Brenda Thompson, MS, LPC, LMFT, NBCC
Licensed Professional Counselor
Licensed Marital & Family Therapist
National Board Certified Counselor

Address: Telemental Health Couonseling
www.counselorefreshinghope.com
Stillwater, Okla. 74074

Phone: 405-533-4090
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Refreshinghope@aol.com

Adult Client Information Form

Today's date: _____

***Note**:* If you have been a patient here before, please fill in only the information that has changed.

A. Identification

Your name: _____ Date of birth: _____ Age: ____

Nicknames or aliases: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ e-mail: _____

Calls or e-mail will be discreet, but please indicate any restrictions: _____

B. Referral: Who gave you my name to call?

Name: _____Phone: _____

Address: _____

May I have your permission to thank this person for the referral? ❑ Yes ❑ No
How did this person explain how I might be of help to you?

_____

_____

C. Religious and racial/ethnic identification

Current religious denomination/affiliation ❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic ❑ Buddhist

❑ Hindu

Other (specify): _____

Involvement: ❑ None ❑ Some/irregular ❑ Active

How important are spiritual concerns in your life? _____

Which (if any) church, synagogue, temple, or meeting are you involved with? _____

Ethnicity/national origin: _____ Race: _____ or other similar way you identify yourself and consider important: _____

D. Your medical care:

From whom or where do you get your medical care?
Clinic/doctor's name: _____ Phone: _____

Address: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

E. Your current employer

Employer: _____ Address: _____

Work phone: _____ or other means of communication _____

Calls will be discreet, but please indicate any restrictions: _____

F. Emergency information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?
Name: _____ Phone: _____ Relationship: _____

Address: _____

Significant other/nearest friend or relative not residing with you: _____

G. Your education and training

Dates From	Dates To	Schools	Special classes?	Adjustment to school	Did you graduate?

H. Employment and military experiences

Dates From	Dates To	Name of employers	Job title or duties	Reason for leaving

I. Marital/Relationship history

	Spouse's name	Spouse's age at marriage	Your age at marriage	Your age when divorced/widowed	Has spouse remarried?
First					
Second					
Third					

J. Significant nonmarital relationships

	Name of other person	Person's age when started	Person's age when ended	Your age when started	Your age when ended	Reasons for ending
First						
Second						
Third						
Current						

K. Family-of-origin history

Family Member	Name	Living? (Y/N)	Age	Health Good	Health Fair	Health Poor	Education	Occupation	If deceased, cause of death
Father									
Mother									
Brothers									
Sisters									
Maternal Granparent(s)									
Paternal Grandparent(s)									
Stepparents									
Others_									

L. Children (Indicate those from a previous marriage or relationship with "P" in the last column.)

Name	Current age	Gender	School	Grade	Adjustment problems?	P?

M. Spiritual Life

Would you like to incorporate spiritual or religious beliefs in your treatment? _____yes _____no

Initial_____

N. Is there any other information you think we should know?

_____
_____
_____
_____
_____

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Adult Checklist of Concerns

Name: _____ Date: _____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked. (For a child, mark any of these and then complete the "Child Checklist of Characteristics.")

- ❑ I have no problem or concern bringing me here
- ❑ Abuse–physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- ❑ Aggression, violence
- ❑ Alcohol use
- ❑ Anger, hostility, arguing, irritability
- ❑ Anxiety, nervousness
- ❑ Attention, concentration, distractibility
- ❑ Career concerns, goals, and choices
- ❑ Childhood issues (your own childhood)
- ❑ Codependence
- ❑ Confusion
- ❑ Compulsions
- ❑ Custody of children
- ❑ Decision making, indecision, mixed feelings, putting off decisions
- ❑ Delusions (false ideas)
- ❑ Dependence
- ❑ Depression, low mood, sadness, crying
- ❑ Divorce, separation

(cont.)

FORM 29. Adult checklist of concerns (p. 1 of 2). From *The Paper Office*. Revised 4/2010.

- ❑ Eating problems–overeating, undereating, appetite, vomiting (see also “Weight and diet issues”)
- ❑ Emptiness
- ❑ Failure
- ❑ Fatigue, tiredness, low energy
- ❑ Fears, phobias
- ❑ Financial or money troubles, debt, impulsive spending, low income
- ❑ Friendships
- ❑ Gambling
- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Guilt
- ❑ Headaches, other kinds of pains
- ❑ Health, illness, medical concerns, physical problems
- ❑ Housework/chores–quality, schedules, sharing duties
- ❑ Inferiority feelings
- ❑ Interpersonal conflicts
- ❑ Impulsiveness, loss of control, outbursts
- ❑ Irresponsibility
- ❑ Judgment problems, risk taking
- ❑ Legal matters, charges, suits
- ❑ Loneliness
- ❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- ❑ Memory problems
- ❑ Menstrual problems, PMS, menopause
- ❑ Mood swings
- ❑ Motivation, laziness
- ❑ Nervousness, tension
- ❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ❑ Oversensitivity to rejection
- ❑ Pain, chronic

- ❑ Panic or anxiety attacks
- ❑ Parenting, child management, single parenthood
- ❑ Perfectionism
- ❑ Pessimism
- ❑ Procrastination, work inhibitions, laziness
- ❑ Relationship problems (with friends, with relatives, or at work)
- ❑ School problems (see also “Career concerns ...”)
- ❑ Self-centeredness
- ❑ Self-esteem
- ❑ Self-neglect, poor self-care
- ❑ Sexual issues, dysfunctions, conflicts, desire differences, other (see also “Abuse”)
- ❑ Shyness, oversensitivity to criticism
- ❑ Sleep problems–too much, too little, insomnia, nightmares
- ❑ Smoking and tobacco use
- ❑ Spiritual, religious, moral, ethical issues
- ❑ Stress, relaxation, stress management, stress disorders, tension
- ❑ Suspiciousness, distrust
- ❑ Suicidal thoughts
- ❑ Temper problems, self-control, low frustration tolerance
- ❑ Thought disorganization and confusion
- ❑ Threats, violence
- ❑ Weight and diet issues
- ❑ Withdrawal, isolating
- ❑ Work problems, employment, workaholism/overworking, can’t keep a job, dissatisfaction, ambition
- ❑ Any other concerns or issues:

_____

_____

Please look back over the concerns you have checked off and choose the one that you most want help with. It is :

_____

_____

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Consent for Treatment Signature Page for Adults

Therapy sessions and file information are confidential. **Client Initials**

Except in cases of: (a) cout orders/subpoenas, (b) to defend legal actions against counselor, (c) need to prevent harm to self or others, (d) suspected child abuse/neglect. Third part billing and lawsuits I bring related to mental health issues may also limit the confidentiality of my file. _____

There are some limitations to my access to my file.

While I have the right to access my file, I understand that doing so may jeopardize the therapeutic process.

I agree to consult with my counselor/therapist about any questions I have concerning the content of my file or sessions. _____

I must sign release forms before information can be exchanged with other agencies.

The privacy of any electronic communication cannot be assured. Do not use email for urgent matters.

I may request restrictions on the use/disclosure of information in my file for treatment, payment and health care operations, but the therapist is not bound to agree with my request. _____

Information from clients' files may be compiled to study various issues such as treatment outcomes, research, and/or client satisfaction.

I understand that names or any other identifying information will not be used in research. _____

My Counselor/Therapist does not provide after-hours or emergency services. (Use 911 for after hour crisis or emergency.) _____

The practice of psychology and related disciplines is not an exact science.

No guarantees have been made to me regarding the results of counseling services.

I am responsible for working with my counselor/therapist to ensure better treatment outcomes. _____

Counselor/Therapist is not a medical doctor and cannot prescribe medications. _____

I consent to undergo all recommended testing and treatment procedures.

I can refuse or discontinue testing or treatment at any time. _____

I agree to pay my clinic bill. Payment is due at the beginning of sessions and I must cancel at least <u>24 hours</u> before my session or I am responsible for the cost of the session.

Consequences of non-payment may include termination of services or being referred to a collection agency. _____

Special payment/reporting arrangements may be made in cases of divorce and court-mandated services. Additional costs for services will be applied to any court-related, legal services required. _____

I acknowledge that my therapist has reviewed the General Consent for Treatment with me and I have Been given a copy to keep for my own records.

_____	_____	_____	_____
Signature of Therapist or Witness	Signature of Client	Printed name of Client	Date(s)

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Agreement to Pay for Professional Services

I, the client (or guardian/legal representative), request that the therapist named below provide professional services to me or to _____, who is my_____ , and I agree to pay this therapist's fee of **$100.00 per 45 minute session** or **$125.00 per 55/60 minute session for individual counseling or $150.00 per 55/60 minute session for couples, marriage or family counseling**. This same fee will be applied per minute/hour of consultation, assessment, or other therapeutic activity unless otherwise negotiated in writing. **Initial Intake Session (first session) is $160.00 for 55/60 minute session. Any appointment cancellations with less than 24 hour notice will be charged a fee of $75.00.**

Payment for services is required at the time services are rendered unless special arrangements have been made with the therapist. If insurance is filed and paid directly to therapist, credit will be applied to client's account or be refunded.

I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform him or her, in person or by certified mail that I wish to end it. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me (or this client) up until the time I end the relationship.

I understand that if I do not pay for services that the services provided may be terminated by the therapist. Continued non-payment of fees may result in further consequences such as my case being referred to a collection agency.

I agree that I am responsible for the charges for services provided by this therapist to me (or this client), although other persons or insurance companies may make payments on my (or this client's) account.
If any part of my fees is being paid by an insurance company or other third party payer, I understand that this may result in limitations to my confidentiality.

_____ _____
Signature of client (or person acting for client) Date

_____
Printed name

I, the therapist, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Signature of therapist Date

_____ Copy accepted by client _____ Copy kept by therapist

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Consent to Use and Disclose Your Health Information

This form is an agreement between you, and me/us, When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here: .

When we examine, test, diagnose, treat, or refer you,we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy from our website, www.refreshinghope.com , or by calling us at (405)533-4090.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing and sending to Brenda Thompson, LPC, LMFT at Refreshinghope@aol.com. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

_____ _____

Signature of client or his or her personal representative Date

_____ _____

Printed name of client or personal representative Relationship to the client

_____

Description of personal representative's authority

_____

Signature of authorized representative of this office or practice

Date of NPP: _____ ❑ Copy given to the client/parent/personal representative

Confidential

Brenda Thompson, LPC, LMFT

National Board Certified Counselor

Notice of Privacy Practices

This notice talks about **privacy information**. We always take great care to safeguard your privacy but this notice is a government regulation requiring us to explain your rights. This notice describes how medical and mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. In the event that the Notice is changed, a new notice will be sent to you by mail or given to you at the time of your next appointment. You may request a copy of our Notice at any time. This notices takes effect April 1, 2010, and will remain in effect until we replace it.

Uses and Disclosures not Protected Health Information

Uses and Disclosures of Protected Heath Information Based Upon Your Written Consent. You will be asked to sign a consent form. Once you have consented to the use and disclosure of your protected health information for treatment by signing the consent form, this agency will use or disclose your protected health information as described below.

Treatment: We may use and discloser, ad needed, your protected health information to provide, coordinate, or manage your health care and any related services.

Health Operations: We may use and disclose, as needed, your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of mental healthcare professionals, evaluating practitioner and provider performance, employee review activities, conducting training programs, accreditation, certification, licensing or credentialing activities, and conducting or arranging for other business activities.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except described in the notice.

Emergencies: We may use or disclose your protected health information in an emergency treatlment situation. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgement, disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required by Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. authorized

Health Oversight: We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

Abuse or Neglect: We may disclose your protected health information to the Department of Human Services which is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse or neglect to the Department of Human Services. In this case, the disclosure will be made consistent with the requirements applicable federal and state laws.

Legal Proceedings: We may disclose your protected health information in the course of any judicial, or administrative proceedings, in response to an order of the court or administrative tribunal (to a subpoena, discovery request or other lawful process.to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et.seq.

Client Rights

Access: You have the right to inspect and copy your protected health information. We will use the format you request unless we cannot practically do so. You must submit request in writing to obtain access to your health information. You will be charged a reasonable cost-based fee for expenses' such as copies and staff time. If you request copies, we will charge you $1.00 for the first page, and $.40 each page thereafter to locate and copy your health information plus postage if you want the copies mailed to you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or us in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

Restriction: You have the right to request a restriction of your protected health information. You may also request that any part of your protected health information not be disclosed by family members or friends who may be involved in your care or notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. If we agree to the additional restriction(s) we will be able to abide by our agreement. (except in an emergency). We are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your protected health information, your protected information will be restricted.

Alternative Communication: You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You must make your request in writing

Alternative Request: You have the right to request that we amend your protected health information. Your request must be in writing and explain why the information should be amended. In certain cases, ewe may deny your request for an amendment. If we deny your request for your amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Disclosure Accounting: You have the right to receive an accounting of certain disclosures we have made, if any, of your protected heath information. This right applies to disclosures for purposes other than treatment or healthcare operations as described in the Notice of Privacy Practices.

Notice: You have the right to obtain a paper copy of this notice from us upon request.

I have read and (if requested) received a copy of the Notice of Privacy Policy.

_____ _____

Client's Signature Date