Healing Path Counseling

Couples Intake Form

Client's Name: _____ Phone#_____ Birthdate: _____

Client's Name: _____Phone#_____ Birthdate: _____

Marital Status (Circle one):

Single / Married / Other

Street Address: _____ Zip Code: _____

Street Address: _____ Zip Code: _____

Email address: _____ Email address: _____

Who can we thank for referring you? _____

EMERGENCY CONTACT

Name of local friend or relative (not living at same address):

Relationship to Client: _____

Home Phone No. _____ Work Phone No. _____

Client Consent

Patient/Therapist Relationship

- You and your therapist have a professional relationship-existing exclusively for therapeutic treatment.
- In the following of ethical guidelines, social relationships between therapist and clients are prohibited. (this includes social media such as Facebook, Twitter, and Linked-In)

Risks and Benefits:

- Counseling is beneficial, but as with any treatment, there are inherent risks.
- During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions.
- The benefits of counseling can far outweigh any discomfort encountered during the process.
- It is our desire, however, to work with you to attain your personal goals for counseling

Capacity or Death:

- In the event of my death or inability to provide therapy, your record will be transferred to another therapist.
- This information will be held by the Arkansas Board of Examiners in Counseling. They can be reached at (501) 683-5800.

Confidentiality:

- Confidentiality is an ethical standard that protects clients from the disclosure of information without their consent.
- Healing Path Counseling follows all ethical standards prescribed by state and federal law.
- We are required by practice guidelines and standards of care to keep records of your counseling.
- These records are confidential with the exceptions notes in the Notice of Privacy Practice provided to you, and when I believe you are a danger to yourself or others.

Consent to Treatment:

- By signing this client information and consent form as the client or the guardian of said client, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form.
- I am voluntarily agreeing to receiving mental health assessment, treatment and services for me (or my child, if said child is the client), and I understand that I may stop services at any time.
- Note: if you are consenting to treatment of a minor child, and a court order has been entered with respect to the guardianship of the child, or impacting your rights with respect to consent to the child's mental health care and treatment, Healing Path counseling will not render services to your child until the Therapist has received and reviewed a copy of the most recent applicable court order.

Signature-Client/Spouse/Partner Date

Signature-Client/Spouse/Partner Date

Therapist Date

HEALING PATH COUNSELING FEES, CREDIT CARD AUTHORIZATION, AND OFFICE POLICIES

APPOINTMENTS

- Appointments are typically scheduled on a weekly basis and are approximately 45 minutes long.
- More frequent sessions or an intensive outpatient schedule are available if determined appropriate by you and your therapist. For progress to be made in counseling, it is crucial that you attend appointments consistently.
- Please notify us within 24 hours of scheduled appointment, if you will be unable to attend (see fee schedule for late and reschedule fees)

OFFICE POLICIES

- Prior to entering counselor's office, please silence your cell phones, and please turn off all electronic devices.
- Please plan for your appointment, and make appropriate arrangements for children, pets, and travel to and from the office.

FEE SCHEDULE:

• Diagnostic & Evaluation Session (1st visit) ($60.00 to hold the appointment, $60.00 due at scheduled time)	$120.00
• Regular Office Visits (45 minutes)	$120.00
• Outside Office Work (inpatient visits, court, collaboration with other professionals, academic, phone/video meetings)	$150.00hr
• **Court appearances-requires a 4-hour minimum retainer due the week of court** $150 per hour thereafter. No refund will be given, if less than 48 hours' notice of cancelling court.	$600.00
• Written Reports (insurance companies, supervisors, etc)	Minimum $25.00
• Returned check fee per check	$50.00
• Cancelled or Rescheduled Appointment without 24 hr. notice	$30.00
• 2nd Cancelled or Rescheduled Appointment without 24 hr. notice	$60.00
• No Show Appointment	$70.00
• 2nd No Show Appointment plus all no shows thereafter	$120.00
• Late Fee for Outstanding Balances (applied monthly)	10%of total bill
• A reasonable fee will be charged for copies of any records requested by the client	

INSURANCE/EMPLOYEE ASSISTANCE PROGRAMS (EAP) /WORKER'S COMPENSATION

- Clients are responsible for full payment at time of services.
- We do not bill insurance, but we will provide, at your request a 1500 form to submit to your insurance on a monthly basis.
- It is your responsibility to obtain the address for the MENTAL HEALTH DEPT of your insurance, and to follow-up regarding processing with your insurance.
- It is your responsibility to contact your human resource department to find out if you have an employee assistance program, and to inform them that you would like to take advantage of the program.
- We must be notified by the EAP that they are covering your sessions prior to your counseling session, or you will be responsible for payment for that session.
- If your appointments are being covered by an Employee Assistance Program, Worker's Compensation, or insurance they may require medical records in order to approve payment. For Healing Path Counseling to release those records, permission needs to be given on the HIPPA form.

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered. I understand that if I chose to end services, I am still responsible for any outstanding balance.

By signing below, you hereby authorize Healing Path Counseling to maintain your credit card on file in the event that there is a later charge to your account. You will be notified via email/telephone prior to any subsequent charges.

Signature-Client/Parent Date

Signature-Parent/Guardian Date

HP Healing Path Counseling

A copy of the document entitled **Privacy Policy: Your Information. Your Rights. Our Responsibilities.**, which outlines HIPAA privacy laws, has been made available for me to review.

_____ _____

Client signature Date

_____

Print Client Name

_____ _____

Witness Date

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ **Date of Birth:** _____

Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting our office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected. **Patient Authorization**

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, legal/court records, educational records, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the above identified patient. I authorize these agencies to share information by mail, phone, in person, fax and/or email contact. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

☐ **I hereby authorize Healing Path Counseling to RELEASE my protected health information (PHI) to:**

_____

☐ **I hereby authorize Healing Path Counseling to OBTAIN my protected health information (PHI) from:**

_____

Disclosure Scope for PHI Release:

Disclosure may include the following verbal or written information: (check all that apply)

☐ Face sheet
☐ History & physical
☐ Laboratory/diagnostic testing results
☐ School
☐ information
☐ Discharge summary
☐ Medication records
☐ Behavioral health/psychological consult
☐ Psychosocial assessment/Family history
☐ ER record report
☐ Psychiatric evaluation
☐ Substance abuse treatment records
☐ HIV/AIDS lab results
☐ & treatment history
☐ Progress & Case Notes
☐ Summary of treatment
☐ records & contact dates
☐ Psychological evaluation/testing results
☐ Other: _____

Information necessary to identify, diagnose, prognosis, or treatment for mental health, substance abuse (alcohol/drug use), and any other relevant information for the purpose of treatment.

All information I hereby authorize to be obtained from the above identified source will be held strictly confidential and cannot be released by Healing Path Counseling, without my written consent. I understand that this authorization will remain in effect for:

☐ The period necessary to complete all transactions on accounts related to services provided to me.
☐ One (1) year
☐ Other: _____

I understand that unless otherwise limited by state or federal regulation and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time. If client is a minor child, I verify that I am the legal guardian/custodian of this child.

_____ _____

Signature of Client/Legal Guardian or Legally Authorized Representative *Date*

_____ _____

Witness *Date*

Healing Path Counseling

Adult Information Form

Name: _____
Date: _____
Please check your therapy goals:
Anxiety ___ Anger ___ Career Development ___ Depression ___ Education ___ Family ___ Financial ___

Grief/Loss ___ Legal ___ Partner/Marital ___ Physical Health ___ PTSD/Trauma ___ Stress ___ Substance Use ___

Work/Life ___ Workplace issues ___ Other _____

MEDICAL HISTORY

Name of Primary Care Physician: _____
Date of last medical evaluation: _____
Current medications being taken: (Please list additional medications on the next page)

1. _____ Dosage/Freq. _____ 3. _____ Dosage/Freq. _____
2. _____ Dosage/Freq. _____ 4. _____ Dosage/Freq. _____

Prescribed by: _____

Please check yes or no to the questions below and explain any yes answers below.

	YES	NO
1. Have you ever been hospitalized for psychiatric reasons?	____	____
2. Do you use recreational drugs or have you used in the past?	____	____
3. Do you currently drink alcohol or have you used alcohol in the past?	____	____
4. Have you ever received treatment for alcohol or drug use?	____	____
5. Did you experience any developmental, academic, or behavioral Problems as a child or while in school, with peers or teachers?	____	____

Please explain any yes answers in the space below. (Ex. Hospitalization or treatment dates, outcomes, drug and alcohol usage, etc.)

Describe any important medical history, ailments, chronic, or other health problems experienced by you or any immediate family

Family and Household Information

How would you describe your support network? (friends, relatives, etc.): Poor ___ Fair ___ Good ___ Excellent ___
While growing up did you or any family member experience the following:
Alcohol abuse _____ Drug abuse _____ Sexual abuse _____ Physical abuse _____ Emotional abuse _____
Traumatic Experience (ie, natural disaster, accidental death) _____

Please explain:

HOUSEHOLD INFORMATION

Please list those currently living in household:

Name	Age	Relationship (biological/step)	Lives with
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is there any other information regarding you or your family that you would like to share with your counselor that is not covered on this form? You may also use this space to complete earlier responses.

_____

_____

MENTAL STATUS

Please choose any of the following that describes how you have been feeling lately:

Sad ___ Anxious ___ Depressed ___ Frightened ___ Guilty ___ Ashamed ___ Aggressive ___ Worthless ___

Tearful ___ Irritable ___ Confused ___ Jealous ___ Hopeless ___ Helpless ___ Extreme ups/downs ___

Describe your current working environment: _____

_____

Please check yes or not to the questions below, and explain any yes answers below

	Yes	No
1. Have you had any changes in eating or sleep patterns?	____	____
2. Have you ever considered suicide in connection to your current problem?	____	____
3. Have you ever considered suicide in the past?	____	____
4. Have you attempted suicide recently or in the past?	____	____
5. Have you had any homicidal thoughts recently or in regard to your current problem?	____	____
6. Have you ever considered homicide in the past?	_____	____

Please explain any Yes answers in the space below.

_____

_____

Do you have any close relatives, (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties?

Please list: _____

LEVEL OF FUNCTIONING

Do you currently have concerns in any of the following.

Physical ___ Medical ___ Nutrition ___ Physical Fitness ___ Leisure ___ Military Service ___ Psychological ___

Family ___ Relationships ___ Social Support ___ Recreational ___ Financial ___ Spirituality ___ Location ___

Legal ___ Sexual ___ Vocational ___ Other: _____

Please mark yes or no regarding the following statements.

	Yes	No
1. I sometimes hear voices even though no one nearby is talking to me.	____	____
2. I sometimes feel that forces outside of me control me	____	____
3. I sometimes feel that other people control my thoughts.	____	____
4. I sometimes have the same thought over and over and cannot control it	____	____
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_____
_____
_____

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_____
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_____

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Please explain:

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3. I sometimes feel that other people control my thoughts.	___	___
4. I sometimes have the same thought over and over and cannot control it	___	___
5. I sometimes feel that someone is out to hurt me or something against me	___	___
6. I am sometimes unable to control my behavior.	___	___

Please explain: