Blue Sky Counseling Associates, LLC

1301 Oregon Ave.
Alamogordo, NM 88310
Phone: (575) 443-6166
Fax: (575) 437-0755
E-Mail: contact@blueskycounseling.net

Client Intake Form

Name:_____ Date:_____

SSN:_____ Marital Status:_____

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

_____ Gender:_____

Mailing Address:_____

_____ Referral Source:_____

_____Occupation:_____

Phone Number:_____Email Address:_____

Guardian Name and Phone:_____

Emergency Contact(s):_____

_____

_____

Primary Care Provider:_____

Copy of Insurance Card is required for services

Please provide a copy to your therapist, the office, or text a picture to:

575-214-2886

or email:

contact@blueskycounseling.net

Note: Copay's, Deductibles, and fee's for services are due at time of appointment
(No shows are subject to a $50 fee at discretion of therapist)

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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: _____

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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 and Agreement of Fees

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 have read, understand and agree to the attached disclosures and give my "Informed Consent." I understand that I am responsible for all charges incurred for services my dependents or I receive. **Payment is due when services are rendered.** Unless approved for a lower rate, I understand that the hourly rate for counseling is $175.00 for the initial appointment and $150.00 for additional appointments. No-shows, cancellations or rescheduling less than 24-hours 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_____

Payment In Lieu Of Insurance

Blue Sky Counseling Associates, LLC (BSCA) is committed to provide the same quality mental health services to all of its clients, regardless of income/lack of insurance. Any person may elect to pay for services based on a sliding scale negotiable fee by initiating an agreement with your provider and providing current proof of income, such as a recent pay stub(s).
If you choose not to use your insurance provider, BSCA, 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

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. Co-Pay, Negotiable and Special Services Fees

Co-pay's, deductibles, and **negotiated payments** are expected **at the time services are rendered**. We are legally required to collect the indicated patient share of payment in order to have a contract with your insurance company. It is your responsibility to be aware of your co-pay and/or deductible before engaging in services. We do our best to verify but do not always receive complete information at the time of service.

Special Services are available at these suggested rates, to be negotiated with your provider(*Advance Payment Required*):

Personal Clinical Evaluation & Report	$150.00 per hour or page
Court Mandated Clinical Evaluation & Report	$350.00 per hour or page
Substance Abuse Evaluation & Report	$175.00
Domestic Violence Evaluation & Report	$175.00
Court Appearance & Testimony (Minimum Charge: $1,400.00)	$350.00 per hour
Copies of File (A $25 additional fee may apply if file is archived)	$30.00 + .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 **at time of service**.

_____
Client/Parent/Guardian 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.

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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 BSCA, its therapists, staff or business associates, 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. BSCA must comply with all legitimate court orders.

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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 within this office during which the client's confidential information may be disclosed. The client understands that other licensed professionals are obligated to maintain the client's confidentiality. Additionally, by utilizing your insurance benefits, your insurance company has the right to documentation of your treatment protocols and diagnosis. If you do not want this information available you may chose to utilize private payment option.

Disclosure of Licensure Level

Client acknowledges that BSCA utilizes only independently licensed therapists in accordance with NM Counseling and Practice Board regulations. (PhD., PsyD., LMFT, LPCC, LISW/LCSW, and PCNP)

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 COVID-19), and psychological or psychiatric problems unless otherwise specified below.

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Client is aware of the risk involved if meeting face to face in the office with therapist in regard to Covid-19 spread and releases BSCA from responsibility in the event of contact with Covid-19 while in the office. Client agrees to take all CDC prescribed precautions while in office environment. In the event client or a family member tests positive for Covid-19, client agrees to inform the therapist if they have had face to face counseling sessions. This disclosure will be kept confidential according to Federal Regulations noted above.

Consent for Telehealth Treatment

Client understands the following regarding telehealth:
Along with benefits to this treatment, there are some potential risks such at interruptions, unauthorized access and technical difficulties. It is not possible to guarantee confindentiality while engaging in telephonic or video counseling sessions due to the nature of technology and media. We offer a HIPAA compliant website but other types of video and telephonic platforms may be utilized under agreement between client and therapist.
Client accepts possible additional cost of phone, Internet and data use by their provider. In the event of an emergency during a session, client agrees to share location and emergency contact information and to utilize emergency services (911, ER) if directed to by therapist.

Telemed with Psychiatric Nurse Practitioner

We offer medication management via Telemed. If so choosing this service, client may access this from BSCA office site or from their own smart device or computer. Client understands that BSCA does not provide refills and the PNP may not be available for medication refill call ins within 72 hours or less. Client is directed to contact his/her PCP for medication needs until our PNP is available. The office staff at BSCA is unable to preform this service.

Client/Guardian Signature _____ Date_____

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Assignment of Insurance of Benefits

I request that payment of authorized benefits on my behalf be paid to BSCA 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_____

Notice of Privacy Practices

HIPAA Privacy Practices describes how BSCA, including its associates and staff 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.

Client/Guardian Signature_____Date_____

Client's Rights and Responsibilities

I,_____ hereby acknowledge that I have been informed that I am entering into a professional relationship with BSCA 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. Each provider is and independent practitioner. Any grievance should be discussed with my provider, or sent to the appropriate licensing board.

I have read and/or had explained what it means to become a client of BSCA, I agree to their terms and wish to become a client.

Client/Guardian Signature_____ Date: _____