

**CONFIDENTIAL QUESTIONNAIRE**

**Dr. David Kaptain, LMFT, CADC,**

**Licensed Marriage & Family Therapist & Certified Alcohol and Drug Addictions Counselor**

**PERSONAL INFORMATION**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell \_\_\_\_\_

Street, City, ZIP: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Education (last year completed): \_\_\_\_\_

Occupation: \_\_\_\_\_ Business Phone: \_\_\_\_\_

May we leave a message at your home? \_\_\_Yes \_\_\_No Business? \_\_\_Yes \_\_\_No

Circle One: Single Married Separated Divorced Widowed  
If married, how long? \_\_\_\_\_

Spouse's name and occupation: \_\_\_\_\_

Names and ages of children: \_\_\_\_\_

In case of emergency, please contact the following: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Referred to Family Legacy by: \_\_\_\_\_

**HEALTH INFORMATION**

Rate your overall health (check one): \_\_\_Very Good \_\_\_Good \_\_\_Average \_\_\_Poor

Are you sleeping through the night? \_\_\_Yes \_\_\_No

Have you had a change in weight recently? \_\_\_Yes \_\_\_No  
If Yes, about how much? \_\_\_Loss \_\_\_Gain

Are you experiencing fatigue or lack of energy? \_\_\_Yes \_\_\_No

Present medications and purpose: \_\_\_\_\_

(Please turn over and complete the other side)

**OTHER INFORMATION**

Have you recently suffered loss from a significant social, business, or family relationship? \_\_\_\_\_ Yes  
\_\_\_\_\_ No If Yes, please explain: \_\_\_\_\_

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Have you had previous counseling? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If Yes, please list the dates, name of therapist and reason for counseling: \_\_\_\_\_

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What religious organization do you attend, if any?

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Briefly describe your belief about God and if/how you see your faith being part of the change process in your counseling:

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What has brought you here today and what would you like the counseling process to accomplish?

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**Please circle the areas you may wish to discuss during the counseling process:**

- |            |                 |                      |                   |
|------------|-----------------|----------------------|-------------------|
| abortion   | childhood hurts | marital issues       | sexual issues     |
| abuse      | communication   | occupation           | spirituality      |
| anger      | depression      | parenting            | stress            |
| anxiety    | finances        | parents/in-laws      | substance abuse   |
| appearance | grief/loss      | relational conflicts | suicidal thoughts |

## **FAMILY LEGACY COUNSELING** **NOTICE OF PRIVACY PRACTICES**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law enacted to ensure the privacy and security of a consumer's Protected Health Information ("PHI"). PHI is individually identifiable health information that is transmitted or maintained in any form or medium. Some examples of PHI include an individual's name, social security number, address, and date of birth.

Family Legacy Counseling (counselors and office manager, heretofore referred to as "we") is required by law to protect the privacy of your mental health information. We are also required to send you this notice which explains how we may use information about you and when we can give out or "disclose" that information to others.

The terms "information" or "health information" in this notice include any personal information that is created or received by a mental health care provider that relates to your mental health and/or that of your child(ren), the provision of mental health care to you, or the payment of such care.

We have the right to change our privacy practices. If we do, we will provide the revised notice to you within 60 days by direct mail or post it on our Family Legacy Counseling website, [www.familylegacycounseling.com](http://www.familylegacycounseling.com).

### **HOW WE USE OR DISCLOSE INFORMATION**

**We must** use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you ;
- Where required by law.

**We have the right** to use and disclose health information to operate our business. For example, we may use your health information:

- For collection of payment of grossly overdue or delinquent accounts; account information may be disclosed to a billing collection agency.

**We may** use or disclose your health information for the following purposes under limited circumstances:

- For appointment reminders. We may use health information to contact you for appointment reminders using phone numbers provided by you.
- To persons involved with you care: We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency or when permitted by law.
- For reporting victims of abuse, neglect or domestic violence to government authorities, including a social service or protective service agency.
- For judicial or administrative proceedings such as in response to a court order, search warrant or subpoena.
- For law enforcement purposes such as providing limited information to locate a missing person.
- To avoid a serious threat to health or safety by, for example, disclosing information to public health agencies.

If none of the above reasons applies, **then we must get your written authorization to use or disclose your and/or your child's health information**. The dated Release of Information specifies what information may be disclosed, to whom, and during what period of time. Your written authorization to disclose your health information would apply in the following situations:

- For payment of fees due us (whether by insurance or other third party payees such as churches) and to process claims for mental health care services.
- For treatment information from other family members, referring physicians, other mental health counselors, or physicians to whom we may refer you. This information may be shared via phone consultation, in person, by fax or direct mail.
- For specialized government functions such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.

- If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is our intent to meet the requirements of the more stringent law.

To protect your health information records:

- Information requested by referring or referred physicians or other mental health counselors may be shared in summary form rather than in case note form when possible.
- Appointment reminders will only be left with phone/fax numbers that are provided by you and with your permission.
- Mental health records are stored in color-coded folders applicable solely to your or your child's counselor.
- Mental health records are stored in locked file cabinets when not in use.
- After five years of appointment inactivity, health information records are shredded or burned.

### **HIGHLY CONFIDENTIAL INFORMATION**

Federal and applicable state laws may require special privacy protections for highly confidential information about you. "Highly confidential information" may include confidential information under Federal law governing alcohol and drug abuse information as well as state laws that often protect the following types of information:

1. HIV/AIDS;
2. Mental health;
3. Genetic tests;
4. Alcohol and drug abuse;
5. Sexually transmitted diseases and reproductive health information; and
6. Child or adult abuse or neglect, including sexual assault.

### **WHAT ARE YOUR RIGHTS**

The following are your rights with respect to your health information.

- **You have the right to ask to restrict uses or disclosures** of your information for treatment, payment or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment of your health care. We may also have policies on dependent access that may authorize certain restrictions. *Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.*
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address).
- **You have the right to see and obtain a summary copy** of health information that may be used to make decisions about you such as claims.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time.

### **EXERCISING YOUR RIGHTS**

If you have any questions about this notice or want to exercise any of your rights, please call Family Legacy Counseling at (515) 727-1338.

**FAMILY LEGACY COUNSELING  
5415 NW 88<sup>TH</sup> ST STE 100  
JOHNSTON IA 50131**

**DAVID KAPTAIN, PH.D., CADC, LMFT  
FEE AGREEMENT**

At Family Legacy we believe counseling is a process whereby a client seeks to resolve emotional, relational, and/or spiritual difficulties with the assistance of another caring individual. David will bring to the session his professional knowledge and experience, but the ultimate responsibility for growth and change rests with the client. You are invited at any time to ask questions about your counselor, his methods, and/or the direction the counseling is headed.

The cost for therapy is \$150 for the first session and \$110 for each session thereafter. Sessions normally last 50 minutes. It is expected that you will pay this fee prior to each session, if your account shows a balance of \$220.00, services will be suspended until the balance is brought up to date or arrangements made with the office to bring the account up to date. **Please initial \_\_\_\_\_** A processing fee of \$10.00 will be added to those accounts that require a statement to be sent for unpaid balances. By maintaining a zero balance on your account for co-pays, private pay, testing or other fees you will be able to avoid the processing fee. This excludes billed insurance balances. **Please initial \_\_\_\_\_** David is covered by Wellmark Blue Cross/Blue Shield insurance. We do not submit insurance claims for any other insurance, but we would be happy to provide you with receipts or any other needed information for you to submit your claims to your insurance carrier.

Appointments can be made and messages left for David through the Family Legacy office at **515-727-1338**. If you need to cancel an appointment, you must notify our office within 24 hours of that appointment. As other clients may be waiting for openings, failure to notify our office within 24 hours will result in you being charged ½ the fee, or \$55.00, for the missed appointment. **Please initial \_\_\_\_\_**

In the event of an extreme emergency, instructions will be given on the voice message for how David can be reached after hours. Should he be unable to be contacted, please call one of the other emergency names/numbers given, or pursue 24-hour assistance from a local emergency room, shelter, or police department.

We, the undersigned client (s) have read, understand, and agree to abide by the above policies.

Client \_\_\_\_\_ Date \_\_\_\_\_

Client \_\_\_\_\_ Date \_\_\_\_\_

**Disclosure for Mandatory Child Abuse or Dependent Adult Abuse Reporting:** The counselors at Family Legacy are required by State Law, Code Section 232 & 235, to report suspected incidence of child abuse or dependent adult abuse.

**Family Legacy Privacy Rights:** I have read and understand my privacy rights at Family Legacy.