HEALING PATH COUNSELING
COUPLES INTAKE FORM

Client's Last Name	First	Preferred Phone Number	Birth Date	Occupation	Employer
Client's Last Name	First	Preferred Phone Number	Birth Date	Occupation	Employer

Is this your legal name? ❑Yes ❑ No | If not, what is your legal name? | (Former Name) | Marital Status (Circle One) Single / Married / Other

Street Address	City	State	Zip Code	Can we leave a message/voicemail? ❑ Yes ❑ No
Street Address	City	State	ZIP Code	

Social Security #-	Email Address:	P.O. Box	City	State	Zip Code
Social Security #-	Email Address:	P.O Box	City	State	Zip Code

Who can we thank for referring you? (Please check one box & list name)	❑ Doctor	❑ Counselor	❑ Family	❑ Website
❑ EMDRIA	❑ Psychology Today	❑ Friend	Name:	

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 noted in the Notice of Privacy Practices 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 ahead for your appointment, and make appropriate arrangements for children, pets, and travel to and from the office.

FEE SCHEDULE:

• Diagnostic & Evaluation Session (1st visit) ($50.00 to hold appointment, $50.00 due at scheduled time)	$100.00
• Regular Office Visits (45 minutes: Individuals, Couples, Family & Group)	$100.00
• Outside Office Work	$150.00/hr.
• **Court appearances require a 4 hour minimum retainer due the week of court**	**$600.00**

$150 per hour thereafter. No refund will be given if less than *48 hours* notices of cancelling court.

• Written Reports (insurance companies, supervisors, etc.)	$25.00 (minimum)
• Returned check fee (per check)	$50.00
• Cancelled or Rescheduled Appointment without 24 hr. notice	$25.00
• 2nd Cancelled or Rescheduled Appointment without 24 hr. notice	$50.00
• No Show Appointment	$50.00
• 2nd No Show Appointment	$100.00
• **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 for you 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. In order for Healing Path Counseling to release those records, permission needs to be given on the HIPAA 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 creditcard 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-Client Date

HIPPA AUTHORIZATION FORM

I, _____, whose date of birth is _____, authorize **HEALING PATH COUNSELING** to disclose to and/or obtain from _____ the following information:

Description of Information to be Disclosed (Patient/Client should initial each item to be disclosed.)

____	Assessment	____	Testing Information
____	Diagnosis	____	Educational Information
____	Psychosocial Evaluation	____	Presence/Participation in Treatment
____	Psychological Evaluation	____	Continuing Care Plan
____	Treatment Plan or Summary	____	Progress in Treatment
____	Current Treatment Update	____	Other _____

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify:-

_____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to **HEALING PATH COUNSELING**. .

Expiration

Unless revoked in writing, this authorization form is valid until _____. If no date is indicated, the release is valid for one year from the date signed.

Conditions

I further understand that **HEALING PATH COUNSELING** will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: _____

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Re-disclosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Other types of information may be re-disclosed by the recipient of the information in the following circumstances:

Storage of Records

Healing Path Counseling utilizes a third-party electronic medical record system to store your records. The third-party system is HIPAA compliant, and all employees of the third-party company must sign a confidentiality agreement prior to working for the company. Your signature below confirms your agreement to having your medical records stored electronically.

Upon request, I will be given a copy of this authorization for my records.

_____

Signature of Client Date

_____

Signature of Client Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual.

_____

_____ Check here if client refuses to sign authorization.

_____

Signature of Staff Witness Date

HEALING PATH COUNSELING
ADULT INFORMATION FORM

Name: _____ Date: _____

Please list your therapy goals:

_____

_____

MEDICAL HISTORY

Name of Primary Care Physician: _____

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

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?	O	O
2.	Do you use recreational drugs, or have you used in the past?	O	O
3.	Do you currently drink alcohol, or have used alcohol in the past?	O	O
4.	Have you ever received treatment for alcohol or drug use?	O	O
5.	Did you experience any developmental, academic, or behavioral problems as a child or while in school, with peers or teachers?	O	O

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

_____

_____

_____

Describe any important inedicl l history, chronic, ailments, 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: (circle those that apply)

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 Therapist that is not covered on this form? You may also use this space to complete earlier responses. _____

_____

MENTAL STATUS

Please circle any of the following that describe 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 no to the questions below, and explain any yes answers below.

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

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: (Circle all that apply)

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

Please explain:

_____

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_____	_____	_____	_____
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_____

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_____

_____

_____

_____

_____