INITIAL EVALUATION

PERSONAL DATA INVENTORY

Client Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Date of Birth: _____ Gender: M ____ F ____
Occupation: _____
Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____
Education: (last year completed) _____ Other Training: (type and years) _____
_____
Insurance: _____ Plan: _____ Group #: _____

MARRIAGE AND FAMILY INFORMATION

Name of Spouse: _____ Address: _____
Phone: _____ Occupation: _____
Is your spouse willing to come for counseling? Yes _____ No _____ Not sure? _____
Have you ever separated? Yes _____ No _____ When? From _____ to _____
Have either of you ever filed for divorce? Yes _____ No _____ When _____
Date of Marriage: _____ Any previous marriage(s)? No ___ Yes ___ When? _____
List children and ages _____

EMERGENCY CONTACT INFORMATION

Contact Name: _____ Relationship: _____
Contact Phone Number: _____

RELIGIOUS BACKGROUND

Denominational preference: _____
Church attended in childhood: _____
Religious background of spouse: _____
Is faith an important part of your life? _____
Are you interested in Christian Counseling Services? _____

HEALTH HISTORY

List all-important present or past illnesses, injuries, or handicaps: _____

Date of last medical exam: _____ Family Doctor: _____
Phone: _____ Address: _____
Allergies: _____

CURRENT MEDICATIONS

Condition	Medication	Dose (mg)	Frequency	Duration	Compliant	Start Date	Effective
					Yes No		Yes No

PREVIOUS TREATMENT EXPERIENCE (Mental Health and Substance Abuse)

Level of Care: In-Patient / Out-Patient / Day Program / Intensive Outpatient

Date	Provider	Level of Care	Duration	Condition (MH/SA)	Outcome

FAMILY HISTORY

Is there any history of mental health or substance abuse diagnoses in your family? _____Yes/No/Unknown
(If yes, place an X in the appropriate box below and specify mental health diagnosis, if known, e.g. depression, anxiety, etc.)

Diagnosis	Mother	Father	Siblings	Child	Spouse/SO	Other
Mental Health						
Substance Abuse						

Information and Consent for Counseling

I. Client Agreement/Contract

Your counselor desires to work with clients who have the capacity to resolve their own challenges with their assistance. Some clients need only a few counseling sessions to achieve these goals, while others may require months or years of counseling. As a client, you have the right to end our counseling relationship at any point. If counseling is successful, you should feel that you are able to face your immediate challenges.

Your counselor will keep confidential anything that you say with the following exceptions: (1) you direct me to tell someone else, (2) we determine that you are a danger to yourself or others, or (3) I am ordered by a court to disclose information. Also, (4) it is mandatory that I report child abuse.

Sessions are approximately 45 minutes in duration. Please note that it is impossible to guarantee any specific results regarding your counseling goals. Your counselor will help you identify your issues, but it is up to you to do the work. Together we will work to achieve the best possible results for you.

II. Legal Issues

If you are in the midst of any type of legal issue such as litigation, a dispute with your employer, separation or divorce, please inform your counselor immediately. Please be aware that in custody cases, we typically need signed permission from both parents, and that medical records are frequently subpoenaed when litigation is involved.

III. Payment Policy

Your counselor agrees to provide counseling services for you in return for a fee. The fee for each session will be due at the time of service. Cash and personal checks are acceptable for payment. There is a $25.00 service charge for all returned checks. Your counselor will provide you with a receipt for all fees paid if you would like. Check with your insurance company to determine if your coverage honors outpatient counseling provided by your therapist. Please note that many insurance companies require surveys that request information about symptoms, diagnosis, and treatment. By using insurance you are granting permission for your counselor to communicate confidential information to your insurance company. Please remember that your counselor has no control of, or responsibility for how information is handled once it is released to third parties. If you are using your insurance, and that insurance provider changes, or your co-pay changes, please let your counselor know as soon as possible.

IV. Cancellation/Office Hours

In the event that you will not be able to keep an appointment, you must notify your counselor 24 hours in advance. If your counselor does not receive such advance notice, you will be responsible for paying a $50.00 cancellation fee (not covered by insurance). Your counselor's voice mail is available 24 hours a day in order for you to leave a message.

V. Emergencies

Your counselor cannot assume responsibility their client's day to day functioning, as some more intensive treatments are designed to do. It is the responsibility of the client to discuss expectations of after-hours care with the therapist upon intake so that, if necessary, an appropriate referral can be made. In the case of an emergency, when a client fears harm to him/herself or another, please dial 911 or go to your nearest emergency room, as this is not an emergency facility.

My signature below indicates that I grant consent for Geannine M. LeBude LCSW to provide counseling to myself and/or minor members of my family. I also acknowledge that I have received a copy of *Client Rights and Responsibilities*, and *Crisis/Emergency Procedures*.

Client/Guardian Signature _____ Date _____

Therapist _____ Date _____

VI. To Parents of Teenagers

I understand the need for confidentiality between my teenager and his/her therapist and that confidentiality will be maintained unless the therapist determines that my teenager is a danger to self or others.

Parent/Guardian Signature _____Date_____

VII. Insurance Assignment

I, the undersigned, have insurance coverage with _____ and assign directly to Geannine M. LeBude, LCSW all medical benefits. If my insurance company does not cover for any reason, I agree that I am financially responsible for all charges. I also hereby authorize Geannine M. LeBude, LSCW to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that all services provided outside of my therapy session, which are not covered by insurance, will be billed separately.

Client/Guardian Signature _____Date_____

MAGELLAN HEALTH SERVICES
MEMBER'S RIGHTS AND RESPONSIBILITIES STATEMENT

Statement of Members' Rights

Members have the right to:

- Be treated with dignity and respect.
- Be treated fairly, regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Have their treatment and other member information kept confidential. Only where permitted by law may records be released without the member's permission.
- Easily access care in a timely fashion.
- Know about their treatment choices. This is regardless of cost or coverage by their benefit plan.
- Share in developing their plan of care.
- Receive information in a language they can understand.
- Receive a clear explanation of their condition and treatment options.
- Receive information about Magellan, its providers, programs, services and role in the treatment process.
- Receive information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Give input on the Members' Rights and Responsibilities policy.
- Know about advocacy and community groups and prevention services.
- If asked, Magellan will act on the member's behalf as an advocate.*
- Freely file a complaint or appeal and to learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Request certain preferences in a provider.
- Have provider decisions about their care made on the basis of treatment needs.
- Receive information about Magellan's staff qualifications and any organization Magellan has contracted with to provide services.*
- Decline participation or withdraw from programs and services.*
- Know which staff members are responsible for managing their services and from whom to request a change in services.*

Statement of Members' Responsibilities

Members have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers and Magellan information that they need. This is so providers can deliver quality care and Magellan can deliver appropriate services.
- Ask questions about their care. This is to help them understand their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the member and provider.
- Follow the agreed upon medication plan.
- Tell their provider and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments. Members should call their provider(s) as soon they know they need to cancel visits.
- Let their provider know when the treatment plan is not working for them.
- Let their provider know about problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of care they receive.
- Let Magellan and their provider know if they decide to withdraw from the program.*

* This standard is required for our *Condition Care Management* (CCM) products.

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

_____

Member Signature Date

The signature below shows that I have explained this statement to the patient. I have offered the member a copy of this form.

_____

Provider Signature Date

ADULT SCREENING

Name _____ Male/Female Age_____ Date _____
Counselor: Geannine M. LeBude MSS, LCSW

Please check appropriate response as felt during the past two to three weeks.

Feelings	Never or Rarely (0)	Sometimes (1)	Often (2)	Almost Always (3)
I feel sad				
I feel like a failure				
I have lost interest in my work				
I do not look forward to the future				
I feel guilty				
I have lost interest in my hobbies				
I feel that others do not like me				
I am unhappy with myself				
I doubt my own judgment				
I am easily frustrated				
I wish I were dead				
I feel lonely				
I avoid being around people				
My eating patterns have changed i.e. Overeating or loss of appetite				
I have suicidal thoughts				
I deserve to be punished				
I have difficulty making decisions				
I fell emotionally shut down				
I feel worn out				
I feel worthless				
I am not interested in sex				
I feel hopeless				
I blame myself for other people's problems				
I feel spiritually dead				
I have difficulty paying attention				
Total Scores				

Sum Total of Scores _____

Patient Care Communication Form

Physician's Name _____ Telephone Number _____

Address _____

Dear Doctor _____,

Your Patient, _____ was recently referred by _____

We hope that the following information will be helpful in coordinating this patient's care.

Date of Initial Consultation: _____ **Date of Next Appointment**:_____

Diagnoses and/or Presenting Problems: _____

_____

Treatment Recommendations: _____

_____

Medications:_____

Please call if further information would be helpful.

Geannine M. LeBude LCSW
1930 East Marlton Pike Suite M-69
Cherry Hill, NJ 08003
Telephone Number: 856-874-9200
Fax Number: 856-874-9801

Sincerely,

_____
Clinician Signature

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 24 CFR Part 2. A general authorization for release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

AUTHORIZATION

I, _____ hereby authorize Geannine M. LeBude LCSW
Print Patient's Name **Treating Clinician**

Please Check One

_____To release any applicable mental health information to my primary care physician (PCP) named above.

_____To release any applicable substance abuse information to my PCP named above.

_____To release only medical information to my PCP named above.

_____Not to release any information to my PCP named above.

I may revoke this authorization at any time except to the extent that the action has been taken in reliance upon it. If I do not revoke this authorization, it will expire one (1) year after I have terminated treatment.

_____ _____ _____
Print Name of Patient or Guardian ID Number Date of Birth

_____ _____
Signature of Patient or Guardian Date

SUBMIT ALL FORMS