

**Heidi Lasser, LCPC**  
3709 N. Locust Grove Rd., Ste 100  
Meridian, ID 83646

**Patient Information**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

**\*\*\* We call to confirm appointments. Please circle phone numbers that are ok for us to contact you at. May we leave a message? Yes \_\_\_\_\_ No \_\_\_\_\_ \*\*\***

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ School: \_\_\_\_\_

Teacher: \_\_\_\_\_ School Counselor: \_\_\_\_\_

Please list all individuals living at home: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medical Information**

Family Doctor/ Pediatrician: \_\_\_\_\_

Clinic: \_\_\_\_\_

Please List all medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How were you referred? \_\_\_\_\_

**Treatment Authorization**

Patient Name: \_\_\_\_\_

(Please print)

I authorize Heidi Lasser, LCPC to provide counseling, payment and healthcare operations for me or the above minor. I understand that I may revoke this authorization at any time.

\_\_\_\_\_  
Patient/Guardian Signature \_\_\_\_\_  
Date

Relationship to Patient: \_\_\_\_\_

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**Insurance Information**

**Patient's Name:** \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Insured's Name:** \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Primary Insurance Company Name:** \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insured's ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Secondary Insurance Company Name:** \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insured's ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Signature on File**

Please Initial:

\_\_\_\_\_ I authorize use of this form on all my insurance submissions.

\_\_\_\_\_ I authorize release of information to all my insurance companies.

\_\_\_\_\_ I understand that I am responsible for my bill.

\_\_\_\_\_ I authorize my provider to act as my agent to help me to obtain payment from my insurance company.

\_\_\_\_\_ I authorize payment direct to my provider.

I permit a copy of this authorization to be used in place of the original.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Heidi Lasser, LCPC**  
3709 N. Locust Grove Rd., Ste 100  
Meridian, ID 83646  
**Privacy Act**

We value the trust you place in us and will work diligently to maintain your trust. This document describes the privacy practices of our clinic and our commitment to keeping your confidential information secure. You have the right to request a copy of this document.

In an effort to effectively process insurance claims and service our clients, it is sometimes necessary for us to receive information from, as well as disclose information to, healthcare providers, government agencies, insurance companies, health benefit plans or other authorized personnel. Such information may come from enrollment forms, medical claims information, medical reports and other sources and forms as necessary to provide services or process claims.

The information received may include name, social security number, claim information, and employment information. This list provides some examples of the type of information that may be received or released by our clinic.

**Our Commitment**

- ◆ We will protect, according to the strict standards of security and confidentiality, any information shared with us.
- ◆ We will limit the collection and use of information to the minimum required to provide superior service.
- ◆ We will permit only authorized employees, who are properly trained in the handling of personal information, to have access to that information. We use physical, electronic, procedural and computer access controls.
- ◆ We will not share your personal information for any purpose other than to provide services to our clients, conduct a health benefit or insurance transaction, as disclosed to you, to which you consent or as otherwise required by law.
- ◆ We may provide to you, upon written request, a record of any subsequent disclosures or medical record information made to Heidi Lasser.
- ◆ We will work with you to keep all personal information accurate. This requires that you notify us of any change in your personal information. We will correct any inaccurate information, if possible.
- ◆ You have the right to review your file and request that we amend it if the information is incorrect.
- ◆ You may request a copy of your file and that request will be granted unless we are required by law or ethics to refuse the request.

**When I Disclose Information**

- ◆ We may disclose information to third parties upon your written request/authorization.
- ◆ We may disclose information to another person or entity in order to conduct a health benefit or insurance transaction/function, or for the purpose of allowing the person or entity to administer a health benefit plan, conduct a health benefit or insurance transaction/function.
- ◆ We may disclose personal information to comply with law or legal process to which we are subject, including a facially valid administrative or judicial order, search warrant, subpoena or lawful discover request.
- ◆ We may disclose information for the purpose of conducting an audit.
- ◆ We may disclose personal information to a person engaged to provide services to enable Heidi Lasser to perform a service, health benefit or insurance transaction/function.
- ◆ We may disclose, at some future time, personal information not presently disclosed, as permitted by law.

If you have any questions concerning this privacy notice, please contact me:

Heidi Lasser  
3709 N. Locust Grove Rd.  
Meridian, ID 83646  
(208)855-2295 ext. 103

My signature below indicates that I received this information and the opportunity to discuss any questions about privacy with policies for Heidi Lasser.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Heidi Lasser**  
 3709 N. Locust Grove Rd.  
 Meridian, ID 83646  
**Intake Questionnaire**

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

Counselor: \_\_\_\_\_ Sessions Available: \_\_\_\_\_

Please rate the severity of current symptoms using this rating scale: 1-None 2-Mild 3-Moderate 4-Severe

	1	2	3	4		1	2	3	4		1	2	3	4
Sleep Disturbance					Obsessions/ Compulsions					Physical Pain				
Appetite Disturbance					Phobias					Grieving				
Episodic Crying					Mood Swings					Substance Abuse				
Low Energy					Irritability					Eating Disorder				
Depressed Mood					Anger/ Temper					Co-worker Conflict				
Poor Concentration					Aggressive Behavior					Family Issues				
Stress/Anxiety/Worry					Homicidal Thoughts					Relationship Conflict				
Panic Attacks					Suicidal Ideation					Stress- Work/Home				
Low Self-esteem					Cut or Hurt Self					Academic Problems				
Memory Loss					Sexual Problems					Other				

**How long have you been experiencing the problem(s) that made you decide to get counseling?**

Number of Days: \_\_\_\_\_ Number of Weeks: \_\_\_\_\_ Number of Months: \_\_\_\_\_ Number of Years: \_\_\_\_\_

**My most serious problem is:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**What do you hope to accomplish in seeking assistance at this time?** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Medical**

Do you have <u>current</u> significant health conditions or concerns?	Yes	No
Are you <u>currently</u> taking any medications?	Yes	No

**Life / Work / Relationships**

My daily life is full of things that keep me interested.	Yes	No
Do you exercise regularly? _____ minutes _____ hours per week	Yes	No
How long does it take you to fall asleep? _____ minutes		
When you were a child, did you feel abused or neglected by parent(s)?	Yes	No
Have you ever had your driver's license suspended or revoked?	Yes	No
Do you have trouble relating to others?	Yes	No
Have you become so frustrated that you physically struck another person or object?	Yes	No
Have you ever been harmed or are you afraid of someone who is close to you?	Yes	No
Do you feel that you are shy or lack self-confidence?	Yes	No
Have you received counseling in the past?	Yes	No

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**Limits of Confidentiality**

We are dedicated to preserving the confidentiality and privacy of all our clients. Some state laws, however, specify certain circumstances when mental health clinicians and professionals may be required to break confidentiality.

1. If the clinician has reasonable cause to believe that a child under the age of eighteen years is suffering from serious physical or emotional injury resulting from abuse inflicted upon the child (including sexual abuse), or from neglect (including malnutrition), the clinician is required to report that information to the authorities;
2. If the client presents a clear and present danger to self and refuses to accept appropriate treatment, the clinician may release relevant information to protect the client;
3. If the client communicates to the clinician an actual threat of physical violence against a clearly identified or reasonably identifiable victim(s), relevant information may be released to protect the potential victim(s);
4. If the client has a history of physical violence which is known to the clinician, and the clinician has a reasonable basis to believe that there is a clear and present danger of physical violence against a clearly identified or reasonably identifiable victim(s), relevant information may be released to protect the potential victim(s);
5. If there is a threat of imminently dangerous activity by the client against self or another person(s), the clinician may disclose client communications for the purpose of placing or retaining the client in a psychiatric hospital;
6. If the client introduces a mental condition as an element of claim or defense in a legal proceeding (except one involving child custody or adoptions) the judge may order the clinician to disclose confidential client communications;
7. In any case of child custody or adoption, the judge may order the clinician to disclose confidential client communications if the judge determines that the clinician has evidence bearing significantly on the client's ability to provide suitable care or custody and it is more important to the welfare of the child that the communication be disclosed than the relationship between the client and the clinician be protected (in cases of adoption, or dispensing the consent to adoptions, the judge must determine that the patient has been informed that communications to the clinician would not be privileged);
8. If, after the death of a client, any party acting on behalf of the decedent introduces evidence of the client's mental condition as an element of claim or defense, the judge may order the clinician to disclose confidential client communications;
9. The clinician may provide diagnostic or treatment information to an insurance company or review board, non-profit hospital or medical service corporation, or health maintenance organization for the purpose of administration or provision of benefits and expenses;
10. If the clinician has reasonable cause to believe that an elderly person (over age 60) or handicapped or disabled person over the age of 17 has died or is suffering abuse by the client, the clinician may be obligated to report this information to the proper state agency.
11. Information acquired by a clinician in the course of professional practice may be disclosed to another appropriate professional as part of a professional consultation;
12. If a judge compels the clinician to reveal confidential client information.

**Apart from the above-listed expectations, client information may only be shared upon the express written consent of the patient or parent/guardian.**

If you have any questions about confidentiality or this statement, please feel free to ask your clinician.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Parent (Guardian Signature)

\_\_\_\_\_  
Date

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### **Disclosure Statement**

Welcome to Green Leaves Counseling. I am pleased that you have chosen to seek treatment at our office. To fully inform you of your treatment options, I would like to take this opportunity to outline your “rights” and tell you more about myself.

#### **Patient’s Rights:**

1. You have the right to refuse treatment. If you are uncomfortable or dissatisfied with your treatment, please let me know. If we are unable to resolve the issue, I will be happy to refer you to someone else for treatment.
2. You have the right and responsibility to choose who provides treatment. You are responsible for accepting and approving the mode of treatment that you receive. Successful counseling requires that both the counselor and the client agree upon the treatment methods utilized.
3. You have the right to confidential communication. The limits by law are disclosed in an accompanying document to assist you in understanding what is and is not confidential information.
4. You have the right to expect that a licensee has met minimal qualifications of training and experience required by state law.
5. You have the right to examine public records maintained by the Board of Counselors and to have the Board confirm the credentials of a licensee.
6. You have a right to obtain a copy of the Code of Ethics.
7. You have the right to report complaints to the Board of Counselors.
8. You have the right to be informed of the cost of the professional services before receiving services.
9. You have the right to be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services.
10. You have the right to know: sexual intimacy between a counselor and patient is never appropriate, and should be reported to the Counselors Licensing Board.

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**Information about Heidi Lasser:**

1. **Education, Training, Work Experience:** I have a Bachelor's Degree in Sociology with a Criminology emphasis and a Master's Degree in Guidance and Counseling with a Community Counseling focus. I have been counseling since 1985, with a focus on counseling groups, families, and individuals.
2. **Licensure Information:** I am a Licensed Clinical Professional Counselor in the state of Idaho (license number LCPC-3965.) I offer counseling services to children, adolescents, families, couples, and adults on a wide variety of issues. I specialize in abuse, trauma, grief, anxiety, self-esteem issues, depression, and family difficulties.
3. **Treatment Philosophy:** I use an eclectic approach to match each client's specific issue. This may include one or more of the following approaches: cognitive behavioral therapy, client-centered therapy, reality therapy, EMDR (Eye Movement Desensitization and Reprocessing), IRRT (Imagery Rescripting and Reprocessing), DBT (Dialectical Behavior Therapy), Structural Family Therapy, Strategic Family Therapy, etc.

**Financial Requirements:**

1. Fees for services are charged on a "per hour" basis. My current fee is \$95 per therapeutic hour (50 minutes).
2. Additional fees are charged for: letters, reports, court work, copy of records, clinical supervision, returned checks, and collection agency. I would be happy to discuss the fee policy for these services. (see attached fee schedule)
3. If a patient has medical insurance that will pay all or part of the fee, the billing company will assist in the filing of claims. The patient is responsible for any fee not covered by the insurance and is responsible for keeping the billing company informed of any change in the insurance coverage. The patient is also responsible for obtaining all referral information required for insurance reimbursement. The Billing Company is Idaho Medical Reimbursement Services. Please contact them at (208) 884-8505.
4. **24-Hour Notice of Cancellation:** I require a 24-Hour Notice of Cancellation. Individuals who fail to properly cancel/reschedule appointments will be charged a fee of \$35 for sessions before 5pm and \$95 for sessions scheduled for 5 pm or later. This includes when a client does not show up or is more than 15 minutes late for a scheduled appointment. Insurance companies will not pay these charges; therefore, the patient is responsible for the fee. Additional appointments will not be scheduled until any such fees are paid in full.

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**Disclaimer by the State of Idaho:**

The State of Idaho requires Counselor Disclosure Statements to include the following disclaimer:

***“Licensure of an individual does not imply endorsement by the Counselor Licensing Board nor effectiveness of treatment.”***

You may contact the Idaho Counselor Licensing Board at the Bureau of Occupational Licenses at:

The Owyhee Plaza  
1109 Main Street, Suite 220  
Boise, Idaho 83702-5642  
Phone (208) 334-3233

**Confirmation of Reading and Understanding this Disclosure Statement:**

My signature below confirms that I read this Disclosure Statement and agree to its terms and limitations.

\_\_\_\_\_  
Patient or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Heidi Lasser, MA, LCPC, NCC

\_\_\_\_\_  
Date

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**Agreement and Contract**

- ◆ 30 Minute Initial Consultation                      Free
  
- ◆ Intake Assessment and Treatment Planning                      \$160
  
- ◆ Clinical Session                      \$95 Hourly  
    \*Will do sliding fee scale if no Insurance.
  
- ◆ Clinical Supervision / Consultation                      \$80 Hourly
  
- ◆ Court Report Writing/Letters                      \$250
  
- Half day Court appearance                      \$450
  
- Full day Court appearance                      \$800
  
- ◆ Request for Records :  
    \$25 Administrative Wage for time and postage, plus \$0.25 per page.  
    Fees are due before documents are mailed or faxed.
  
- ◆ Returned check fee \$25 per check  
    And/or bank fees per check
  
- ◆ Unpaid balances are subject to collection agency and court expenses.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date