Hope and Healing Counseling Center, LLC

468 E. Main Street, Suite 200
Abingdon, VA 24210

126 Martin Luther King Jr Blvd
Bristol, TN 37620

Date: _____

Identifying Information
Name: _____
Date of Birth: _____ Age: _____ Gender: _____ SS#: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____

Would you be willing to receive appointment reminders and other correspondence via (Yes or No for each)?
****Please be aware there are risks to confidentiality when using technology****
_____Text _____Email _____Cell phone voicemail _____Home Phone _____Work Phone _____ Mail
Which is your preferred method? (1st) _____ (2nd) _____ (3rd) _____
(4th) _____ (5th) _____

If Client is a Child/Student:
Parent/Guardian Name: _____
Relationship to Child: _____
School Attending: _____ Grade: _____

If Client is an Adult:
Place of Employment: _____
Occupation: _____
Spouse/Partner Name: _____

In Case of Emergency, notify:
Name: _____ Relationship to Client: _____
Address: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

Billing Information (Person responsible for payment):
Name: _____ Relationship to Client: _____
Address: _____
Home Phone: _____ Cell Phone: _____ Word Phone: _____
Employer: _____

Insurance Information:
Insurance Company: _____ Phone: _____
Claim Address: _____City/State/Zip: _____
Member/Policy # _____ Group #: _____
Member Name: _____ DOB: _____ SS#: _____
Member Employer: _____

Referral Source: Who may I thank for referring you to me? _____

New Client: Welcome to Hope and Healing Counseling Center. Congratulations on your first step toward exploring growth in your mental health. This is an opportunity to acquaint you with information relevant to treatment, confidentiality and office policies. Your therapist will answer any questions you have regarding any of these policies.

Services: The services are available in the areas of individual, couple and family concerns.

Appointments: Appointments are usually scheduled for 45-60 minutes and are made by the therapist. The frequency of visits will vary depending on your individual needs, and your therapist's availability.

Initial here: _____

If an appointment is missed or canceled with less than 24 hours notice, you will be billed $40.00. Anyone who misses more than three (3) appointments without appropriate notification within a 12-month period may be discharged and referred elsewhere for treatment. You may discontinue treatment at any time, but you are asked to notify your therapist of your decision. **Initial here**: _____

If a check written for services is returned for nonsufficient funds, you will be charge a $35 processing fee. Any further services will need to be paid for by cash only. **Initial here**: _____

Fees for Service: In the event you have no insurance, the self-pay fee for a 45-60 minute session is a flat rate of $70. This fee is to be paid at the time of the visit. **Initial here**: _____

You may also be billed for any other services such as telephone conversations lasting more than 5 minutes, interventions outside of therapy session, or completion of forms or letters requested on your behalf at a prorate $100 per 45-60 minutes. Court appearances are to be prepaid at a base rate of $300, plus $100 per hour to be billed for hours exceeding 2 hours, including drive time**.** Please make your payment directly to **HOPE AND HEALING COUNSELING CENTER** at the time services are rendered. **Initial here: _____**

Insurance: Our counselors currently participates with some insurance plans. The cost of sessions is based on your insurance plan. The counselor would be more than happy to submit a claim for you to your insurance company after you have paid for counseling services in full. This in no way guarantees how much, or even if, you will be reimbursed by your insurance company and is merely a courtesy provided. *I hereby authorize the insurance carrier listed on the previous page to make payments directly to the counselor or Hope and Healing Counseling Center and understand I am financially responsible for all charges incurred that are not covered in full by my insurance. I further understand that if I enroll in another insurance plan, it is my responsibility to notify the counselor otherwise I will be responsible for payment. I authorize the release of any medical information necessary to process claims on my behalf.* **Initial here: _____**

Financial Terms: You are responsible for payment at each session. In case of excessive delinquent accounts, your therapist reserves the right to turn unpaid balances over to a collection agency.

Initial here: _____

Treatment Philosophy: Brief therapy is goal-directed, solution-focused treatment. Each therapist may utilize different theoretical approaches and will discuss with you the benefits and goals involved. You will be expected to assume an active role in the treatment process. Although the course of your treatment is designed to be helpful, the therapist cannot make any guarantees about the outcome of your treatment. Although there are believed to be many benefits of counseling, people tend to make changes in the course of treatment which can be uncomfortable and challenging. Certain diagnosis can result in preexisting conditions in the future for insurance coverage. Treatment records are not generally written in a manner which serves to be helpful to support disability claims. **Our counselors do not perform Child Custody Evaluations.** **Initial here: _____**

Limits of Confidentiality Statement: Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged". However, there are limits to the privilege of confidentiality**.** These situations include:

1. Suspected abuse or neglect of a child, elderly person, or a disabled person
2. When your therapist believes you are in danger of harming yourself or others. If you report that you intend to physically injure someone, the law requires your therapist to inform that person as well as the legal authorities
3. If your therapist is ordered by a court to release information as part of a legal involvement in litigation, etc.
4. When your insurance company is involved, e.g., in filing a claim, insurance audits, case review or appeals, etc.
5. As a result of a natural disaster whereby protected records may become exposed
6. When otherwise required by law
7. When you sign a Release of Information giving your permission for the therapist to share your protected information with a designated person.

Initial here: _____

Record Keeping: Active charts are double locked and on site. A clinical chart is maintained describing your condition, treatment, dates of services, and progress notes describing each therapy session. Your records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section above.

Initial here: _____

Complaints: You have a right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, please inform your provider immediately so the situation can be discussed in attempt for resolution. You may first contact the counselor at Hope and Healing Counselor Center directly for any questions or concerns. You have the right to submit a grievance to your therapist at any time during care or to send the complaint directly to the Patient Rights Advocate of the State in which you are seen. **Initial here: _____**

Emergency Access: In the event of a mental health emergency, including suicidal and/or homicidal ideations, you are instructed to contact 911 or go to the nearest emergency room. You may also call Respond at 1-800-366-1132. Please do not contact therapists or other employees of Hope and Healing Counseling Center in the event of a mental health emergency, as the role of an outpatient therapist and/or other employees is not to be the primary responder or coordinator of emergency/crisis interventions. **Initial here: _____**

Communication and Social Media: It is the policy of Hope and Healing Counseling Center for you to access your therapist through the patient portal messaging function of Office Ally and/or via the agency's main number of (423) 646-4247. Phone availability is only between the office hours of 8:30 am to 5:00 pm, Monday through Friday; confidential voicemail is available for after hours and weekends, but not monitored outside of office hours. Therapists and other employees of the agency will also only have contact with you during these same office hours, and are not available after hours, weekends and/or in the event of a mental health emergency. Please refer to the Emergency Access section above for any emergencies between therapy sessions.

It is the policy of Hope and Healing Counseling Center for electronic means of communication (i.e. email, text, etc.) be limited to only that pertaining to appointments, specifically for canceling, rescheduling, scheduling, or confirmation of appointments. Electronic means of communication are never to be deemed appropriate in emergency situations, and you are directed the Emergency Access section above for any emergencies between therapy sessions.

In addition, given the Code of Ethics for Professionals, no therapist or other employee of Hope and Healing Counseling Center may connect with any current or previous Client through any form of social media (i.e. Facebook, Twitter, Instagram, etc.) as a means of maintaining boundaries of Client-Professional relationships.

Please be aware there are risks to confidentiality when using technology **Initial here: _____**

Client Notification of Privacy Rights: The Health Insurance Portability and Accountability Act (HIPAA) has created new client protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides client protections related to the electronic transmission of date ("the transaction rules"), the keeping and use of client records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide clients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. My Client Notification of Privacy Rights is my attempt to inform you of your rights in a simple, yet comprehensive, fashion. Please read this document, as it is important that you know what client protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and, as such, you will find that I will do all I can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for further clarification.

By law, I am required to secure your signature indicating you have received this Client Notification of Privacy Rights Document. Thank you for your thoughtful consideration of these matters.

Signing below, I understand and have been provided a copy of Client Notification of Privacy Rights Document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgement form.

IF CLIENT IS A MINOR or ADULT DEPENDENT:

Consent for CHILD or Dependent Treatment:
You are reporting that you have legal responsibility for your child, (*name of child*) _____.

You give your permission for the counselor at Hope and Healing Counseling Center to see your son/daughter for treatment or counseling, with and /or without you being present in the same session. You understand that you are the holder of confidential privilege-the right to withhold disclosure of private information about your child. However, in the interest of developing a trust relationship between the therapist and your child, you give the therapist permission to reveal or withhold information that in his/her clinical judgment is necessary to best help and protect your child.

_____
Signature of Parent/Legal Guardian

IF CLIENT IS AN ADULT:

Consent for ADULT Treatment:
You are hereby consenting to treatment with the counselor signed below until you otherwise notify your counselor. By signing below, you are stating that you have read and understood this policy statement and you have had your questions answered to your satisfaction. You accept, understand and agree to abide by the contents and terms of this agreement.

_____ _____
Signature of Client/Legal Guardian **Date**

Name: _____ Date of Birth: _____

Current Concerns: Please mark X in appropriate column below

Personal/Emotional Issues	
Relationship/Marriage	
Sexual Concerns	
Job/Vocational	
Health Issues	
Financial Issues	
Legal issues	

Spiritual Issues	
Conflict with family	
Adjustment to change	
Recent Death/Loss	
Victim of Abuse	
Post-traumatic Stress	

Symptom Checklist: Please mark if symptoms are present now (N) or have been at any time in the past (P).

Victim Physical Abuse	
Victim Sexual Abuse	
Victim Emotional Abuse	
Victim of Neglect	
Perpetrator of Abuse	
Seasonal mood changes	
Low energy/Tiredness	
Depressed mood	
Crying episodes	
Frequently sad/unhappy	
Unable to enjoy life	
Loss of interest	
Loss of social interest	
Feeling hopeless	
Low motivation	
Unresolved grief	
Excessive worry	
Panic Attacks	
Restlessness	
Specific Fear or Phobia	
Obsessive/compulsive	
Cutting or burning of self	
Other self harm	
Anger outbursts	
Frequently irritable	
Risk taking behaviors	
Seeing/hearing/smelling/ feeling things others do not see/hear/smell/feel	
Feeling as if others are out to get you	
Short attention span	
Impulsive	
Problems with memory	
Loss of time	

Easily distracted	
Excessive talking	
Low self esteem	
Poor social skills	
Easily frustrated	
Stealing	
Risk Taking	
Destruction of property	
Fire setting/fire play	
Gang association	
Difficulty concentrating	
Flashbacks	
Recurrent nightmares	
Self-induced vomiting	
Use of diet pills	
Regular use of laxatives	
Preoccupied with weight	
Loss of appetite	
Binge eating	
Overweight	
Headaches	
Dizziness	
Fainting	
Rapid heartbeat	
Frequent indigestion	
Difficulty sleeping	
Excessive sleeping	
Problems with alcohol	
Problems with drugs	
Pornography use	
Frequent physical pain	
Low sexual satisfaction	
Loss of interest in sex	
Other sexual concerns	
Not Listed	

Name: _____ Date of Birth: _____

Mental Health:
Have you previously had any of the following (Yes/No)?
_____ Individual Counseling _____ Marriage/Couples Therapy _____ Group Therapy
_____ Sex Therapy _____ 12-Step Program _____ Medication Management
_____ Psychiatric care _____ Inpatient mental health or substance use evaluation

If yes to any of the above, please provide the following:

Therapist/Provider/Facility	Dates Attended	Reason Seen	Helpful? Yes/No

Have you ever been given a mental health diagnosis (Yes/No)? _____
If yes, what was the diagnosis? _____
Who diagnosed and when? _____
Any medications given at that time? _____

If there a family history of any of the following problems (Yes/No)?
_____ Alcoholism _____ Substance Abuse _____ Mental Illness _____ Suicide

If yes, please provide name, relationship to client and problem: _____
_____
_____

Are you aware of any substance use by your mother during pregnancy with you? _____

As a child did you experience any of the following problems (Yes/No)?
_____ Learning disability _____ Hyperactivity _____ Bed wetting _____ Depression
_____ School fears _____ Sexual/Physical Abuse

Have you ever taken a leave from work for mental health or substance use problems? _____
If yes, how long? _____

Suicide/Homicide:
Have you attempted suicide (Yes/No)? _____ If yes, indicate date and means _____
Do you currently have suicidal thoughts (Yes/No)? _____
If yes, please explain? _____
Do you currently have violent or homicidal thoughts or plans? _____
If yes, please explain _____

Do you have friends or family who you talk to when you have concerns or problems? _____
Do you participate in regular social activities? _____ A religious group? _____
If yes to the above, please list: _____

Name: _____ Date of Birth: _____

Please list any significant disturbing events, traumas or losses you have experienced in your lifetime:
NOTE: If any memory came to mind when you read the above statement it is significant enough to list

Disturbing Event/Trauma/Loss	Age at time of experience

Current Living Situation:
Marital/Relationship Status:
_____ Single
_____Married/Permanent Partner (how long? _____)
_____ Living with Partner (how long? _____)
_____ Previous marriages/partnerships (how many? _____)
_____ Separated (how long? _____)
_____ Divorced (how long? _____)
_____ Widowed (how long? _____)

Names of persons living in household	Age	Relationship to client	Gender

Medical History:
Primary Care Physician: _____ Phone: _____
Address: _____
Date of most recent medical examination: _____

Please list current prescription medications, over-the-counter medications and herbal supplements:

Medicine/Supplement	Dosage	Date Started	Reason	Prescribing Physician

Please list any known medication allergies: _____
_____

Have you had or do you have any of the following? (Please mark Past/Present/No)

_____ Head injury	_____ Seizures	_____ Thyroid problems	_____ Hypertension
_____ Heart disease	_____ Lung disease	_____ Liver disease	_____ Kidney disease
_____Hepatitis	_____ Tuberculosis	_____ HIV/AIDS	_____ STD
_____ Hypoglycemia	_____ Diabetes	_____ Cancer	_____ Asthma
_____ Arthritis	_____ Chronic pain	_____ Headaches	_____ Anemia

Name: _____ Date of Birth: _____

Hospitalization/Illness/Surgery/Injury Dates

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Reproductive History (Females Only):
Number of pregnancies: _____ Number of live births: _____

Lifestyle History: Provide mark usage present now or have been at any time in the past.

Alcohol	
Nicotine	
Marijuana	
Synthetic Drugs	
Narcotics	
Cocaine	
Crack	

Heroine/Opiates	
PCP/LSD/Mescaline	
Inhalants	
Over-the-counter	
Prescription drugs	
Caffeine	
Pornography	

When do you typically use substance? _____
_____
How has your use affected your family, friends or job? _____
_____
Have there been any negative consequences to your use (If yes, please explain)? _____
_____
Have you ever tried to cut back or slow down (If yes, please explain)? _____
_____
Have you ever had withdrawal symptoms when trying to stop using (if yes please explain)? _____
_____

Family History
Mother's age: _____ If deceased, how old were you when she died? _____
Father's age: _____ If deceased, how old were you when he died? _____
Number of brothers? _____ Their ages: _____ _____ _____ _____ _____ _____ _____
Number of sisters? _____ Their ages: _____ _____ _____ _____ _____ _____ _____
I was child number: _____ in a family of _____ children

Was the family home disrupted by separation/divorce? _____ If yes, how old were you? _____
Was the family home disrupted by serious illness/accident? _____ If yes, how old were you? _____
Was the family home disrupted by death? _____ If yes, how old were you? _____

Were you or your siblings adopted or raised with parents other than your natural parents (Yes/No)? _____
Have you or a family member ever experienced the following (Yes/No)?
_____ Emotional Abuse _____ Physical Abuse _____ Sexual Abuse _____ Spiritual Abuse
_____ Neglect _____ Domestic Violence
If yes, please explain: _____
_____
List any other major family problems: _____

Name: _____ Date of Birth: _____

Work History:
Place of employment/school: _____
Current employment status: _____ Employed full time _____ Employed part time _____ Unemployed
_____ Retired _____ Self-employed _____ Student _____ Homemaker
Job/School satisfaction: _____ Very satisfied _____ Fairly satisfied _____ Not at all satisfied

Have you ever been in the military? If yes, Date Enlisted: _____ Date of Discharge: _____
Branch: _____ Where: _____ Rank at Discharge: _____
Combat experience (Yes/No)? _____ If yes, please explain: _____
_____

Spirituality:
How does God (or some higher being) fit into your life, or does he? _____
_____
What are some things you would like to see happen in your spiritual life, if anything? _____
_____

Strengths/Resources: Describe your strengths and resources including extended family, extracurricular activities, talents, hobbies, support groups, friends, spiritual beliefs, personality and special interests (include family, school, church and community):

Strength/Resource	How often now?	How often in past?	With whom?

How would you (the client) describe yourself in no more than a few short sentences? _____
_____
_____
_____

What would you like to accomplish, or what would you like to be different in your life, as a result of attending counseling? List as many as you like and use the back if more room is needed
_____
_____
_____
_____
_____
_____

_____
Printed name of person completing form Relationship to Client

_____
Signature of person completing form Date form completed