistent with the protections provided by Health Insurance Portability and Accountability Act (HIPAA) and Part 2 of Title 42 of the Code of Federal Regulations, disclosure of confidential materials may be court ordered. Blue Sky Counseling Assoc., LLC must comply with all legitimate court orders.

BLUE SKY COUNSELING ASSOCIATES, LLC
DBA ALAMOGORDO COUNSELING ASSOCIATES

1301 OREGON AVE.
ALAMOGORDO, NM 88310
PHONE: (575) 443-6166
FAX: (575) 437-0755

## Disclosure of Relationships

Client acknowledges that he/she has been advised that their provider may participate in case staffings and clinical supervision sessions with other licensed mental health professionals during which the client's confidential information may be disclosed. The client understands that other licensed professionals and clinical supervisors are obligated to maintain the client's confidentiality

## Disclosure of Licensure Level

Client acknowledges that Blue Sky Counseling Associates, LLC utilizes both independently (PhD., PsyD., LMFT, LPCC, LISW/LCSW, LPAT, LADAC and CNP) and non-independent (LPC, LMHC, LMSW, LSAA, LAMFT) licensed providers to serve its clients. Providers who are not independently licensed receive clinical supervision in accordance with legal and ethical requirements. You may request to work with an independently licensed provider but this may result in delays or higher costs of treatment.

## Disclosure of Treatment Protocols

Client acknowledges that he/she that during the course of treatment, a number of different treatment approaches and strategies may be employed. The client understands that if at any time during the course of treatment he/she has any questions regarding the process, purpose, or procedure being used, that he/she is encouraged to request clarification immediately.

Client acknowledges that some clients will be offered a treatment approach known as Eye Movement Desensitization and Reprocessing (EMDR). The client understands this approach has been validated by research and is being successfully used for a variety of complaints as research continues. The client understands that they may obtain whatever additional information they need either from their provider or from other sources regarding EMDR. The client understands that they may choose whether or not to engage in or continue treatment using the EMDR or any other treatment approach.

## Alcohol/Drug/Infectious Disease/Psychiatric Records

Alcohol/Drug/Infectious Disease/Psychiatric Records are protected by Federal Regulation 42CFR, Part 2, and release of these records requires specific consent. This protection covers all records and information including verbal and facsimile communication and provides that specific consent is necessary for the release of the following: Drug or alcohol abuse, infectious diseases (including HIV), and psychological or psychiatric problems unless otherwise specified below.

Client/Guardian Signature_____Date_____

BLUE SKY COUNSELING ASSOCIATES, LLC
DBA ALAMOGORDO COUNSELING ASSOCIATES

1301 OREGON AVE.
ALAMOGORDO, NM 88310
PHONE: (575) 443-6166
FAX: (575) 437-0755

## Assignment of Insurance of Benefits

I request that payment of authorized benefits on my behalf be paid to Blue Sky Counseling Associates, LLC for any services furnished to me, my dependents or my family. I also authorize release of Protected Health Information (PHI) needed to determine eligibility or process claims for services rendered to me or my dependents to my insurance carrier(s) or other payment sources.

Client/Guardian Signature_____ Date_____

## Client's Rights and Responsibilities

I,_____hereby acknowledges that he/she has been informed that he/she is entering into a professional relationship with Blue Sky Counseling Associates, LLC and its providers.

I understand that I have the right to consideration and respect. I understand that I am expected to make my own decisions and to take responsibility for my actions. I understand that my provider will help facilitate change that I decide I want to make. My provider adheres to the ethical standards of the certification/licensing boards with whom he/she is associated. Any grievance should be discussed with my provider, their supervisor or sent to the appropriate licensing board.

I have read and/or had explained what it means to become a client of Blue Sky Counseling Associates, LLC, I agree to their terms and wish to become a client.

Client Signature_____ Date_____

Parent/Guardian Signature_____ Date_____

# Notice of Privacy Practices

HIPAA Privacy Practices describes how Blue Sky Counseling Associates, LLC, including its therapists, staff and contractors, hereafter referred to as "BSCA" may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. A copy of your HIPAA rights is available on request and is posted in the office.

**This notice was published and became effective on January 1, 2019**

I understand the conditions and limitations contained in the Notice of Privacy Practices and wish to enter treatment with BSCA.

Client/Guardian Signature_____Date_____

BLUE SKY COUNSELING ASSOCIATES, LLC
DBA ALAMOGORDO COUNSELING ASSOCIATES

1301 OREGON AVE.
ALAMOGORDO, NM 88310
PHONE: (575) 443-6166
FAX: (575) 437-0755

## Payment In Lieu Of Insurance

Blue Sky Counseling Associates, LLC makes an attempt to maintain relationships with third party payers (e.g. insurance companies) to make services available and to control costs to our clients. In the event that a relationship with your particular payer source does not exist or you prefer not to utilize a third party payer, BSCA, at its sole discretion, may agree to accept your negotiated payment amount as full payment for services. These payments may not count toward required deductibles or co-insurance costs mandated by your payer source.

## Co-Pay, Sliding Scale and Special Services Fees

Blue Sky Counseling Associates, LLC, is committed to provide the same quality mental health services to all of its clients, regardless of income. Any person may elect to pay for services based on the sliding fee scale described below by simply informing your provider and providing current proof of income, such as a recent pay stub(s). As always, co-pay and sliding scale payments are expected at the time services are rendered.

| Household Income | Initial Appointments | | Subsequent Appointments | | | |
|---|---|---|---|---|---|---|
| | Counseling | Med. Mgt. | Individual Counseling | Family Counseling | Med. Mgt. (15 min.) | Med. Mgt. (30 min.) |
| $0 - $20,000 | $70.00 | $95.00 | $55.00 | $65.00 | $65.00 | $80.00 |
| $20,001 - $70,000 | $85.00 | $105.00 | $65.00 | $75.00 | $75.00 | $90.00 |
| $70,001 - $100,000 | $100.00 | $120.00 | $75.00 | $85.00 | $85.00 | $100.00 |
| $100,001 - $150,000 | $130.00 | $150.00 | $100.00 | $110.00 | $105.00 | $120.00 |
| $150,001 and above | $175.00 | $200.00 | $140.00 | $150.00 | $135.00 | $160.00 |

**Special Services** (*Advance Payment Required*):

| | |
|---|---|
| Clinical Evaluation & Report | $275.00 |
| Substance Abuse Evaluation & Report | $175.00 |
| Domestic Violence Evaluation & Report | $175.00 |
| Court Appearance & Testimony (Minimum Charge: $80.00) | $50.00 per hour |
| Copies of File (A $25 additional fee may apply if file is archived) | $25.00 + .50/pg |
| Postage (If reports are required to be mailed) | USPS rates |

I understand that I have an option on how I pay for services.

Client Initial
☐ I wish to pay for services based on this sliding scale fee. My annual household income is $_____. I understand that I may be required to provide supporting documentation.

Client Initial
☐ I wish that services be billed through my insurance company. My insurance company is: _____. I understand that I am personally responsible for co-payments and deductibles or any amounts not paid but authorized by my insurance company.

_____ _____
Client/Parent/Guardian Signature Date BSCA Representative Signature Date