FOR INDIVIDUAL ADULT CLIENTS

Counseling I am seeking: ☐**Individual** ☐**Couples** ☐**Group Therapy**

CLIENT INFO	**EMPLOYER & STATUS**
Date of Birth:____/_____/_____ Name:_____ Preferred Name: _____ Preferred Gender Pronouns:_____ Gender: M ☐ F ☐ Other: _____ Address:_____ City:_____Zip:_____ Email: _____ I would like to receive email updates from MFS/TAC ☐**Yes** ☐**No** Home #:_____Cell #:_____ Work #:_____Other #:_____ On what number may we leave a **confidential message**: ☐Home ☐Cell ☐Other	Company:_____ Address:_____ City:_____Zip: _____ ☐I am self-employed ☐I am unemployed I ☐am retired I am: ☐Single ☐Married ☐Divorced How many people live in your household?

How did you hear about Monarch Family Services/The Adolescent Center and Mental Health?

Another Counseling or Mental Health Treatment Center
Referral from relative, friend or MFS/TAC Client
Therapist, Psychiatrist, Physician or Hospital Staff
Internet Search
DFPS
Other

EMERGENCY CONTACT INFO

Notify:_____ Phone: _____
Relationship to client: _____

HEALTH AND MEDICAL

Primary Care Physician:_____Phone:_____
Psychiatrist:_____Phone:_____
Please list any medical problems: _____
Please list any current medications:

WHEN ARE YOU AVAILABLE FOR A WEEKLY APPOINTMENT? (☑ all availability)

50 Minute Sessions	MON	TUES	WEDS	THURS	FRI	SAT
9am, 10am, 11am, 12noon						
1pm, 2pm, 3pm, 4pm						
5pm, 6pm, 7pm, 8pm						

ADDITIONAL INFO

Are you required by a court of law to receive counseling as part of a legal proceeding? ☐**Yes** ☐**No**
Have you obtained services from MFS/TAC before? ☐**Yes** ☐**No** If yes, when? _____
Are you currently affiliated with any of MFS/TAC's volunteer or adjunctive programs? ☐**Yes** ☐**No**
Are you interested in group therapy? ☐**Yes** ☐**No** If yes, what kind?

Client name: _____
Client ID#: _____

Symptom Assessment

Please give as accurate account as you can and if you have any questions or concerns, we invite you to discuss them with your intake counselor.

(✓ your concerns)

I AM EXPERIENCING…	Never	Seldom	Often	Always	For how long?
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					
Phobias: unusual fears about specific things					
Panic Attacks: Sweating, trembling, shortness of breath, heart palpitations					
Recurring, distressing thoughts about a trauma					
"Flashbacks" as if reliving the traumatic event					
Avoiding people/places associated with trauma					
Nightmares about traumatic experience					
I AM FEELING…	**Never**	**Seldom**	**Often**	**Always**	**For how long?**
Decreased interest in pleasurable activities					
Social Isolation, Loneliness					
Suicidal Thoughts					
Bereavement or Feelings of Loss					
Changes in sleep (too much or not enough)					
Normal, daily tasks require more effort					
Sad, hopeless about future					
Excessive feelings of guilt					
Low self-esteem					
I NOTICE...	**Never**	**Seldom**	**Often**	**Always**	**For how long?**
I am Angry, Irritable, hostile					
I feel euphoric, energized and highly optimistic					
I have racing thoughts					
I need less sleep than usual					
I am more talkative					
My moods fluctuate: go up and down					
I HAVE…	**Never**	**Seldom**	**Often**	**Always**	**For how long?**
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					
Obsessive Thoughts					
Been hearing voices when alone					
Problems with my speech					

Client name: _____
Client ID#: _____

I HAVE…	Never	Seldom	Often	Always	For how long?
Risk Taking behaviors					
Compulsive or repetitive behaviors					
Been acting without concern for consequence					
Been physically harming myself					
Been violent toward other(s)					
I USE THE FOLLOWING….	**Never**	**Seldom**	**Often**	**Daily**	**For how long?**
Alcohol					
Nicotine (Cigarettes)					
Marijuana					
Cocaine					
Opiates					
Sedatives					
Hallucinogens					
Stimulants					
Methamphetamines					
MY EATING INVOLVES…	**Never**	**Seldom**	**Often**	**Always**	**For how long?**
Restriction of food consumption					
Bingeing and Purging					
Binge Eating					
A lot of weight loss or gain					
I HAVE…	**Never**	**Seldom**	**Often**	**Always**	**For how long?**
Concern about my sexual function					
Discomfort engaging in sexual activity					
Questions about my sexual orientation					
EMPLOYMENT & SELF-CARE	**Never**	**Seldom**	**Often**	**Always**	**For how long?**
I have problems getting/keeping a job					
I have problems paying for basic expenses					
I am afraid of becoming homeless					
I have problems accessing healthcare					

PERSONAL AND FAMILY HISTORY

Have <u>you or a close relative</u> ever been hospitalized for a psychiatric illness? ■**Yes** ☐**No**
Does anyone in your family have a mental illness? ☐**Yes** ☐**No**
Has anyone in your family every attempted or committed suicide? ☐**Yes** ☐**No**
Does anyone in your family have a substance abuse problem? ☐**Yes** ☐**No**
Have you ever been arrested? ☐**Yes** ☐**No**

If "yes" to any of the above, please briefly explain: _____
_____
_____
_____
_____

Client name: _____
Client ID#: _____

1) How well you are doing on your job: **(✓)**

0☐ Not Working 1☐ Cannot Function 2☐ 3☐ Serious Problems 4☐ 5☐ Moderate Problem 6☐ 7☐ Mild Problems 8☐ 9☐ No Problems

2) How well you are doing in your marital/significant other relationship:

0☐ N/A 1☐ Cannot Function 2☐ 3☐ Serious Problems 4☐ 5☐ Moderate Problem 6☐ 7☐ Mild Problems 8☐ 9☐ No Problems

3) How well you are doing in your family relationships:

0☐ N/A 1☐ Cannot Function 2☐ 3☐ Serious Problems 4☐ 5☐ Moderate Problem 6☐ 7☐ Mild Problems 8☐ 9☐ No Problems

4) How well you are doing in relationships with people outside your family:

0☐ N/A 1☐ Cannot Function 2☐ 3☐ Serious Problems 4☐ 5☐ Moderate Problem 6☐ 7☐ Mild Problems 8☐ 9☐ No Problems

5) Please rate your current physical health:

0☐ Very Poor 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ Excellent

6) Please rate your general happiness and well-being:

0☐ Very Poor 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ Excellent

Consent for Treatment

Please read carefully

Psychotherapy is a working cooperative relationship between you and your counselor. Each member of this cooperative relationship has certain responsibilities. Your counselor will contribute their knowledge, expertise, and clinical skills. You, as the client, have the responsibility to bring an attitude of collaboration and a commitment to the therapeutic process. While there are no guarantees regarding the outcome of the treatment, your commitment may increase the likelihood of a satisfactory experience.

I. Fees and Appointments

1. Appointments are 55 minutes in length, and take place on a weekly, biweekly or monthly basis. Your counselor holds your specific hour for you each week. If you are unable to keep an appointment, please cancel as soon as possible. Any cancelled appointment less than 24 hours will be charged a $25 no show fee. We ask that you pay the receptionist prior to your session each week. We reserve the right to suspend therapy if services are rendered and not paid for after three sessions.
2. There is a $25.00 service fee for any returned checks or insufficient funds. If determined that therapy will continue, you must agree in writing to a specific payment plan to reduce your overdue balance to zero, while continuing to pay the weekly agreed upon fee.

II. Confidentiality

1. Communication between you and your counselor is confidential. This means that your counselor will not discuss your case orally or in writing without your expressed written permission (please see the following section on "Training and Supervision").
2. Your counselor has an ethical and legal obligation to break confidentiality under the following circumstances:
   a. If there is a reason to believe there is an occurrence of child, elder, or dependent adult abuse or neglect.
   b. If there is reason to believe that you have serious intent to harm yourself, someone else, or property by a violent act you may commit.
   c. If you disclose that you knowingly develop, duplicate, print, download, stream, or access through any electronic or digital media or exchanges, a film, photograph, video in which a child is engaged in an act of obscene sexual conduct.
   d. If <u>you</u> introduce your emotional condition into a legal proceeding.
   e. If there is a court order for release of your records.

III. Training and Clinical Supervision

1. The Adolescent Center and Mental Health is a training center for Master's and Doctoral level counseling and psychology interns. All counselors at MFS/TAC are under the supervision of licensed mental health professionals.
2. In order to ensure that counselors receive the best possible training, and that clients are well served, a licensed clinician will attend each session.
3. Counselors are generally on a time-limited contract with MFS/TAC. Therefore, it is possible that your counselor may leave MFS/TAC prior to the end of your therapy. If this occurs we will take reasonable steps to ensure a smooth transition.

IV. Counselor Availability and After Hours Emergencies

Our administrative staff will check for voice mail messages during normal business hours. Messages left outside of normal MFS/TAC hours of operation will be picked up the next business day. If you have an emergency that needs immediate attention you may need to seek assistance at the nearest emergency services department or by calling 911.

V. Child Care Release

MFS/TAC does not provide childcare and is not responsible for children or adolescents left unsupervised in the waiting room. Minors must be picked up following their appointments on time. If you must leave your child in the waiting room during a session, it is your responsibility to provide appropriate supervision for that child. Children under the age of 10 may not be left without supervision in the waiting room.

VI. Additional Rights and Responsibilities

In addition to your right to confidentiality, you have the right to end your counseling at any time, for whatever reason and without any obligation, with the exception of payment of fees for services already provided. You have the right to question any aspect of your treatment with your counselor. You also have the right to expect that your counselor will maintain professional and ethical boundaries by not entering into other personal, financial, or professional relationships with you.

MFS/TAC reserves the right to discontinue counseling at any time including, but not limited to, a violation by you of this Consent for Treatment, a change or reevaluation by MFS/TAC of your therapeutic needs, MFS/TAC's ability to address those needs, or other circumstances that lead MFS/TAC to conclude in its sole and absolute discretion that your counseling needs would be better served at an another counseling facility. Under such circumstances, MFS/TAC will suggest an appropriate counselor(s) or counseling agency.

Your signature below indicates that you have read and understand this information and have received a copy of this consent form and give permission to MFS/TAC to provide counseling services and that this contract is binding for all future sessions you may have with this entity.

Print Name:_____ Date: _____

Signature of Client #1: _____

Print Name:_____ Date: _____

Signature of Client #2: _____

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION
FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, AND
ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Patient Name: _____

Patient Address: _____

Patient Phone Number: _____

In the course of providing services to you, we may create, receive, and store individually identifiable information, including information that relates to health care and payment for health care ("Personal Information"). It is often necessary to use and disclose this Personal Information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a HIPAA Notice of Privacy Practices that describes these uses and disclosures. As described in our Notice of Privacy Practices, the use and disclosure of your Personal Information for treatment purposes not only includes care and services provided here, but also disclosures of your Personal Information as may be necessary or appropriate for you to receive follow-up care from another health care professional. Similarly, the use and disclosure of your Personal Information for purposes of payment may include, for example, the submission of this information to a billing agent for processing claims or obtaining payment and/or submission of claims to insurers.

When you sign this consent document, you expressly agree that we can and will use and disclose your Personal Information to treat you, to obtain payment for our services, and to operate The Adolescent and Mental Health and Monarch Family Services. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You also acknowledge, by your signature below, that you have received a copy of our HIPAA Notice of Privacy Practices.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY PERSONAL INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

I ALSO ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE HIPAA NOTICE OF PRIVACY PRACTICES.

Patient Signature:_____ Date: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

Relationship to Patient: _____

Print Name: _____

Patient Information and Informed Consent for TeleCounseling Service

TeleCounseling is providing therapy/counseling services using interactive audio and visual (video) electronic systems where the provider and the patient are not in the same physical location. The interactive electronic systems incorporate network and software security protocols to protect patient information and safeguard the data exchanged.

Requirements

A computer and a webcam with microphone to video conference using a HIPAA compliant online company specializing in telemedicine. As with any medical procedure, there may be potential risks associated with the use of TeleCounseling. These risks include, but may not be limited to:

Therapy conducted online is technical in nature and problems may occasionally occur with Internet connectivity. Difficulties with hardware, software, equipment, and/or services supplied by a 3rd party may result in service interruptions. Any problems with Internet availability or connectivity are outside the control of the clinician, and the clinician makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, the session will be rescheduled for a later day and time.

Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate medical decision making by the psychiatrist or therapist.

The provider may not be able to provide treatment to the patient using interactive electronic equipment, or provide for or arrange for emergency care that the patient may require, in cases of connection failure.

Delays in evaluation and treatment may occur due to deficiencies or failures of the equipment.

Although highly unlikely, security protocols can fail, causing a breach of privacy of confidential personal information.

A lack of access to all of the information that might be available in a face to face visit, but not in a TeleCounseling session, may result in errors in provider judgment.

My Rights

I understand that the laws that protect the privacy and confidentiality of medical information also apply to TeleCounseling.

I understand that the technology used by the provider is encrypted to prevent the unauthorized access to my private medical information.

I have the right to withhold or withdraw my consent to the use of TeleCounseling during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment.

I understand that the provider has the right to withhold or withdraw his or her consent for the use of TeleCounseling during the course of my care at any time.

I understand that the provider will not record any of our TeleCounseling sessions without written consent.

I understand that the provider will not allow any other individual to listen to, view, or record my TeleCounseling session without my express written permission.

My Responsibilities

I agree to take full responsibility for the security of any communications or treatment information involved with my own computer and with my own physical location.

I understand that I am solely responsible for maintaining the strict confidentiality of my user ID and password and I will not allow another person to use my user ID to access the Services. I also understand that I am responsible for using this technology in a secure and private location, so that others cannot hear my conversation.

I understand that the company that the doctor has chosen to conduct the online appointment (see Guidelines) is an independent company specializing in HIPAA compliant telemedicine. My doctor has no responsibility for that company's operations or security of my protected health information. In addition, the company might send me emails or communication, such as appointment reminders. I understand that the provider is not responsible for this communication. If I am receiving any unwanted communication from the company, I will call/contact the company directly and address my concerns with them.

I will not record any TeleCounseling sessions without written consent from the provider. I will inform the provider if any other person can hear or see any part of our session before the session begins.

I have read and understand all of the clinic policies of The Maple Counseling Center, and that they apply to all telemedicine as well as all in-person visits.

I consent to paying fees that are the same as an in-office visit for the type and length of service provided, through the billing department at The Maple Counseling Center.

I understand that a TeleCounseling appointment is scheduled the same as an in-office appointment would be, and should I not be available for the appointment, or cancel it less than two full business days in advance, there will be a charge for a missed appointment for the time my practitioner has reserved for the scheduled appointment.

Patient Consent to the Use of TeleCounseling

I have read and understand the information provided in the preceding pages regarding TeleCounseling. I have discussed this information with my provider and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of TeleCounseling in my medical care and authorize the provider to use TeleCounseling in the course of my diagnosis and treatment.

Patient Name: First:_____ MI:_ Last: _____

Date of Birth: _____/_____/_____

Signature of Client or Parent/Guardian: _____

Payment Information

*****NOT FOR CPS CLIENTS*****

Our goal is to provide quality service to all of our clients in a timely manner. Failure to keep scheduled appointments ("no-show) is costly to our office and you. Patients who are unable to keep their appointments are requested to give more than ***24 hours notice*** *prior to their appointments. We realize this is not always possible and the practice will consider each individual case. Providing such notice allows our office to offer other persons the opportunity to see our providers, thus using the time more efficiently.*

> *If an established patient fails to provide notice of a cancellation of their appointment, a* ***$30 fee*** *will be billed to his/her account for each missed appointment*
> *If a new patient fails to show twice they will incur a* ***$50 no-show fee****. A third missed visit will result in discharge.*

*Credit card number*_____ *Expiry Date:* _____

*CVV Code:*_____ *ZIP:* _____ *Card holder:* _____

Client's signature: _____