

Daniels and Associates, LLC

Counseling - Coaching - Wellness

CONFIDENTIAL CLIENT INFORMATION—ADULT

Client Name: _____ Date of Birth: _____ M / F

Client Name: _____ Date of Birth: _____ M / F

Relationship Status (circle): Single Engaged Married Divorced Separated Widowed

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Alternate Phone: _____

E-Mail: _____

Employment (circle): Full-time Part-time Not employed Student

Occupation _____ Employer/School _____

Emergency Contact: _____

Relationship: _____ Phone Number: _____

Family Physician or Primary Care Provider: _____

How were you referred to us? _____

General Information

Have you ever sought help in counseling before? Yes No

If yes, please explain: _____

Have you ever been hospitalized for a mental health reason? Yes No

If yes, please explain: _____

Have you ever had suicidal thoughts, feelings, or attempts? Yes No

If yes, please explain: _____

Have you ever been arrested? Yes No

If yes, please explain: _____

Do you currently have any homicidal or assaultive thoughts or feelings? Yes No

If yes, please explain: _____

Do you struggle with any of the following? (circle all that apply)

Anxiety Depression Sleep Issues Chronic Pain Anger Relationship Issues Trauma

Substances Co-Dependency ADD/ADHD Self Esteem Issues OCD Grief/Loss

Client Name: _____

Family History

Who raised you? _____

If there were changes, please list and indicate the age you were when changes occurred:

of siblings _____ # brothers _____ # sisters _____ Your place in the birth order _____

Which family members are you close to? _____

Which family members are a problem for you? _____

Who else provides emotional support for you? _____

Medical Information

Please rate your overall health: Very Poor 1 2 3 4 5 6 7 8 9 10 Very Good

Current medications: _____

Please list any significant medical conditions (HBP, Gastric Reflux, Fibromyalgia, etc.):

Substance Use Information

What is your current substance usage (alcohol, caffeine, tobacco, cannabis, etc.): _____

Do you recognize any addictions in your life (alcohol, drugs, gambling, sex, internet, work)? Yes No

If yes, please explain: _____

Religious/Spiritual History

Are religious and spiritual recourses important to you? Yes No

Are you open to sharing this part of your life as appropriate in your treatment? Yes No

Are you active in any local church or community of faith? Yes No

Congregation: _____ How often? _____

Do you have a favorite Bible story, verse or character? Yes No

If yes, please explain: _____

How do you maintain or nurture your spiritual life? _____

Client Name: _____

Briefly describe the problem for which you are seeking help:

SEVERITY OF PROBLEM: 0=NO PROBLEM 5=DISABLING	INDICATE ANY PROBLEMS IN THE FOLLOWING AREAS:	EXPLAIN
0 1 2 3 4 5	Sleep too much	
0 1 2 3 4 5	Sleep too little	
0 1 2 3 4 5	Interrupted sleep	
0 1 2 3 4 5	Other sleep problems	
0 1 2 3 4 5	Memory	
0 1 2 3 4 5	Concentration	
0 1 2 3 4 5	Attention	
0 1 2 3 4 5	Loss of interest in usual activities	
0 1 2 3 4 5	Feelings of sadness	
0 1 2 3 4 5	Loss of energy	
0 1 2 3 4 5	Feeling tired all the time	
0 1 2 3 4 5	Periods of crying	
0 1 2 3 4 5	Feeling of hopelessness	
0 1 2 3 4 5	Loss of sexual desire	
0 1 2 3 4 5	Outbursts of anger	
0 1 2 3 4 5	Change in appetite	
0 1 2 3 4 5	Hearing voices when no person is present	
0 1 2 3 4 5	Unable to recall periods of time in childhood after age 5	
0 1 2 3 4 5	Unable to recall some period of your day	
0 1 2 3 4 5	Walking in sleep	
0 1 2 3 4 5	Nightmares	
0 1 2 3 4 5	Overwhelming fears	
0 1 2 3 4 5	Racing thoughts	
0 1 2 3 4 5	Thoughts that won't go away that are constantly in your head	
0 1 2 3 4 5	Thoughts of harming someone else	
0 1 2 3 4 5	Thoughts that some person or people are trying to harm you	
0 1 2 3 4 5	Noticing items in your home and not knowing where they came from or how they got there	
0 1 2 3 4 5	Feelings of being controlled by forces outside yourself	

0 1 2 3 4 5	Feeling compelled to repeat activities for no reason
0 1 2 3 4 5	Unable to relax
0 1 2 3 4 5	Blackouts
0 1 2 3 4 5	Excessive sweating
0 1 2 3 4 5	Death of family members or friends
0 1 2 3 4 5	Panic attacks
0 1 2 3 4 5	Mood swings
0 1 2 3 4 5	Spending sprees
0 1 2 3 4 5	Changes in energy level
0 1 2 3 4 5	Other:

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FINANCIAL AGREEMENT

Counseling fees (individual, couple, family and EMDR) are \$100 per 50-minute session.

Fees for **Marriage or Pre-Marital** counseling which include a **Prepare-Enrich** assessment are \$400 (includes Prepare-Enrich Assessment and three counseling sessions. (A \$100 deposit is required when scheduled, the balance is due at the first session, as some preliminary work is required of your counselor).

Payment is expected at the time of service unless other arrangements have been made.

Accepted method of payments include: cash, credit, debit, HSA card or personal check. Checks are to be made payable to **DANIELS AND ASSOCIATES, LLC**.

Health Insurance. **DANIELS AND ASSOCIATES, LLC** will not bill your insurance directly. If you would like to use health insurance benefits for counseling, we ask that you pay your fee upfront, then seek reimbursement through your health insurance plan. Your counselor will provide you with the necessary forms for you to seek reimbursement.

At least **24 hours-notice** is required for cancelation. If a scheduling emergency occurs, the client is to contact the counselor as soon as possible. If adequate notice is not provided, or the client is a "no show" for the scheduled appointment, the client will be billed the entire session amount for the missed appointment.

PRINTED: Client Name

SIGNATURE: Client

Date

INFORMED CONSENT

The following information is for your benefit so you can enter a cooperative counseling partnership in an informed manner. Counseling is a helping relationship for which you are voluntarily entering for assistance with specific and stated problems. It is expected that you will benefit from your counselor relationship, but there are no guarantees that you will. Keep in mind that it is common to feel worse before feeling better. It is also expected that the counseling relationship should end through mutual agreement once desired goals have been reached; however, you have the right to terminate counseling at any time. Understand that you have the right to refuse any recommended services, and to be advised of the consequences of that refusal.

CONFIDENTIALITY

Legal Confidentiality

By law, the counselor considers all information and issues presented in the course of counseling as privileged and confidential. Confidential information may be released only with the written consent of the person being treated or that person's legal guardian. State law also requires the release of confidential information under the following conditions:

1. The client threatens suicide.
2. The client threatens harm to another person(s), including murder, assault, or other physical harm.
3. The client is a minor (under age 18) and reports suspected child abuse or neglect, including but not limited to, physical beatings, and sexual abuse.
4. The client reports abuse of the elderly.
5. The client reports sexual exploitation by a counselor.

In addition, in certain circumstances, a judge may require court-ordered counseling records, a deposition or testimony from a counselor. The contemplation, commission of a crime or harmful act is not considered confidential communication.

Consultation and Professional Training

In accordance with legal and ethical standards, the counselor may be required to participate in direct supervision. The counselor requires your consent to obtain professional supervision or collegial consultation outside this practice when he/she feels it will facilitate the work with the client or the client's family. The client's name and any uniquely identifying information about the client or his/her family will be deleted or changed to protect identity. **The client's signature on this form indicates the client's consent.**

Professional Records

The laws and standards of counseling require the keeping of case records. Records are locked and kept on site, or stored electronically through a secure cloud service. The client is entitled to receive a copy of his/her records or a summary of the client's care per a written request. These request forms for the summary care are available from the counselor. Please note that these are professionally-held records and can be misinterpreted and/or upsetting to untrained readers. If a client wishes to receive his/her records it is recommended that they be reviewed with the counselor so that the contents can be discussed. The client has the right to amend the record, if he/she finds something disagreeable or concerning. Client records will NOT be disclosed to others unless the clients requests the counselor to do so in writing, or unless the law compels the counselor to do so. Communications between the counselor and client will otherwise be deemed privileged and confidential as stated under the laws of this state. The client will be charged an appropriate fee for any professional time spent in responding to requests for information. Meetings will be scheduled at mutually convenient times.

In the unfortunate event of a counselor's inability to continue care (e.g., extended illness, termination, retirement, death) the client's records will be transferred to another counselor within the practice, or to a trustee so designated by the practice, who will consult with the client as to referral options for continuation of care.

AUTHORIZATION TO TREAT

Authorization for Treatment

My signature below indicates that I have read and understand this policy statement and its limits and have had my questions answered to my satisfaction. I accept, understand and agree to abide by the contents and terms of this agreement and further, I am voluntarily consenting to my counseling for specific and stated problems.

PRINTED Client Name

SIGNATURE Client

Date

PRIVACY PRACTICES NOTICE (HIPAA - FEDERAL LAW)

INTRODUCTION

This notice contains summary information about the **Health Insurance Portability and Accountability Act (HIPAA)**, a Federal Law that provides privacy protections and patient rights regarding the use and disclosure of a patient's Protected Health Information (PHI). Daniels and Associates, LLC is dedicated to maintaining the privacy of your PHI as part of providing professional care and are required by law to keep your information private. The Federal Law requires that Daniels and Associates, LLC obtain each patient's signature acknowledging that we have provided this information.

PROTECTED HEALTH INFORMATION (PHI)

Protected Health Information (PHI) is any information that is collected about patient's health conditions, treatment or any information that could identify the patient. PHI includes any information - verbal, recorded, written or electronically transmitted. In this office, PHI is likely to include but not limited to: your personal history and demographic information; reasons you came in for counseling; diagnoses; treatment plan; progress notes; records we get from others who treated you or evaluated you; information about medications you took or are currently taking; billing and insurance information.

The Law states that this information **can only be used or disclose if the patient signs a written authorization.**

There are other situations that require only that the patient provide written, advanced consent, and the patient's signature on this agreement provides that consent for those activities as outlined in this notice. If any disclosure is needed beyond what is listed in this notice, a patient will be asked to sign a separate Release of Information Form before any PHI is disclosed.

USES OF PHI UNDER HIPAA

The HIPAA law allows for the following disclosures of a patient's PHI to an outside entity for the following purposes:

- Treatment: Providing, coordinating or managing a patient's health care and other services related to your healthcare. For example, coordinating care with your Primary Care Physician.
- Payment: Obtaining reimbursement for a patient's healthcare or billing a patient for services rendered.
- Health Care Operations: Activities that relate to the performance and operations of this practice. Which may include: quality assessment and improvement activities, audits, administrative services and clinical peer review.

LIMITS OF CONFIDENTIALITY

- If a therapist believes a child has been the victim of injury, abuse, neglect or deprivation of necessary medical treatment, the law requires that the therapist make a report to the appropriate law enforcement authority. Once such report is filed, the therapist may be required to provide additional PHI information.
- If the therapist believes that any adult patient who is either vulnerable and/or incapacitated has been the victim of abuse, neglect, or financial exploitation, the law requires that a report be filed with the appropriate state official.
- If a patient communicates an explicit threat of imminent, serious or physical harm, to a clearly identified or identifiable victim, and the therapist believes that the patient has the intent and ability to carry out such a threat, the therapist must take protective actions that may include notifying the potential victim, contacting law enforcement, or seeking hospitalization for the patient. Additionally, if the patient threatens harm to him/herself the therapist may be obligated to seek hospitalization for patient or to contact family members or others who can help provide protection.
- A therapist may occasionally find it helpful to consult with other healthcare and mental health professionals about a case. During a consultation, every effort will be made to avoid revealing the identity of a patient. The other professionals are also legally bound to keep the information confidential. The therapist will note all consultations in the patient's Clinical Record.

