Liz La Colla, LSCSW
2945 SW Wanamaker Drive
Topeka, Kansas 66614
785-249-3067

Today's Date_____

Client's first name_____ Last_____ MI_____

Gender- Male_____ Female_____ Date of Birth _____ Age_____

Date of Birth for person that carries the insurance _____

Address_____

City_____ State _____ Zip code _____

Home Phone Number_____ Cell_____

May I leave a message or text information to cell ____Yes ____ No Home _____Yes _____NO

Client Social Security Number _____

Marital Status _____

Employer_____ Work Number _____

Emergency Contact_____ Relationship _____

Phone_____

If client is a minor-Parent Name_____ Phone _____

Briefly explain reason(s) for this visit; current symptoms_____

_____

Who can I thank for this referral? _____

Primary Physician Name _____Date of Last physical_____

List any health problems you are currently being treated for_____

Are you currently taking any medications for emotional health? Yes _____ No _____

If yes, what medications: _____

If no, have you taken them in the past? _____Psychiatrist _____

Do you exercise daily? Yes_____ No_____ What kind of exercise _____

Are you sleeping well at night? _____ if not, describe your sleep patterns and Problems i.e. nightmares, inability to get to sleep, difficulty staying asleep _____

How would you rate your emotional health? Poor _____ Fair _____Good _____excellent_____

Describe your mood (check all that apply) Anxious ____ Detached ___ Happy _____ Depressed ____Jittery _____ Angry_____ Other, Please explain_____

Do you find it difficult to concentrate? Yes____ No ____ If yes, how often_____

Do you have difficulty controlling your anger? ____Yes ____No If yes, how often_____

How do you cope with problems? _____

Are you having problems with relationships? Yes_____ No_____ If yes, with who? _____

Do you or someone close to you have an addiction such as: Alcohol_____ Drugs_____ Gambling_____ Sex_____ Other_____?

Have you ever sought therapy or psychiatric services before today? Yes ___ No___ If yes, when? _____

Where _____Briefly explain why _____

Have you ever been hospitalized for psychiatric reasons? Yes_____ No_____

If yes, when? _____ Where _____

Briefly explain why_____

Mental health diagnosis you have been given or treated for_____

Have you ever considered suicide? Yes _____ No_____ If yes, when? _____ Currently? _____

Payment and Billing Policy: Authorization to release information and assignment of benefits: I understand that I am financially responsible for all charges related to the mental health services incurred through participation in mental health services with Liz La Colla for the mental health services that have been provided to me or anyone that I am responsible for. Including co-pays, deductibles, and cost of services for out of network rates or private pay if Liz LaColla is not a provider with your insurance company.

I authorize Liz La Colla and her authorized representatives to provide to if any insurance company(s), all information concerning my treatment. If my therapist chooses to accept assignment of insurance benefits, the amount authorized by the insurance will be accepted. I hereby assign and transfer to Liz La Colla all monies to which I am entitled from my insurance relative to the services reported, but not to exceed my indebtedness to said therapist. I understand that I am responsible to pay the amount the insurance deems as my co-pay or deductible to my therapist or if my therapist is not a contracting provider with my insurance company I am responsible for the full amount of services.

Full payment or your co-pay is expected at the time of service. Special arrangements may be made with the Liz La Colla for monthly payments if needed and must be done in writing. There is a $30.00 fee for all returned checks. If payments are not being made regularly, the balance may be turned over to a collection agency or attorney.

Regarding telephone consultation: You may be charged for telephone consultations with you, your attorney, or any other party regarding you. These charges are based on time and are equal to my normal fee for in person psychotherapy. Telephone consultation is not paid by insurance and will be billed in full to you.

Informed Consent As a client, you need to be informed of certain key aspects involving all counseling situations. Counseling attempts to teach you alternative ways of coping with problems in living. As such, no guarantee exists that you will automatically feel better from coming to counseling. Although most people do feel better, some people initially feel worse. Please initial below acknowledging that you understand this information and give voluntary consent to participate in therapy.

After hours coverage: Since I am in practice alone, I do not have coverage while I am on vacation. I do change my voicemail to let callers know that I am out of town. Please go to the nearest hospital of choice if you need immediate care.

Office hours: My hours are between 8 am and 9 pm Monday through Thursday. Please do not call or text after hours unless it is an emergency. I will make every effort to return calls as soon as possible.

No show and late cancellation policy: If you need to change an appointment please remember that it needs to be 24 hours in advance or you will be charged for the appointment which is 125.00. Insurance does not cover missed appointments, so you will be responsible for paying this out of pocket. Please make these changes during business hours.

If you have not arrived for you appointment or called within 15 minutes of the scheduled time than I will assume you are unable to make it and will many times leave. This is considered a missed appointment and you will be charged for the appointment as addressed in the late cancellation policy.

Confidentiality: I understand that information which I provide to my therapist is confidential and cannot be released without my written authorization. Some limitations, by law and professional ethics, to confidentiality do exist. Under the following circumstances, information may be released without my permission to the appropriate authorities.

- If incident or any suspicion of child abuse/neglect or exploitation to my therapist.
- If I threaten to harm myself or someone else.
- If I make my mental status a court issue or if a judge orders release of my records.

Regarding report writing: You may be charged for preparation of reports or letters which may be required at any time during your psychotherapy process. These charges are based on time and are equal to my normal fee for in person psychotherapy and cannot be billed to your insurance company and will be billed in full to you.

Notice of privacy practices: I have been given an opportunity to read a copy and/or receive a copy of the Liz La Colla notice of privacy practices. I understand that if I have any questions regarding the notice or my privacy rights I can contact Liz La Colla.

Consultation: I authorize my therapist to use consultation to discuss information about my care and treatment, thereby ensuring optimal help. No identifying information will be shared.

Release Of Information: I _____ authorize Liz LaColla to release, share, exchange information including but not limited to progress notes, assessments, attendance, participation in therapy and risk to self or others as well as recommendations and collaboration as written records, by phone, in person, by mail or fax. For the purpose of coordinating my treatment, reimbursement for therapy, protecting myself or others from harm, or patient request.

I understand that electronic MAIL (E-mail) is not confidential and can be intercepted and read by other people. I give permission to communicate regarding my care via email. Yes_____ No_____.

Information may be shared with my insurance company as well as:

Physician_____

Psychiatrist_____

Other_____

Other_____

Signature and initials below is acceptance and understanding for the following policies

1.) Payment and billing Procedure _____Initial

2.) Informed Consent _____ Initial

3.) Confidentiality _____ Initial

4.) Cancellation Policy _____ Initial

5.) Privacy Practices _____Initial

6.) Consultation _____Initial

Signature_____ Date _____