Key Counseling and Consultation, LLC

181 Granville St. Gahanna, OH 43230 Phone: (614) 478-3050
Email: info@keycounseling.org Website: http://www.keycounseling.org

2015 Office & Appointment Policies

Welcome, we at Key Counseling and Consultation, LLC look forward to working alongside you and your loved ones during your counseling experience. Below are a few highlights to assist you with your first appointment.

- Before your initial appointment, print single sided and complete the following forms. *Please **fill them out in their entirety***. Read them carefully to be informed of what you are signing. Having these ready ahead of time will save you twenty to thirty minutes of the initial counseling session. Should you be unable to bring these New Client Forms with you, contact us at (614) 478-3050, ***prior*** to your arrival.

- Payment is collected at the ***beginning*** of each session, with the exception for those with a credit/debit card and authorization on file.

- Our office is located in the Gahanna Medical Professional Building in Suite 200 B at 181 Granville St. Gahanna, Ohio 43230. We are located across from the Key Bank and next to the PNC Bank. Once you come into the building our suite is immediately to your right.

- All sessions are 50 minutes in length, unless prior coordination has been made. A wrap up typically begins a couple of minutes before the end of our time together. This is usual and customary and abides with the ethical standards of the therapeutic process and guidelines.

Again, welcome to Key Counseling and Consultation, LLC. We look forward to seeing you soon.

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Client Intake Form

(Please Print Legibly)

Today's Date

_____/____/_____

CLIENT INFORMATION (Insurance Policy Holder)

Client's Last Name	First	Middle		Marital Status (Circle One) Single / Married / Other
Is this your legal name? - Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Gender ❑ Male ❑ Female ❑ Transgender
Street Address	City	State	ZIP Code	Social Security - -	Home Phone No. ( ) Y N	MSG
P.O. Box	City	State	ZIP Code	Cell Phone No. ( ) Y N	
Occupation	Employer			Work Phone No. ( ) Y N	

Referred to Provider by (Please check one box & list)

❑ Website ❑ Search engine ❑ Advertisement ❑ Social network
❑ Friend ❑ Physician's Office ❑ School ❑ Church
❑ Social Organization ❑ Event ❑ Other

Email Address:	Alternative Email Address:

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.

REASON FOR SEEKING THERAPY

_____

Thoughts of harming self? Y N Thoughts of harming others? Y N

Legal cases or proceedings for which you will be requesting copies of your therapy records? Y N

ISURANCE INFORMATION

Insurance Company:_____ Effective Date: _____

Policy #: _____ Group #: _____

Company Address (located on the back of your card under "where to send claims"):

_____

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Consent for Treatment

Dear Client,

In beginning our work together it is important for you to understand both the nature and limitations of the relationship. Please review the following policies to help you understand these areas. Also, please excuse the exhaustive nature of this material but it represents the current legal and ethical requirements of a practicing therapist.

APPOINTMENTS. Your appointment is reserved for you. It is your responsibility to notify your therapist ***24 hours in advance*** if you are unable to attend. Cancelations of appointments less than 24 hours in advance and "no shows" are subject to a cancellation fee. One late cancel/no show appointment is given per calendar year to account for unforeseen and emergency circumstances.

CONFIDENTIALITY. The material you disclose is confidential and cannot be released without your written consent. There are certain circumstances, however, under which Key Counseling and Consultation. may be legally required to disclose this information. These include:

1) If there is suspicion or reasonable belief that child abuse has or may be occurring.
2) If there is suspicion that an elder or dependent adult abuse has occurred.
3) If you make a threat to harm another person.
4) If you pose a risk to yourself or others.
5) If you enter into a legal proceeding in which you raise the issue of your mental status.

PAYMENTS & FEES. The standard fee for therapy is $125 for individuals and $145.00 for couples and families. Sessions are 50 minutes. If arrangements are set up for extended appointment times, the fees will be adjusted accordingly. You are expected to pay for services at the time they are rendered unless other arrangements have been made. If you are using your insurance benefits, we will collect your co-pay at each visit at the time of service and bill your insurance company for the remaining balance. We currently accept checks, cash and all major credit cards. In the event your insurance does not cover any portion of the claim, it is **your responsibility** to take care of any outstanding balances. Preferred payment method is by credit or debit card, payments may also be made with cash or personal check at the beginning of the session. There is a $30.00 charge for returned checks.

PROBABLE LENGTH OF SERVICES & TERMINATION OF THERAPY. Based upon your identified goals for therapy, your therapist will discuss with you the general course of therapy. Time of therapy can vary according to commitment, motivation, personality, and readiness for change. Treatment is not always precise and feelings of frustration, lack of clarity, and/or confusion may arise. Change frequently involves difficult emotions and/or some internal turbulence. However, the challenges of therapy often result in personal rewards of the client.

RECORDS KEEPING. Your therapist will keep notes of impressions of your work in therapy. These will be limited to the scope of problem formation and the focus and direction of treatment and will be stored in a locked and secured file. They can only be accessed by your consent or the above exceptions to confidentiality.

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ONLINE & SOCIAL NETWORKING POLICY. Emailing and texting should be used for appointment scheduling or billing only, please note that unless you have a secure and encrypted email account your confidentiality cannot be protected. Your therapist's office will respond to email within 48 hours with the exception of holidays and weekends. Please be advised that a digital copy of all communication will become part of your documented record..

EMERGENCY POLICIES. Your therapist will gladly see you more often for office visits during times of crisis and will make every attempt to respond to such needs if these requests are made clear in session or on voicemail messages. However, your therapist will not be able to respond immediately to emergencies over the phone or to conduct sessions or interventions over the phone. Emergencies that cannot be addressed by increasing sessions should be handled by either going to your closest hospital emergency room, calling a crisis hotline (Netcare 614-276-2273), or by calling 9-1-1 for crisis response.

TERMINATION. After the first couple of meetings, your therapist, will assess if she can be of benefit to you. Your therapist does not accept clients who she does not feel she can help. In such a case, your therapist will give you a number of referrals that you can contact. If at any point during psychotherapy, your therapist assesses that she is not effective in helping you, she will discuss this with you, and if appropriate, terminate therapy. If you request it and authorize it in writing your therapist will talk to the psychotherapist of your choice in order to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, your therapist will assist you in finding someone qualified, and if she has your written consent, will provide her or him with essential information needed. You have the right to terminate therapy at any time. If you choose to do so, your therapist will provide you with the names of other qualified professionals whose services you might prefer.

COLLECTIONS POLICY. Clients with accounts holding a balance of over $100 will not be seen until the balance is paid. In the event that you fail to make reasonable efforts to pay your bill, Key Counseling and Consultation. retains the right to contact a collections agency for pursuit of accounts that become delinquent. When unavoidable circumstances arise, your therapist will make every effort to work out a reasonable payment agreement. However, for clients who refuse to respect the credit policy, it may become necessary to transfer those accounts to a collection agency. If it becomes necessary to transfer your account to a collection agency, your financial records will then be released to them and your delinquent balance will be recorded with the credit bureau. Please be aware that this action is only a last resort.

FEE FOR SERVICE. I agree to enter therapy with Key Counseling and Consultation and will pay $125 or $145 for each session, if I am not utilizing my insurance benefits or under a sliding fee scale agreement. I understand that I am responsible for complete payment for sessions and understand the collection procedures if I have not paid or made arrangements to pay for more therapy sessions.

I HAVE READ THE FOREGOING AND UNDERSTAND WHAT IT SAYS, TO THE EXTENT THAT IF I HAVE ANY QUESTIONS REGARDING THIS FORM, I WILL ASK MY THERAPIST AT KEY COUNSELING AND CONSULTATION TO CLARIFY THESE POLICIES.

_____ _____
Client/Parent or Guardian Signature Date

_____ _____
Client/Parent or Guardian Signature Date

_____ _____
Therapist Date

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective January 18, 2011

As part of my role in providing mental health services to you, I will be handling information about you that is personal. Federal and State law determine how this information is handled. To comply with these laws, I request that you accept and review this Notice and then sign an Acknowledge Form, which states that you have been given an opportunity to review this Notice of Privacy Practices and that you have been offered a copy of this Notice for your records.

I am allowed by law to use and disclose information about you for three purposes: 1) treatment, 2) payment (when applicable), and 3) health care operations. If any protected health information (PHI; information in your health record that could identify you) is to be used for any other purpose, a written authorization from you will be requested. Other information about your rights and policies regarding our PHI are described below.

This notice describes our policies related to the use and disclosure of your healthcare information.

Use and disclosure of protected health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allows us to use and disclose your health information for these purposes.

TYPES AND USES AND DISCLOSURES

TREATMENT: Consultation, diagnosis, providing care and referrals. Examples of treatment disclosures include the disclosure of psychological information about you to your primary care physician or other health care providers to assist in your diagnosis and treatment.

PAYMENT: Everything related to billing and collection of fees or service.

HEALTHCARE OPERATIONS: Things that I need to do to maintain the quality of services that you receive, such as if I hire an administrative assistant who may contact you to schedule and confirm appointments.

USES AND DISCLOSURE REQUIRING AUTHORIZATION

Written permission is required for specific disclosures above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, and health care operations, I will obtain an authorization for you before releasing information. I will also need to obtain an authorization before releasing your “psychotherapy notes” (notes I will make about your conversations during private, group, couples, or family counseling session). Psychotherapy notes are given a greater degree of protection than PHI. You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that I have relied on that authorization or if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

Used and Disclosures with Neither Consent nor Authorization

I may use or disclose your protected health information (PHI) without your consent or authorization in the following instances:

Serious Threat to Health or Safety. If I believe you possess a clear and substantial risk of imminent serious harm to yourself or another person, I may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm.

Victims of Domestic Violence and Abuse as Required by Law. This includes situations involving a child, elder or person who is mentally retarded that would involve abuse, neglect or exploitation. I may disclose your PHI to the government agency or entity that is authorized to receive such information as mandated by federal and state laws if I believe that these situations are occurring.

Judicial or Administrative Proceeding. Disclosure of PHI in response to an order of a court or administrative tribunal (as explicitly authorized), to the extent that such disclosure is expressly authorized, in certain situations in response to a discovery request, subpoena, or other process governed by law.

Government Oversight. May include information to a public health authority, a health oversight agency, a coroner or medical examiner, the military, Veterans Affairs, or another entity for national security purposes.

Worker's Compensation Laws. If you file a worker's compensation claim, I may be required to give your mental health information to relevant parties and officials.

Other Situations as Requested by Law. If required by law, use and disclosure will be limited to the relevant requirements of the law. You will be notified as required by law of any such use and disclosure of your (PHI).

PATIENT RIGHTS

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction that you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations. You have the right to request and receive confidential communication of PHI by alternative means and at alternative locations. For example, you may not want a family member to know you are seeing a therapist. Upon your request I will send your bills or contact you at another location.

Right to Inspect and Copy. You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in your mental health records for as long as I maintain your records. Upon your written request and after 30 days, I will discuss with you the details of the request process. (For a copy of your PHI and/or psychotherapy notes, an initial fee of $25 is charged, and for data recorded on paper the following amounts are charged: one dollar per page for the first ten pages, fifty cents per page for pages eleven through fifty, and twenty five cents per page for the pages fifty-one and higher.)

Right to Amend. You have the right to request an amendment of PHI and psychotherapy notes for as long as PHI and psychotherapy notes are maintained in the record. I will put in your record the changes you request; however, these changes are added to the record; no portions of the record are deleted. ON your request, I will discuss the details of the amendment process.

Right to an Accounting. You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described under Uses and Disclosures with Neither Consent nor Authorization). On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy of this Privacy Notice. You have the right to obtain a paper copy of this notice upon request, even if you have agreed to this notice electronically.

MY DUTIES

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, I am required to abide by the terms currently in effect.

If I revise my policies and practices, I will post a revised copy in the waiting room, and I will offer you an opportunity to receive a copy of this revised policy.

QUESTIONS AND COMPLAINTS

If you have questions about this notice, disagree with a decision made about your PHI or have other concerns I encourage you to discuss them with me. If you believe that your privacy rights have been violated, and you wish to make a written complaint you may send it to: Ohio Counselor, Social Worker, and Marriage and Family Therapist Board 50 West Broad Street, Suite 1075 Columbus, OH 43215-5919, Phone (614) 466-0912 -Website: www.cswmft.ohio.gov.

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NOTICE OF PRIVACY PRACTICES
RECEIPT AND ACKNOWLEDGMENT OF NOTICE

Patient/Client Name: _____

DOB: _____ SSN: _____

Patient/Client Name: _____

DOB: _____ SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Key Counseling and Consultation's Privacy Practices available in our office and at www.keycounseling.org

_____ _____
Client/Parent or Guardian Signature Date

_____ _____
Client/Parent or Guardian Signature Date

_____
*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ Patient/Client Refuses to Acknowledge Receipt:

_____ _____
Therapist Date

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APPOINTMENT REMINDERS

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a computer generated voice message) the day before your scheduled appointments.

Your Name: _____

Your email address: _____

Your cell phone number: _____

Your cell phone carrier (circle one):

Alltel	AT&T	Boost Mobile	Nextel	Sprint	SunCom
T-Mobile	Verizon	VoiceStream	Virgin Mobile	(Other) _____	

Would you like to receive appointment reminders? (check one)

_____ Via a text message on my cell phone (normal text message rates will apply)

_____ Via an email message to the address listed above

_____ Via an automated telephone message to my home phone

_____ None of the above. I'll remember my appointments on my own. (Missed appointment fess will still apply)

Appointment information is considered to be "Protected Health Information" (PHI) under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

_____ _____

Client/Parent or Guardian Signature Date

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Credit Card Authorization

(Credit cards are the preferred method of payment **or** we will need a check retainer on file.)

Please make no marks or added comments to this page of the document. It is your consent to make payment for services rendered and your treatment is conditional on your signing this consent form without modification. This form will be securely stored in your clinical file and may be updated upon request at any time. **Credit cards are the preferred method of payment or we will need a check retainer on file.**

In the case that you miss or fail to cancel an appointment within 24 business hours of the scheduled time, you will be charged a no-show/late cancel fee.

An additional $35 fee will be assessed for 1.) returned checks, and 2.) inaccurately disputed charge-backs.

I, _____, hereby ***authorize Key Counseling and Consultation, LLC*** to bill my credit card at the usual fee for professional services including all of the following:

- Appointments and/or copayments that I elect to pay for by credit card
- Missed appointments
- Appointments that I have cancelled with less than 24 business hours' notice
- Returned checks
- Any outstanding balances from claims not covered by insurance provider

Credit Card/Debit Card Type (check one):

□ Visa □ MasterCard □ Discover □ American Express

Card #_____

Expiration Date: _____ Verification/Security Code (3-digit code on back of card by signature line): _____

Name as Printed on Card: _____

Billing Address: _____

City: _____ State: _____ ZIP: _____

By signing below I am authorizing Key Counseling and Consultation to bill my credit card at the usual fee for professional services as described above.

Signature: _____ Date: _____

Print Name: _____

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CREDIT CARD AUTHORIZATION AGREEMENT

Please note that this form will be securely stored in your clinical file and that you are willing to assume the risk for keeping this information on file. All credit card information will be stored on the InstaMed Provider Portal. Once information is uploaded to the system, it will be encrypted to prevent unauthorized access.

I authorize Ezekiel Peebles, Licensed Professional Clinical Counselor doing business as Key Counseling and Consultation LLC to keep my signature and card information on file and to charge my credit, charge, or debit card, or flex spending account as filled out below for therapy services provided to:

_____

(Therapy client's name: Please Print)

For the following :

- Appointments and/or copayments that I elect to pay for by credit card
- Missed appointments
- Appointments that I have cancelled with less than 24 business hours' notice
- Returned checks
- Any outstanding balances from claims not covered by insurance provider

I understand that this authorization if valid until canceled in writing. I understand that though this information is secured in my client file, and is unlikely to be tampered with, I agree to assume the risk if the file and credit card information is compromised. I understand that charges for on-going services will normally be posted to my credit/debit/flex card account within 72 hours of each session date and my session fee will be charged before the session begins. Additionally, I agree that the card listed below may be charged by therapists doing business as Key Counseling and Consultation LLC in order to settle any outstanding balances accrued by the above listed client upon termination of therapy services including any materials (i.e. books, cd's dvd's) that I have not returned within one week of termination. I understand that if a charge back fee is incurred, I am responsible for that fee. Initial_____

I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact Key Counseling and Consultation LLC for any assistance and/or disclosure, I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with Key Counseling and Consultation and those attempts have failed. Initial_____

I agree that if there are changes to the card I have on file with the office of Key Counseling and Consultation, it will be my responsibility to update the office with the new information. Initial_____

Further, if I am assuming session payment responsibility for the client above whose name is listed in the printed area, and that client is someone other than myself, I understand that I am not entitled to information pertaining to confidential therapy sessions as provided by therapists at Key Counseling and Consultation. Initial _____

I understand and agree to these terms. I understand the conditions of this payment policy and agree to the conditions stated above:

_____

Client Signature Date

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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, _____hereby authorize Key Counseling and Consultation to release confidential information obtained during the course of my treatment to:_____

This Authorization permits the release of the following information:

____ Any and All Information Necessary
____ Diagnosis ____ Treatment Plan ____ Prognosis
____ Progress to Date ____ Clinical Test Results ____ Dates of Treatment
____ Patient Records ____ Summary of Treatment
____ Other_____

I authorize the release of the information described above for the following purpose(s): Case Management and Continuity of Care

The recipient may use the information described above solely for the following purpose(s): Case Management and Continuity of Care

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing.

This Authorization shall remain valid until: ("Expiration Date") _____

By: _____ Date:_____
(Patient or Patient's Representative*)

*If signed by other than Patient, please indicate the relationship between Patient and his/her Representative:

_____

AUTHORIZATION TO EXCHANGE CONFIDENTIAL INFORMATION

I, _____hereby authorize Key Counseling and Consultation to exchange confidential information obtained during the course of my treatment to:_____

This Authorization permits the release of the following information:

____ Any and All Information Necessary
____ Diagnosis ____ Treatment Plan ____ Prognosis
____ Progress to Date ____ Clinical Test Results ____ Dates of Treatment
____ Patient Records ____ Summary of Treatment
____ Other_____

I authorize the release of the information described above for the following purpose(s): Case Management and Continuity of Care

The recipient may use the information described above solely for the following purpose(s): Case Management and Continuity of Care

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing.

This Authorization shall remain valid until: ("Expiration Date") _____

By: _____ Date:_____
(Patient or Patient's Representative*)

*If signed by other than Patient, please indicate the relationship between Patient and his/her Representative:

_____

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APPOINTMENT CANCELLATION POLICY

We pride ourselves in providing time for the personal attention each patient deserves. We respect your time and do our best to keep you from waiting. Your appointment in this office is reserved exclusively for you!
We reserve the right to charge patients who fail to keep their scheduled appointments or who do not reschedule their appointments with adequate notice.

HOW TO CANCEL AN APPOINTMENT
In order to be respectful of the needs of our clients, if it is necessary to cancel your reserved appointment, we require that you contact our office 24 hours prior to your appointment time. An early cancellation gives another person the chance to have access to needed counseling services.

You will receive a text message reminder of your appointment time 24 hours prior to your scheduled appointment. You will be given the option to confirm or cancel your appointment. To cancel an appointment by phone, please call (614) 478-3050 to speak with a member of our team. If you do not reach a team member, you may leave a detailed message on the office voicemail. If canceling your appointment by email, the time stamp of your email must be 24 hours prior to your appointment time. Failure to do any of the above will be considered a no-show.

NO SHOW POLICY
A "no show" occurs when a patient misses a reserved appointment without contacting the office. No shows inconvenience patients who need access to counseling services in a timely manner. Same-day cancellations and tardiness of fifteen minutes or more are considered "no-show" appointments!

Failure to be present at the time of a reserved appointment will be recorded in your chart as a "No Show". If you are a new client and you miss your initial appointment is missed, a $35.00 fee will be assessed. If you are an established client, the first "no show" will result in a $60 fee charged to your account and a letter sent to your home alerting you that an appointment was missed without canceling. If there is a second "no show", an additional $125/$145 fee will be billed to your account and a second letter will be sent. A third "no-show" will result in a fee of $125/$145 and suspension of services and dismissal from the practice. When scheduled together, family members will be billed for each no show appointment.

By signing below, I certify that I have read and understand the terms and conditions of Key Counseling and Consultation's appointment cancellation policy:

_____
Patient Name (Printed)

_____
Patient Parent/Guardian if under the age of 18 (Printed)

_____
Patient Signature Date

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CLIENT CONTACT INFORMATION FOR MESSAGES AND WRITTEN CORRESPONDENCE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. (PHI). The individual is also provided the right to request confidential communications or that a communications of PHI be made to alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Key Counseling and Consultation has permission to contact me at the following: (check all that apply)

☐Home Telephone #_____

☐OK to leave a message with detailed information

☐OK to leave a message with other family members

☐Cell Phone #_____

☐OK to leave a message with detailed information

☐OK to leave message with person answering

☐Work Telephone #_____

☐Ok to leave a voicemail message with detailed information

☐OK to leave a message with

Written Communication

☐OK to mail to my home address

☐OK to email me at

☐OK to fax to this number

☐Other

_____ _____ _____

Client Signature Printed Name Date

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Consent for Audio/Video Taping

(optional)

I,_____ (Client/Parent/Guardian's name or child if age 18 or older) hereby consent for Key Counseling & Consultation LLC staff members to audio and/or videotape sessions related to the assessment and treatment of (Client). As these sessions may include me and other members of our family, I hereby consent to the audio and/or videotaping of myself and other children if we attend these sessions. I understand that use of recorded material will be held in confidentiality and restricted to supervision, training, and consultation with Key Counseling & Consultation LLC staff members in our ongoing goal of improving the quality of behavioral health care we provide our clients and families. Once the tape has been reviewed and is no longer needed for training purposes it will be destroyed by Key Counseling & Consultation LLC staff members.

I hereby give up my rights to any and all interests that I may have in the audio and/or video recordings. I agree and allow Key Counseling & Consultation LLC to be the sole owner of all rights in these audio/video tapings for the purposes described above.

Client Name:

_____

First Middle Last

_____

Client Signature/Legal Guardian Date

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COUPLES COUNSELING PARTICIPATION AGREEMENT

_____ and _____ ("the Clients") have chosen to use the couples counseling to resolve their family differences. The Clients have agreed to engage Ezekiel Peebles, a Board Registered Licensed Professional Clinical Counselor, to assist them with couple's counseling.

The Clients also agree to the following:

1. to provide a full and candid exchange of information between them and their counselor necessary to make a proper assessment of their relationship;
2. be respectful during counseling sessions to improve the flow of information

The counselor agrees to the following:

1. He/she will act as a neutral mental health professional and will not align with either client

The counselor's duties may involve the following:

- ☐ assisting the Clients to achieve outcomes that reflect their goals and interests and address the best interests of their relationship as well as children;
- ☐ improving the Clients' negotiation and problem-solving skills;
- ☐ increasing effective communication among family members;
- ☐ assisting the Clients in recognizing their relational strengths and weaknesses to enhance their future relationship;

Testimony and Future Consulting

The Clients and the counselor agree that if the counseling terminates, the counselor not be called as a witness by either client in any future litigation between the Clients, unless both Clients and the counselor agree otherwise in writing. The Clients and the counselor further agree that, if couple's counseling terminates, the counselor may not be further consulted by either client, unless the Clients reinstitute the couples counseling process.

_____ _____
Client Signature Date

_____ _____
Client Signature Date

_____ _____
Therapist Date

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ADULT INFORMATION FORM

Name: _____ Date of 1st Appointment: _____ Therapist: _____

Date of Birth: _____ Age: _____ Gender: Male _____ Female _____ Transgender _____

MEDICAL HISTORY

Name of Primary Care Physician:
_____

Physician's Address:_____Physician's Phone: _____

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Circle One) YES NO

Please sign here for either answer:_____

Date of last medical evaluation:_____ Date of next appointment:_____

Current medications being taken (please list additional medications on the back side of this form):

1)_____ Dosage/Freq_____ Start Date_____Purpose_____

2)_____ Dosage/Freq _____ Start Date_____Purpose_____

3)_____ Dosage/Freq _____ Start Date_____Purpose_____

4)_____ Dosage/Freq _____ Start Date_____Purpose_____

Prescribed by: _____

Have you ever been seen by a Mental Health Professional? (Circle one) YES NO

Name of Mental Health Professional	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you use recreational drugs? (Circle One) YES NO If no, have you used previously? (Circle One) YES NO

If yes, when did you stop? _____

Type of Drug	How much	How often
_____	_____	_____
_____	_____	_____
_____	_____	_____

Area left intentionally blank

Do you drink alcohol? (Circle One) YES NO If no, did you drink previously? (Circle one) YES NO

If yes, please list:

Type of Alcohol	How much	How often
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you smoke cigarettes? (Circle One) YES NO

Do you use other forms of tobacco? (Circle One) YES NO If yes, what kind? _____

Describe any important medical history, chronic ailments, or other health problems you experience:_____
_____
_____
_____

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments:
_____
_____
_____
_____

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

SCHOOL AND FAMILY HISTORY

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers? (Circle One) YES NO

If yes, please explain:_____
_____

What was the last year of school you completed? _____ If you did not complete high school, please explain:
_____
_____

Please list schools (1) currently attending, (2) last attended, (3) graduated:

(1) School(s)_____ Year(s)_____
(2) School(s)_____ Year(s)_____
(3) School(s)_____ Year(s)_____

How would you describe your current support network? (friends, relatives, etc.):
_____
_____
_____
_____

Please check all information which applies to your biological parents:

MOTHER	____ living	FATHER	____ living
	____ deceased		____ deceased
	____ married		____ married
	____ divorced		____ divorced
	____ remarried ____# of times		____ remarried ____# of times

Area left intentionally blank

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? If so, whom?

_____
_____

Where do your parents live?

Mother _____ Father _____

Describe your relationship with your mother while growing up:

_____
_____
_____

Currently:

_____
_____
_____

Describe your relationship with your father while growing up:

_____
_____
_____

Currently:

_____
_____
_____

Any additional lifestyle factors that may affect your therapy? If so, please describe:

_____
_____
_____

Area left intentionally blank

List first names and ages of brothers & sisters, including yourself:

Name	Age	Relationship (natural, step, half, etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Area left intentionally blank

Describe any family problems which occurred while growing up relating to:

Alcohol/drug abuse:

_____
_____
_____

Sexual/physical/emotional/spiritual abuse:

_____
_____
_____

Area left intentionally blank

MARITAL HISTORY

Marital status:

___Single/never married ___Married ___Separated ___Divorced ___Widowed ___Living w/someone

If currently married, when were you married? _____ If living w/someone, how long? _____

Please list your children:

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

Area left intentionally blank

MENTAL STATUS

Please check any of the following that describe how you have been feeling lately:

☐ Abandonment	☐ Abortion	☐ Absentmindedness
☐ Accidents	☐ Accusing	☐ Addictions
☐ Adoption	☐ Aggression	☐ Alcohol consumption
☐ Anger	☐ Anxiety	☐ Arguing
☐ Arrogance	☐ Attitude	☐ Avoidance
☐ Blaming	☐ Body Image	☐ Boredom
☐ Bossiness	☐ Boundaries	☐ Budgeting
☐ Carelessness	☐ Career change	☐ Codependency
☐ Coming out	☐ Communication	☐ Complaining
☐ Compromise	☐ Compulsive behaviors	☐ Conflict
☐ Confusion	☐ Control	☐ Criticizing
☐ Cynicism	☐ Death/dying	☐ Deception
☐ Decision making	☐ Defensiveness	☐ Defiance
☐ Denial	☐ Dependency	☐ Depression
☐ Dishonesty	☐ Disoriented	☐ Dissociate
☐ Divorce	☐ Drug consumption	☐ Eating problems
☐ Emotions	☐ Envy	☐ Exploration
☐ Failure	☐ Family issues	☐ Fears
☐ Focusing	☐ Forgiveness	☐ Frustration
☐ Gay/Lesbian/Bisexual	☐ Goal setting	☐ Greed
☐ Grief	☐ Guilt and shame	☐ Hallucinations
☐ Hate	☐ Health concerns	☐ Homicidal thoughts
☐ Hopelessness	☐ Hyperactivity	☐ Illusions
☐ Impatience	☐ Impulsiveness	☐ Insecurity
☐ Intimacy	☐ Intolerance	☐ Isolation
☐ Laziness	☐ Leadership development	☐ Learning disability
☐ Legal problems	☐ Life satisfaction	☐ Loneliness
☐ Love	☐ Lying	☐ Marital issues
☐ Minimizing	☐ Moodiness	☐ Motivation

☐ Narcissism	☐ Neediness	☐ Numbness
☐ Obsessive thoughts	☐ Opening Up	☐ Overreacting
☐ Overwhelmed	☐ Pain	☐ Parenting
☐ Perfectionism	☐ Performance anxiety	☐ Personal Growth
☐ Phobias	☐ Physical abuse	☐ Pornography
☐ Possessiveness	☐ Pride	☐ Prioritizing
☐ Problem solving	☐ Procrastination	☐ Promiscuity
☐ Psychotic thoughts	☐ Public speaking	☐ Rebellion
☐ Relationships	☐ Relaxation	☐ Religion
☐ Repression	☐ Resentment	☐ Resistance
☐ Romance	☐ Sadness	☐ Safety
☐ School issues	☐ Self-acceptance	☐ Self-care
☐ Self-esteem	☐ Self-mutilation	☐ Self-obsession
☐ Self-respect	☐ Selfishness	☐ Sexual abuse
☐ Shame	☐ Shyness	☐ Sleeping
☐ Social anxiety	☐ Somatic issues	☐ Spiritual growth
☐ Stealing	☐ Stress	☐ Stubbornness
☐ Success	☐ Suffering	☐ Suicidal thoughts
☐ Tantrums	☐ Time management	☐ Tired/Exhausted
☐ Transitions/Change	☐ Understanding	☐ Values/Beliefs
☐ Violence	☐ Weight	☐ Withdrawal
☐ Worry	☐ Other_____	☐ Other_____

What activities or hobbies do you participate in?

_____

_____

Do you participate in regular exercise? (Circle One) YES NO
Describe:_____

Describe your current working environment:

_____

_____

Have you had any change in sleeping habits? (Circle One) YES NO
Describe:_____

_____

Have you had any change in eating habits? (Circle One) YES NO Describe:

_____

_____

Have you ever **considered suicide** in connection to your **current** problem? (Circle One) YES NO
If so, please give a brief description with dates:

_____

Have you ever **considered suicide** in the **past**? (Circle One) YES NO
If so, please give a brief description with dates:

_____

Have you **attempted suicide recently** or in the **past**? (Circle One) YES NO
If so, please give a brief description with dates:

_____

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? (Circle One) YES NO
If so, please give a brief description with dates:

_____

Have you ever **considered homicide** in the **past**? (Circle One) YES NO
If so, please give a brief description with dates:

_____

LEVEL OF FUNCTIONING

List or describe any current impediments or problems in daily psychological, social or occupational functioning (i.e. isolation from friends/family, significant difficulty getting to work or completing daily tasks, severe financial strain, recent divorce, and problems with supervisor, etc.):

_____
_____
_____

THOUGHTS: Please check any of the following that apply to you:

_____I sometimes hear voices even though no one nearby is talking to me.
_____I sometimes feel that forces outside of me control me.
_____I sometimes feel that other people control my thoughts.
_____I sometimes have the same thought over and over and cannot control it.
_____I sometimes feel that someone is out to hurt me or do something against me.
_____I am sometimes unable to control my behavior.

Please explain:

_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____
_____
_____
_____

Please list your therapy goals:

_____
_____
_____
_____
_____
_____
_____
_____