Transition Counseling Services, LLC • Janna Cash Gilner, LCPC
10925 Antioch Rd, Suite 205 • Overland Park, KS • 66210 • Phone: 913-904-6855 • www.jannacash.com

ADULT INTAKE INFORMATION

Client Name: _____
(First) (Middle Initial) (Last)

Date of Birth: _____ / _____ / _____ Age: _____ Gender: ❒ Male ❒ Female

Relationship Status: ❒ Divorced ❒ Domestic Partnership ❒ Engaged ❒ Married
❒ Separated ❒ Single ❒ Widowed ❒ Other: _____

Home Address: _____
(Street and Number) (City) (State) (Zip)

CONTACT AUTHORIZATION

Messages

Please Call ❒ My Home ❒ My Cell ❒ My Work Number: _____

If unable to reach me:

❒ you may leave a detailed message, as this is a private line

❒ please leave a message asking me to return your call

❒ do not leave a message

The best time to reach me is (day) _____ between (time) _____

May I email you?* ❒ Yes ❒ No E-mail: _____

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Emergency Contact

❒ In case of emergency, contact: (name) _____

(phone #) _____ (relationship) _____

I authorize Janna Cash Gilner/Transition Counseling Services, LLC to waive my confidentiality and contact the above named person, if she deems an emergency exists. This person will be notified of the client's location, condition, and acknowledgment as a client of Janna Cash Gilner/Transition Counseling Services, LLC.

A signature is required to confirm and authorize your preferences listed on this form and consent regarding contacting your referral, how you are contacted, and for whom you have named as your emergency contact.

Signature: _____ Date: _____

REFERRAL SOURCE

Name of referral source, or how you heard about Janna Cash Gilner/Transition Counseling Services, LLC:

_____

May I send your referral a thank you? ❒ Yes ❒ No

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BRIEF PERSONAL HISTORY

Coordination of Care:
Please check any current involvement with any of the following services:
❒ Child & Family Services ❒ Court or Legal Proceedings ❒ Other: _____
Please explain: _____

_____

Please list any *previous* mental health services (psychotherapy, psychiatric services, hospitalizations, etc.) including the provider's name, type of service, city, diagnosis (if any), and date of services:

_____

_____

If in therapy before, what caused you to stop seeing that provider, or specifically, what were you looking for that you did not receive:

_____

_____

Please list any *current* mental health providers (psychiatrist, therapist, etc) and any current medication(s), and condition or diagnosis given:

_____

_____

Please list any *current* medical conditions that you receive treatment or medication(s) for and Physician's name:

_____

_____

FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to the client (father, grandmother, uncle, etc).

❒ Over Activity	❒ Suicide Attempts	❒ Explosive Anger
❒ Drug Abuse	❒ Legal Problems	❒ Eating Disorders
❒ Marital Problems	❒ Developmental Disability	❒ Obsessive Compulsive Behavior
❒ Domestic Violence	❒ Emotional Problems	❒ Bipolar Disorder
❒ Alcoholism	❒ Significant Loss	❒ Schizophrenia
❒ Learning Problems	❒ Anxiety	❒ Schizoaffective Disorder
❒ Suicide	❒ Depression	❒ Delusions/Paranoia

❒ Any other significant family history:

_____

_____

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HISTORY OF CONCERNS/GOALS

My reason for seeking counseling:

_____

_____

_____

Describe your difficulty/struggle and for how long it has been an issue:

_____

_____

_____

Is there a history of similar problems in your family? If yes, please describe.

_____

_____

_____

If not noted elsewhere, please add any worries/concerns you have about your therapy services.

_____

_____

_____

What changes are you hoping for?

_____

_____

_____

I will know that my goals have been reached, when the following things have changed for the better:

_____

_____

_____

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INFORMED CONSENT & COUNSELING AGREEMENT

Signatures below indicate that you have received, read, and understand the practice policies of Janna Cash Gilner/Transition Counseling Services, LLC, and agree to abide by the outlined policies.

CONSENT FOR TREATMENT

I voluntarily consent to services provided by Janna Cash Gilner, which may include assessment and referral recommendations as deemed necessary. I understand that during treatment, things may, at times, feel worse before they get better. Sometimes relationships with family/friends may change as a result of thinking and behaving differently, and this may cause stress. As changes take place, there are shifts in various parts of a person's life. I understand that this is part of the change process and I consent for treatment.

Signature: _____ Date: _____

FINANCIAL POLICIES

Clinical Fees:

The fee for a 60-minute session is $80 and is due at the beginning of each session. Any phone conversation, between sessions, lasting longer than 15 minutes, will be billed as a session. Forms of payment accepted are cash, check, or credit card. Receipts are available by request. Occasionally, there are extra or altered charges. In your case, the fee per session will be $_____.

Cancellation Policy:

Appointments canceled with less than 24-hour notice will be charged $40. A $40 fee will also be charged if you do not show to a scheduled appointment without notice. Appointments missed due to inclement weather or other major problems will not be charged.

Insurance:

I do not accept insurance payment and do not bill insurance companies directly. Your counseling services may be eligible for reimbursement through out-of-network benefits. If you choose to seek reimbursement, it is your responsibility to contact your insurance provider to inquire about reimbursement for out-of-network counseling services. I can provide you with a receipt at the end of each session, which you can submit to your insurance company for out-of-network coverage/reimbursement. You are responsible for filing claims.

Signature: _____ Date: _____

CLINICAL EMERGENCIES

In the event of an emergency or emotional crisis, and you are unable to reach me by phone, or I am out of town, then you are directed to call 911 or go to your nearest hospital emergency room. Once you are safe, you are directed to contact me.

Signature: _____ Date: _____

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LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. State law and professional code of ethics mandate exceptions. Noted exceptions are as follows.

- Duty to Warn – When a client discloses intentions or a plan to harm another person, the counselor is required to warn the intended victim and report this information to legal authorities.
- Duty to Protect – In cases in which the client discloses or implies a plan for suicide, the professional counselor is required to notify legal authorities and make reasonable attempts to notify the emergency contact, family, or a friend of the client.
- Abuse of Children of Dependent/Vulnerable Adults – If an adult client states or suggests that he or she is abusing a child (or dependent/vulnerable adult), has recently abused a child (or dependent/vulnerable adult), or a child (or dependent/vulnerable adult), is in danger of abuse, the professional counselor is required to report this information to the appropriate social service and/or legal authorities. This also applies in cases where the client is the minor child (or dependent/vulnerable adult) who discloses or suggests that he or she has been abused or is in danger of abuse. The counselor is also required to report reasonable suspicion of abuse.
- Prenatal Exposure to Controlled Substances – Professional Counselors are required to report admitted prenatal exposure to controlled substances that are potentially harmful.
- Minors/Guardianship – Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.
- Court Proceedings – If you are involved in a court proceeding, your Professional Counselor will not release information without the written authorization of you or your legally appointed representative, or a court order.

The following are noted exceptions within policy of Janna Cash Gilner/Transition Counseling Services, LLC:

- Insurance Providers (when applicable) – Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to types of services, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.
- Written Request for Release of Information – You may complete a form which requests a Professional Counselor to disclose information regarding your records to a third party.
- Crime Committed Against Staff or Property – In cases of crime, this professional counselor reserves the right to disclose names to authorities if charges are required.
- Legal Disputes – If a client makes claims against the professional counselor, the counselor will be required to disclose information about the client that is pertinent to the counselor's defense.
- Unpaid Balance – Should the client accrue unpaid balances which require creditors, the professional counselor will disclose information required to collect balances due.

You must check the statements below and a signature is required.

❒ I agree to the above limits of confidentiality and understand their meanings and ramifications.

❒ I also confirm that I have been given access to a copy of my HIPPA Authorizations and Client Rights.

Signature: _____ Date: _____

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QUALIFICATIONS

Janna Cash Gilner, LCPC:

- Has a Masters in Counseling.
- Is licensed in the State of Kansas as a Licensed Clinical Professional Counselor.
- Adheres to the Code of Ethics set forth by the American Counseling Association.
- Has received a Certificate in Play Therapy.
- Cannot prescribe medication.
- Does not provide medical or legal advice.

WAIVER OF MEDICAL/PSYCHIATRIC CONSULTATION

I understand that under the provisions of Kansas Law, KSA 65-6404 (b) (3), my counselor is required to consult with my primary care physician or a psychiatrist to determine if there may be a medical condition or medication that is causing or contributing to any observed symptoms of a mental disorder:

Printed Name of Adult:

_____

In the event that I or my minor child(ren) do not have a primary care physician or psychiatrist, I acknowledge that my counselor has recommended that I seek medical consultation.

By signing below I am indicating that I waive my right to such consultation and that I do not wish for my counselor to contact my(our) physicians(s). I am also aware that this waiver will become part of my client record.

Signature: _____ Date: _____

If I choose not to waive this consultation by signing this form, my counselor will request that I complete a separate Release of Information form in order to complete the above-mentioned consultation.