Karen L. Allen, LCSW
IMANI Counseling and Consulting, LLC

Please provide your photo ID(s) and insurance card(s) for us to copy.

PLEASE PRINT Patient Registration Information

FIRST NAME	MIDDLE NAME OR INITIAL	LAST NAME

Nick name (preferred Name)	GENDER	DOB – MM/DD/YYYY	AGE	SSN
	☐Male ☐Female ☐Other			

MARITAL STATUS

☐Single ☐Married, living together ☐Married, not living together ☐Cohabiting with Partner ☐Separated ☐Divorced ☐Widowed ☐Other, explain:

EMPLOYMENT/STUDENT STATUS *(check on from each category, if applicable)*

Employment Status	Student Status
☐Unemployed ☐FT/ PT employed ☐Retired ☐ Self-Employed	☐Not a student ☐Part-Time ☐Full-Time

Employer Name, if employed:

HOME ADDRESS

Street Address *(apt #, if applicable)*	City, State & Zip code

CONTACT INFORMATION

Home Phone	**Work Phone**	**Cell Phone**

Email(s)	Preferred Method of Communication
1)	☐ Home Phone ☐Work Phone ☐Cell Phone
2)	Receive appointment reminders via email or text? ☐Yes ☐No Receive statement/account balances via email? ☐Yes ☐No

INSURANCE INFORMATION ***if not using insurance, skip to responsible party section***

Primary Insurance Company Name	Policy / Plan / ID Number	Group Number
Secondary Insurance Name, *if applicable*	Policy / Plan / ID Number	Group Number

If using an EAP (Employee Assistance Plan), Please indicate the EAP info	EAP Carrier Name:	# of Approved EAP Visits:	EAP Auth Dates: Start:
	EAP Approval Code:		End:

RESPONSIBLE PARTY ☐Same as Patient

This Is the person that is responsible for any unpaid balances (copays, coinsurance and/or deductibles)

Name:		Relationship to Patient: ☐Mother ☐Father ☐Guardian ☐Other, explain
DOB:	SS#	Address ☐*check here if same as patient*

Authorization and Assignment: I authorize the release of medical information necessary to process this and all claims to my insurance company, including Medicare and Medicaid. I request benefits be made payable to **Rendering Provider and** Karen L. Allen, LCSW-C. I acknowledge that I am financially responsible for this and all claims whether or not paid or covered by my insurance company orother organization. I also agree that if my account is referred to a third party for 60 days past due, I will be responsible for the collection agency fee of 35% plus 19% interest and the balance due. *Youagree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide us. Methods of contact may include using pre-recorded or artificial voice messages and/or the use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that Karen L. ALlen, LCSW-C or representative may contact me/us as described above*

⊗ _____ _____

Signature of Patient (Parent/Guardian if minor child) Date

IMANI Counseling and Professional Consulting Services

This form is to make YOU aware of what YOUR insurance does and does not cover and what your financial responsibility are, if any.

PATIENT SELF VERFICATION of INSURANCE BENEFIT COVERAGE

DO NOT COMPLETE IF YOU HAVE MARYLAND MEDICAID

You can bring this form along with the other registration forms, with you the day of your appointment, but please remember to keep a copy for your records.

BEFORE YOU CALL YOUR INSURANCE COMPANY, HAVE READY:

Patient's Name: _____ Date of Birth: _____

Subscriber's Name (spouse/parent): _____ Date of Birth: _____

Insurance Plan Name: _____ ID #: _____ Group #: _____

Your chief complaint (some insurance companies may ask you this) _____

WHEN YOU CALL YOUR INSURANCE COMPANY SAY:

I'm calling to verify my insurance for Mental Health Outpatient Services in an OFFICE setting"

Telephone Number you called: _____ Person you spoke with _____

If they ask where you are receiving services: ***Karen L. Allen, LCSW (Licensed Clinical Social Worker) Tax ID #46-1518935.***

Obtain answers to the following questions:

1. What is my Effective Date of Coverage: _____
2. Do I have a Deductible? ☐No ☐Yes, amount $_____ How much is left $_____
3. Do I have a Co-Pay per visit? ☐No ☐Yes, amount $_____ per visit
4. Or do I have a co-insurance per visit? ☐No ☐Yes: Insurance will pay _____% and I must pay _____%,
5. How many visits are allowed? _____ per calendar or contract year *(circle one)*
6. Is medication management covered? _____ ❒ N/A-I am not coming in for this
7. Is family and/or marriage counseling covered? _____ ❒ N/A-I am not coming in for this
8. Is a referral required? ☐No ☐Yes, *from where?* _____
9. Is an authorization required? ☐No ☐Yes, *from where?* _____

   Telephone number to call to obtain authorization _____

   If you had to obtain an authorization, what is:

   a. Authorization number: _____
   b. Start Date _____ End Date _____
   c. Number of visits authorized: _____

Any Additional Info

Name of person verifying this coverage:

_____ _____

Patient / Parent-Legal Guardian *(circle one)* Date

STATEMENT OF UNDERSTANDING

SERVICES OFFERED:

Imani Consulting provides psychotherapy, supervision, educational and consultation services. I provide non-emergency psychotherapeutic services by scheduled appointment. If I believe your psychotherapeutic issues are above my level of competence, or outside of my scope of practice, I am legally required to refer, terminate or consult.

I am requesting that you read and sign this statement of understanding to acknowledge your understanding of my office policies. Your signature does not bind you to therapy. It does make you responsible for any charges incurred.

Hours of Operation:

My office hours are by appointment only. You may make appointments and contact me through the following methods:
BEST/PREFERRED WAY: imaniconsulting12@gmail.com
For appointments or to leave a confidential message for Karen Allen: (301) 741-7934

Telephone Calls: Any telephone call, which results in more than a 20-minute conversation will be considered a session and will be billed to your insurance company and you will be responsible for any copays/coinsurance, etc. If our telephone conversation lasts more than 30 minutes, I will suggest you schedule a face-to-face appointment.

E-mail: You may also write to me at imaniconsulting12@gmail.com. If you request a reply, please note that in your e-mail. The reply may come in approximately 24 to 48 hours. *It is not my policy to communicate with clients via email unless it pertains to initial contact or scheduling appointments. If you do choose to communicate with this counselor regarding your personal health information via email, I cannot ensure the confidentiality or these communications. I cannot also ensure that electronic communications will be returned in a timely manner. Email communication should not be used for emergency treatment purposes. Any email you send to this counselor will become a part of your health record.*

Auxiliary Service: Occasionally requests are made for mental health evaluations and other reports. A minimum fee of $100.00 will be charged for these reports.

Emergencies: I am generally available on a 24-hour basis. Clients, however, seen in outpatient psychotherapy are assumed to be responsible for their day to day functions. You may reach me in the following ways:
Office Phone: (301) 741-7934 or email imaniconsulting12@gmail.com to make or cancel an appt.
I will attempt to return your call within one hour. This is not always possible as I may be in session with someone else, speaking to a group of people or traveling from one destination to another. If a life threatening situation arises, please go immediately to the nearest hospital Emergency Room or contact the Emergency Psychiatric services in your area.

SESSIONS/MISSED APPOINTMENTS:

A session is generally **45** minutes in length. Children sometimes will only have a 30-minute session. There is no extra charge for other individuals such as spouse, children, relatives or friends who may need to attend at your request. Missed appointments are an inconvenience to me and to someone else that may have needed that appointment time. I ask that you please, cancel your schedule appointment at least 24 hours in advance. If you are late for a scheduled appointment, your appointment time will be cut short. If you are more than 30 minutes late, your appointment may have to be rescheduled. There is a $50.00 fee for late cancellations and missed appointments less than 24 hours. Exceptions are given only in cases of extreme emergencies or inclement weather. ***Please note, your insurance does not and will not pay this fee.***

COURT APPEARANCES

Karen L. Allen does not make any court appearances. Please read and sign Court Appearance Policy.

INSURANCE AND PAYMENT

Understand that it is your responsibility to contact your insurance company to determine if your insurance will cover outpatient mental health services and if pre-certification/authorization is required. Please make sure you are aware of any copays, coinsurances and deductibles. As a courtesy I will submit claims to your insurance company, but make no guarantees as to what your insurance company will cover.

If I am not a participating provider with your insurance plan, you will be considered **SELF-PAY,** payment is required in full and I will supply you with a detailed receipt of payment for the visit(s), which you can submit to your insurance

company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I may be able to refer you to a colleague or you can contact your insurance company for assistance in finding an in-network provider.

Any balances due, are due at the time of service (copayments, coinsurances and deductibles). Any unpaid balances over 60 days, maybe subject to a 1.5% per month interest charge and I reserve the right to use a third party collection agency to secure payment. For your convenience, I accept Cash and All Major Credit Cards.

EAP (Employee Assistance Program). There is no fee for use of your counseling services under your EAP. Services will be rendered according to contracts with your employer. No personal health information will ever be shared or disclosed to your employer without your written consent. Understand that certain EAPs may require their standardized paperwork to be submitted by the counselor for reimbursement, which may include the sessions and any progress. Only their standardized forms will be submitted.

If you have any questions or would like additional information, please feel free to ask during the initial session or anytime during the psychotherapy process.

I have read the preceding information, or it has also been explained to me orally by the therapist, and I understand my rights as a client or as the client's responsible party.

_____	_____
Print Client's Name	Date of Birth
_____	_____
Client's or Responsible Party's Signature	Date

CLIENT RIGHTS, CONFIDENTIALITY AND HIPAA

CLIENT RIGHTS

In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.

You are entitled to receive information from your therapist about the methods of therapy, the techniques used, the duration of your therapy (if known), and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time. In your intake forms, you will receive a Fee Structure as well as information concerning techniques and methods of treatment.

There may be times when I need to consult with a colleague or another professional about issues raised by clients in therapy. Client confidentiality is still protected during consultation by me and the professional consulted. Signing this disclosure statement gives me permission to consult as needed to provide professional services to you as a client.

In marriage and family counseling, the therapist holds to a "no secrets" policy. All members of the couple or family system are treated equally and "secrets" are not kept by the therapist. There is no differential or discriminatory treatment of family members.

CONFIDENTIALITY

Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, for example, some of the exceptions would include: suspected child abuse, molestation or incest, a client is in danger of hurting self or others, danger of violence, suspected abuse of the elderly or others unable to care for themselves, suspected threat to national security, subpoenaed testimony in criminal court cases, orders to violate privilege by judges in child custody and divorce cases. When treating couples or families, confidentiality among family members is not a guarantee.

CHILDREN AND ADOLESCENTS

A child fourteen or younger seen in this office must have the signature of a parent. In the case of divorce, the authorization must be signed by both parents or the court document presented giving sole custody

NOTICE OF PRIVACY PRACTICES ***(Effective March 26, 2013) Summary***

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed by Karen L. Allen, LCSW-C, the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this counselor has the right to change its Notice of Privacy Practices from time to time and that I may contact this counselor at any time at the address(s) listed to obtain a current copy of the Notices of Privacy Practices. I understand that I may request in writing that this counselor restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the counselor is not required to agree to my requested restrictions, but if the counselor does agree, then it is bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

_____ _____

Signature of Patient (Parent/Guardian, if minor child) Date

COURT APPEARANCE POLICY

I am a Licensed Clinical Social Worker/Therapist, who provides clinical services to parents, families and children. This clinical work takes the form of individual counseling, marital counseling, and services to children. In my clinical role, I cannot assist my clients in divorce or custody litigation, and I disclose this fact to each client and client family who come to me for services. As a Licensed Clinical Social Worker/Therapist, I cannot disclose any marital therapy, couples counseling or family therapy information without the consent of all my clients.

Please do not ask me to write any reports for the court as I cannot do so. Do not ask me to testify in court, because this will destroy my professional relationship with my clients. I am not a custody evaluator and do not do Child and Family Investigation work or Parental Responsibility/Parenting Time evaluations. If the court has appointed a CFI or a PR/PT evaluator, those are the individuals that can make recommendations to the court, unless that is why you initially sought out my services. I cannot make recommendations to the court concerning parental responsibility or parental time issues. That would exceed my role as a therapist, and would adversely affect my ability to help families, parents and children.

I/we have read and fully understand the forgoing statement and agree to its terms as a condition of counseling services.

_____ _____

Signature of Patient (Parent/Guardian, if minor child) Date

_____ _____

Signature Other Date

IMANI Counseling and Professional Consulting Services

INTAKE QUESTIONNAIRE

Please provide the following information and answer the questions below. Please note: Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Patient Name:

Last	First	Middle

Name of Parent/Guardian (if patient under 18 years of age):

Last	First	Middle

Patient's Gender: □ Male □ Female	Date of Birth:	Age:

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Please list any children and ages:

Name(s)	Age:

Contact Information:

Home Phone:	May we leave a message? □Yes □No
Work Phone:	May we leave a message? □Yes □No
Preferred Email:	May we email you? □Yes □No ***Please note: Email correspondence is not considered to be a confidential medium of communication**

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Referred by (if any):

Reason for visit:

GENERAL MENTAL AND MEDICAL HEALTH INFORMATION

Patient Mental Health History:

Are you under the care of a psychiatrist? □ No ☐Yes

Name of Psychiatrist or Psychiatric Nurse: _____

Address: _____City: _____Zip_____

List Any Medication and dosage prescribed by Psychiatrist:

Medication Name	Dosage:

Have you ever been hospitalized for emotional problems? □ No □ Yes

If yes: When_____Where_____

Have you ever had previous individual therapy? □ No □ Yes - Date(s): _____

Name of Therapist: _____

Address:_____City:_____Zip_____

Telephone: _____

Have you ever been treated for substance abuse? □ No □ Yes - Date(s): _____

Are you currently being treated now for substance abuse? □ No □ Yes – Where _____

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No ☐ Yes If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No ☐ Yes If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
□ No ☐ Yes If yes, please describe? _____

8. Do you drink alcohol more than once a week? □No ☐Yes

9. How often do you engage recreational drug use? □Daily ☐Weekly □Monthly ☐Infrequently

10. Are you currently in a romantic relationship? □No □Yes - If yes, for how long? _____
On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently?

_____

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 you in the space provided (father, grandmother, uncle, etc.).*

Problem	Answer	Relationship to You
Alcohol / Substance Abuse	☐Yes ☐No	
Anxiety	☐Yes ☐No	
Depression	☐Yes ☐No	
Domestic Violence	☐Yes ☐No	
Eating Disorder	☐Yes ☐No	
Obesity	☐Yes ☐No	
Obsessive Compulsive Behavior	☐Yes ☐No	
Schizophrenia	☐Yes ☐No	
Suicide Attempts	☐Yes ☐No	

Additional Information

1. Are you currently employed? □No □Yes If yes, name your employer:_____

Do you enjoy your work? Is there anything stressful about your current work? _____

_____

2. Do you consider yourself to be spiritual or religious? □No □Yes
If yes, describe your faith or belief:_____

3. What do you consider to be some of your strengths? _____

_____

4. What do you consider to be some of your weakness? _____

_____

5. What would you like to accomplish out of your time in therapy? _____

_____

Patient Medical History:
Please complete: This is very important information. Please feel free to add any additional information that you feel is needed.

Current Physician and/or Primary Care Provider _____

Address:_____City_____Zip_____

Phone:_____

Medications prescribed by this M.D. (Name and dosage)

Medication Name	Dosage:

Please list any and all physical illnesses that are now being treated by MD

_____
_____
_____
_____
_____

1. How would you rate your current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (Please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in: _____?

4. Please list any difficulties you experience with your appetite or eating patterns. _____

What would you want your therapist to know about your physical or emotional health:

_____
_____
_____

IMANI Counseling and Professional Consulting Services
4329 Northview Drive, Bowie, MD 20716 Telephone: 301-741-7934 Fax: 301-805-8510

AUTHORIZATION FOR RELEASE OF MEDICAL AND/OR MENTAL HEALTH INFORMATION
(also known as PHI – Protected Health Information)

It is important for your counselor/therapist to have all of your medical information to ensure that you receive the best care possible. The purpose of sending or receiving health information is to assist in identifying the best possible treatment which may be needed.

Client Name: _____ DOB: _____

I authorize the following provider to release information to Karen L. Allen, LCSW-C dba Imani Counseling and Professional Consulting Services at the address above.

Dr./Provider/Counselor: _____

Address:_____

Telephone:_____ Fax: _____

INFORMATION TO BE RELEASED (please check all that apply):
MEDICAL HEALTH INFORMATION: ☐ All medical records ☐ Lab reports ☐ All progress notes

BEHAVIORAL HEALTH INFORMATION
☐ All mental and behavioral health information
☐ Type of professional services rendered (psychotherapy, psychiatric, addiction treatment)
☐ Dates on which services were performed
☐ Treatment plan and recommendations
☐ Alcohol/substance addiction treatment records
☐ All progress notes
☐ Intake/termination statements
☐ Psychiatric records
☐ Other, please provide a description of the information to be disclosed. Include the relevant dates:

_____

_____ _____
Patient/Client Signature (18 years or older) Date

_____
Signature of Responsible Party (if patient is minor)

- The unauthorized disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act. Disclosures may only be made pursuant to a valid authorization by the client or as provided in Title III or IV of that Act. The Act provides for civil damages and criminal penalties for violations (D.C. Code § 6-2004 (1995)).

- If the records or information being released involve treatment for alcohol or substance addiction, my records are also protected by federal law and regulations relating to "confidentiality of alcohol or drug abuse patient records." (42 C.F.R. Part 2, 42 U.S.C. § 290dd-2).
- If the records or information released involve treatment for alcohol or substance addiction, this information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). Federal rules prohibit 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 42 C.F.R. Part 2. A general authorization for the 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 client.

To the extent that I am authorizing an entity, which is a covered entity pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to disclose protected health information:

- I understand that I may revoke this authorization at any time unless the applicable entity has already taken action based on this form (or unless this authorization is given as a condition of obtaining insurance coverage and the insurer has certain legal rights to contest the policy or a claim under the policy).
- If I revoke this authorization, I must do so in writing.
- Information regarding the procedure for revoking this authorization must be sought from the entity authorized to make the disclosure.
- I understand that I may refuse to sign this authorization. I understand that pursuant to HIPAA a health care provider may not deny me treatment because I refuse to sign the authorization, unless the treatment is research related.
- I understand that information disclosed based on this authorization may be re-disclosed by the entity or the person who receives the information. Once disclosed, it is possible that the information will no longer be protected under federal medical privacy law.
- The use or disclosure of the requested information may result in direct or indirect payment from a third party to the entity making the disclosure, including copying fees.
- I may inspect or copy the protected health information to be used or disclosed subject to the discretion of my provider and based on my right to access to my protected health information, pursuant to HIPAA.