East-West PSYCHOTHERAPY

Informed Consent Adult

Counseling is a cooperative venture with responsibility resting on both the counselor and the client. In order to enable you and your counselor to work most effectively together, we ask that you carefully read the information below. If you have any questions, your counselor will be happy to discuss them with you.

East-West Psychotherapy exists to provide counseling from a Christian perspective for individuals, couples, families, and groups. The Center's services are available to residents of the community regardless of religious affiliation.

_____ (initial) **CONFIDENTIALITY:**

The Health Insurance Portability and Accountability Act (HIPPA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPPA provides patient protections related to the electronic transmission of data, the keeping and use of patient records, and storage and access to health care records. HIPPA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. An explanation of those rights is attached to this document.

Communications between client and counselor are confidential and will not be revealed unless required by law such as in situations of child abuse or threats of physical harm to self or others or subpoena of a court. If your clinician is unlicensed, communications with your counselor are not protected by privilege which means that they may be subject to subpoena by the courts should litigation be brought against you. If you believe that you may need the testimony of a counselor in a court of law, a licensed mental health professional would be an appropriate choice.

Your counselor will be discreet if it is necessary to contact you at home or at work. If you have a specific number that is best for contact please let your counselor know.

_____ (initial) **COUNSELING FEES:**

The nominal fee for counseling sessions will be determined by your individual counselor. We ask that your account be kept current and that payment be made prior to beginning each session. Should the fee not be paid for two sessions, no further sessions will be scheduled until the balance is paid. ***A charge of $25.00 will be made for returned checks plus the amount of the unpaid session.***

_____ (initial) **INSURANCE:**

Our individual counselors participate in a variety of payment forms. Please discuss you method of payment with your counselor.

_____ (initial) **CANCELLATION OF APPOINTMENTS:**

Your appointment time is important to you, to your therapist, and to others who are in need of therapy. If you must cancel your appointment, please phone your counselor and leave a message on their voicemail at least 24 hours in advance of your scheduled appointment. ***A charge of $75.00 will be made for the time reserved when cancellations are received less than 24 hours in advance, except in case of illness or emergency. You are personally responsible for this charge and all future appointments may be cancelled until this fee is paid.***

_____ (initial) **TELEPHONE CALLS:**

Should you need to contact your counselor, you may leave a message on their provided phone number. All calls that are over 15 minutes in length, your counselor may ask if you would like to schedule a session or continue the telephone call for your nominal fee for a 50-minute session.

_____ (initial) **EMERGENCY PROCEDURES:**

If you have an emergency, you will need to contact either a hospital emergency room or the police depending on the situation. If you feel your life or someone else's is in danger call 911.

I have read the above information and voluntarily request counseling services at East-West Psychotherapy Associates, and I agree with these terms and conditions*

Signature_____ Date_____

**The signature of the custodial parent or guardian is required for clients under 18 years of age.*

East-West PSYCHOTHERAPY

Adult Intake Form

The Health Insurance Portability and Accountability Act (HIPPA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the “medical records privacy law,” HIPAA provides patient protections related to the electronic transmission of data (“the transaction rules”), the keeping and use of patient records (“privacy rules”), and storage and access to health care records (“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 patients 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 HIPPA law and regulations are extremely detailed and difficult to grasp if you don’t have formal legal training. This Patient Notification of Privacy Rights is our attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what patient protections HIPPA 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 we make every effort to do all we 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 for further clarification.

By law, East-West Psychotherapy is required to secure your signature indicating you have received a copy of the Patient Notification of Privacy Rights document.

East-West Psychotherapy Associates
HIPAA Compliance Officer

Patient Name (print) _____

I have received a copy of the East-West Psychotherapy Associates Patient 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 that I have the right to review this document and that I may at any time now or later, ask any questions about or seek clarification of the matters discussed in this document. Signing below indicates only that I have received a copy.

_____ _____
Patient Signature Date

_____ _____
Patient Signature if patient is a Minor Date

_____ _____
Guardian Signature if patient is Legal Charge Date

The following form, which will become a part of your confidential record, will enable us to gain a quicker understanding of you. Please answer each question as completely and carefully as you can. You may use the back of any page for additional comments.

Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Present Address: _____
Street

_____
City / State *Zip*

Phone: _____ Email: _____ Ethnicity: _____

Years of Education: _____ Referred by: _____

Marital Status: Single _____ Married _____ (# of Years _____) Divorced _____ Separated _____

Presently Living With: Parents _____ Spouse _____ Roommate _____ Alone _____ Other _____

Occupation: _____ Total Hours/Week _____

Employed by: _____ Phone: _____

Religious Affiliation: _____ Church: _____

Are you a member? Yes _____ No _____ Active _____ Inactive _____

Family member to notify in case of emergency: Name: _____

Address: _____ Phone: _____

Relationship	Name	Age	Grade in School Last Completed	Occupation if Out of School
Spouse				
Father				
Mother				
Brother(s)				
Sister(s)				
Children				

Describe any physical problems you have that require medication or physical care: _____

_____

Are you currently receiving medical treatment? Yes_____ No _____

When did you last consult with your primary care physician? _____

Are you currently taking any prescription medications? Yes _____ No_____ If yes, please list by name and dosage:

_____

_____

Previous Counseling/Therapy Yes _____ No _____ If yes, when? _____

With whom? Name _____ Address: _____

_____

Briefly describe the problem which prompted you to seek counseling at this time: _____

_____

_____

_____

Have there been times when the problem got better or disappeared? Yes_____ No _____

If yes, when? _____

What do you think helped? _____

_____

Were there times when the problems were especially bad? Yes _____ No _____

If yes, when? _____

What made it bad? _____

_____

Are there other people who play a major role in causing your problems or in helping you cope with your problems?

Yes _____ No _____

Explain briefly: _____

_____

Is there anything else that you believe might be important for your counselor to know at this time? _____

_____

_____

Using the scale below, please choose a number that reflects the extent of your concern about each of the issues listed below. Please rate every item.

0	1	2	3	4	5	6	7	8	9	10
No Concern					Moderate Concern					Extreme Concern

_____ Anger

_____ Depression

_____ Education

_____ Eating Difficulties

_____ Fearfulness

_____ Nervousness

_____ Financial Problems

_____ Marital Problems

_____ Physical Problems

_____ Problems with social relationships

_____ Problems with children

_____ Problems with parents

_____ Religious/Spiritual Concerns

_____ Sexual Concerns

_____ Thoughts of Suicide

_____ Trouble Making Decisions

_____ Unhappy Most of the Time

_____ Use of Alcohol

_____ Use of Alcohol by Family Member

_____ Use of Other Drugs

_____ Work

_____ Worry

_____ Other (specify) _____

I have read the East-West Psychotherapy Associates information sheet and voluntarily request counseling services at East-West Psychotherapy in accord with the terms described on the information sheet.

_____ _____

Patient Signature Date

For clients age 17 and under, the signature of his/her guardian or custodial parent is required.

_____ _____

Guardian Signature if patient is Legal Charge Date

PLEASE SUBMIT PAYMENT WITH THIS FORM PRIOR TO FIRST SESSION

PLEASE COMPLETE THE FOLLOWING:

1. The most important thing to me is

2. I worry about

3. What I do best is

4. I have sometimes felt guilty about

5. What makes me angry is

6. My biggest mistakes were

7. My job

8. My personality would be better if

9. I often felt that mother

10. My temper

11. My childhood

12. My biggest disappointment

13. To me, sex is

14. I would be better liked if

15. I often felt that father

16. My children (child) (brothers and sisters)

17. Women are

18. What hurts me most is

19. My biggest problem in life is

20. Men are