CONSENT FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

Name (Adult) _____ Age _____ DOB _____

Address: _____ Phone: _____

Who is the client? _____ Relationship to Adult above: _____

Describe the problem you or the client is having: _____

Professional Disclosure: I am a Master's level mental health clinician, practicing with a License issued from the State of Arkansas. I am not a medical doctor, or a doctor of Psychology. My primary role is to provide professional counseling services. If you have questions, you are welcome to ask for clarification of my credentials, specializations, and training.

Risks and Benefits: I am aware that there are both risks and benefits to counseling. While most people experience some level of distress that leads them to seek counseling, it should be understood that when a counselor and client are working towards the goals of counseling, distress, problems in relationships, and other unforeseen circumstances may arise. It is also understood that a goal of counseling will be to alleviate or manage these potential stressors, but an exacerbation of problems may occur. The benefits of therapy may include, but are not limited to, the diminishing of symptoms, distress, relationship growth and a general sense of well-being. However, individual results are not predictable and may vary.

Confidentiality: In accordance with HIPAA and Arkansas state law, we are to keep your medical records confidential. The only exceptions to this are:

1. When the client gives directive/consent for the counselor to communicate with others.
2. When there is a threat to life either by homicide or suicide.
3. When there is a strong suspicion of abuse or neglect to children, elderly, or the handicapped.
4. When counseling records are subpoenaed by a court of law.

Fees: Individual and family counseling sessions last 45-55 minutes. The first session is a Diagnostic Interview. All other sessions are considered Ongoing Psychotherapy. We have established a *Standard Fee* for the Diagnostic Interview and also for the Ongoing Psychotherapy sessions. Additional fees may be assessed for work including special testing, court appearances, document creation, excessive phone calls, extra session time, or consultation with 3rd parties. Payment for services are expected at the end of each session. Concerns about payment will be discussed during the first session. I give permission for the provider to file insurance on my behalf(if provided).

Emergency Notification:
My counselor can be called in the case of psychological emergencies. However he will not always be available by phone or in the evenings. If I cannot reach my counselor I can call 911 or go to the nearest emergency room.

Cancellation: Your appointment time is held for you alone; thus, we require 24 hours notice for appointment cancellations. Except in true emergencies, you will be charged full fee for a late cancellation or "no show".

I have read and understand the above information and agree to receive counseling for myself or for my child. I also give consent for my mental health clinician to leave a voicemail or text on my phone, or to contact me via email, as provided. If necessary, I give consent to my mental health clinician to file insurance claims regarding my payment and healthcare operations.

_____ _____ _____
Signature of Client (Adult, Legal Guardian) Print Name Date

_____ _____
Signature of Mental Health Clinician Date

3980 W. Wedington Dr. Fayetteville, AR 72704 (479) 263-7602

CLIENT DEMOGRAPHICS

Client's Name _____ DOB _____

Address _____ City _____ State _____ Zip Code _____

Cell Phone _____ Alternate_____ (Cell) (Work) (Home)

Occupation _____ Emergency Contact Name/Phone _____

Referred by _____ May we send a note of appreciation to this person? Yes___ No____

(This note will not release any information other than the fact that you have initiated counseling.)

IF CLIENT IS A MINOR (complete this section)

Mother's Name _____ Phone _____ (Cell) (Work) (Home)

DOB _____

Address(if different than child) _____ City _____ State ___ Zip Code _____

Occupation _____Employer/Phone _____

Father's Name _____ Phone _____ (Cell) (Work) (Home)

DOB _____

Address(if different than child) _____ City _____ State ___ Zip Code _____

Occupation _____Employer/Phone _____

INSURANCE INFORMATION(please provide copy of insurance card with paperwork)

Primary Ins. _____ ID# _____ Group # _____

Name of Policy Holder _____ DOB _____ Ins. Phone # _____

CONSENT TO FILE INSURANCE ON YOUR BEHALF _____ (Initials)

If you know… DEDUCTIBLE _____ REMAINING _____ COPAY _____

COINSURANCE _____ INDIV COUNSELING Y / N MARRIAGE/FAMILY Y / N

Personal Information

Client Name_____ **Date of Birth**_____ **Age**_____

Marital Status (# of YEARS): ❑ Married_____ ❑ Divorced_____ ❑ Widowed_____
❑ Separated_____ ❑ Engaged_____ ❑ Cohabitating_____ ❑ Single

Spouse's Name_____ **Date of Birth**_____ **Age**_____
Spouse's Place of Employment_____ **Work Phone**_____

Marriage Information:
Is your spouse willing to come to counseling? ❑ Yes ❑ No
Have you ever been separated? ❑ Yes ❑ No
Have either of you ever filed for divorce? ❑ Yes ❑ No
How long did you know your spouse before marriage? _____
How long did you date your spouse? _____
How long were you engaged? _____

List all others living in your home:

Name	Age	Birthday	Relationship (ex. son, daughter)	School or Place of Employment

History of the Presenting Problem or Complaint
State the nature of your problem: _____
What do you want to accomplish during your sessions? _____
_____
Why are you coming at this time? _____

Problem/Symptom Checklist

❑ Alcohol / Drugs	❑ Family	❑ Marriage	❑ Singleness
❑ Aging	❑ Fear	❑ Money/Budgeting	❑ Smoking
❑ Anger	❑ Finances	❑ Mood Swings	❑ Stress Management
❑ Anxiety	❑ God / Faith	❑ Other Addiction	❑ Trauma
❑ Co-Dependency	❑ Grief / Loss	❑ Parenting	❑ Violence
❑ Child Custody	❑ Guilt	❑ Past Hurts	❑ Weight Control
❑ Communication	❑ Hopelessness	❑ Premarital	❑ Work / Career
❑ Depression	❑ Intimacy	❑ School / Learning	❑ Other_____
❑ Disabled	❑ In-laws	❑ Self-Esteem	❑ Other_____
❑ Divorce/Separation	❑ Loneliness	❑ Sexual Issues	❑ Other_____

Medical History
Any hospitalizations within the last five (5) years;_____

Have you ever received psychiatric or psychological help or counseling of any kind before? ❑Yes ❑ No
Do any of your family members have a history of mental illness? ❑ Yes ❑ No If yes, please explain whom and the nature of the illness._____
Have any of your family members ever received psychiatric or psychological help or counseling of any kind before? ❑ Yes ❑ No

Rate Your Physical Health: ❑ Very Good ❑ Good ❑ Average ❑ Declining ❑ Poor
Recent Weight Changes: *Gained*_____*Lost*_____
Check if Applicable: ❑ Difficulty Sleeping ❑ Difficulty Eating ❑ Headaches
How many hours of sleep do you average each night? _____

Medication(s): (taken for anxiety, nervousness, depression, or related types of problems.)

Name	**Dosage / How Often**	**Reason Taken**	**How Long Taken**	**Response / Side Effects**

Doctor's Name: _____

Doctor Consent:
Do you give your counselor Consent to Release Information to your Medical Doctor as to why you are coming?

_____
Signature

Have you ever experienced any of the following?

❑ Physical Abuse
❑ Emotional Abuse
❑ Spousal Abuse
❑ Sexual Abuse
❑ Rape
❑ Harsh Physical Punishment as a child
❑ Incest
❑ Sexual advances towards you as a child
❑ Other_____

If so, please explain_____

Crisis Information:
Any current suicidal thoughts, feelings, or actions? ❑ Yes ❑ No
Any current homicidal thoughts, feelings, or actions: ❑ Yes ❑ No
Do you have a history of anger of impulse control problems? ❑ Yes ❑ No
Have you experienced any significant losses and/or deaths within the last five (5) years? ❑ Yes ❑ No
If yes, please explain_____

Have you ever been arrested? ❑ Yes ❑ No If yes, please explain_____
Have you ever served time in jail? ❑ Yes ❑ No If yes, please explain_____
Do you currently use any drugs including marijuana? ❑ Yes ❑ No History of Use? ❑ Yes ❑ No
Do you smoke or use tobacco products? ❑ Yes ❑ No
Do you drink alcoholic beverages including beer, wine, or liquor? ❑ Yes ❑ No

Religious Background
Do you consider yourself a religious person? ❑ Yes ❑ No ❑ Uncertain
Do you believe in God? ❑ Yes ❑ No ❑ Uncertain
Do you pray to God? ❑ Often ❑ Never ❑ Occasionally
Are you saved? ❑ Yes ❑ No ❑ Not sure what you mean
Do you read the Bible? ❑ Often ❑ Sometimes ❑ Never
Meaningfulness of your faith/religion: ❑ High ❑ Medium ❑ Low
Church you attend _____