Counseling at Anne Contee

Mindful Counseling, Cultivating Awareness

Welcome! Thank you for choosing to begin therapy with me. Appointments can be scheduled by email. Below you will find information regarding expectations and policies. I will be happy to answer any questions you may have regarding this information.

NEW CLIENT FORMS

Please complete the following forms below. Separate forms for each individual are needed for families and couples. All forms and information provided will be kept confidential.

Informed Consent and Services Information Form
Provides information on services, policies, and includes acceptance of treatment and services policies.

Client Information & Wellness Assessment
Comprehensive questionnaire that collects important information related to treatment. If you find any of the questions uncomfortable to answer, you may leave it blank or write, "not ready to share" to let me know.

Confidential Communications Request Form
Consent form for how you would like me to communicate Protected Health Information with you. Please indicate any communication restrictions you have on this form.

Notice of **HIPAA** Policy and Practices
This document outlines important information about the privacy and confidentiality of your Protected Health Information. Please read it carefully and sign the form to acknowledge that you have read and understood.

Authorization to Release/Obtain Information Consent Form (Optional)
Complete this form to authorize me to either obtain or release relevant information to another person or facility if needed.

PREPARING FOR YOUR FIRST APPOINTMENT

Please arrive to your appointment on time because your appointment will not be extended even if you are late. The first 15 minutes or so may be used to fill out New Client Forms, if you have not completed them in advance.

The first appointment is about answering any questions you may have and learning about each other. I will tell you a little bit about themselves, my professional interests, and explain to you what therapy is. I will ask you about how I can help or why you have come for therapy. Please bring any notes if it is easier to remember. Objectives, goals, and expectations will be discussed.

I am committed to providing a safe and comfortable place. If you feel uncomfortable in any way, please let me know. You are not obligated to answer any questions that you are uncomfortable with. Reflecting on your first appointment may be very helpful. Consider how you would like to proceed. I am happy to provide a referral to a specialist or discuss any concerns you may be experiencing.

INFORMED CONSENT FOR TREATMENT FORM

Welcome to Counseling with Anne Contee. Thank you for choosing to enter into therapy. Below you will find information regarding therapy expectations and policies.
I will be happy to answer any questions you may have regarding this information.
Signing this form allows me to treat you.

Anne Contee's POLICIES and PROCEDURES Risks and Benefits:

Counseling is beneficial but as with any treatment, there are risks. During counseling, you will have discussions about personal issues which may bring uncomfortable emotions such as anger, guilt and sadness. These emotions may even be directed at me. The benefits of counseling can outweigh any discomfort encountered during the process, but it may take time. Some of the possible benefits include improved personal relationships, reduced feelings of emotional distress, development of healthy coping strategies and specific problem solving. These benefits cannot be guaranteed. It is my desire however, to work with you to attain your personal goals for counseling.

It is your responsibility to provide necessary information to facilitate effective treatment. You are expected to play an active role in your treatment, including working with me to outline your treatment goals and assess your progress, completing any questionnaires, or complete homework assignments (if any). Your progress in therapy often depends much more on what you do in between sessions than the actual sessions.

My goal is to provide the most effective therapeutic experience available to you. If at any time you feel that we are not a good fit, please discuss this with me so we can determine if transferring to a more suitable Counselor is right for you who could provide you with a fresh perspective.

Confidentiality:

I adhere to the ethical and legal standards/principles of the mental health profession.

Counseling services as well as the storage and disposal of Protected Health Information (PH I) will be kept confidential within these ethical and legal limitations.

You will be informed if information regarding you is released . You will be asked to sign a **Authorization to Release/Obtain Information Consent Form** so that I may speak with others (mental health professionals, family members, doctors, teachers, psychiatrists, etc.) about issues discussed. In general, information will only be released with your written consent.

I am legally obligated to release information about your treatment without your consent in the following circumstances:

- I believe you pose harm and/or threat to yourself or another person
- You are unable to care for yourself and/or require hospitalization
- You reveal that a child or an elderly person is being abused (or suspected abuse or neglect of a child, elderly person or a disabled person)
- You are under the age of 17 and have been sexually or physically abused, raped or the victim of another crime
- When the information is court ordered by a subpoena or a parole officer
- In natural disasters whereby protected records may become exposed

I may occasionally consult with other mental health professionals about a case to provide you the most complete and helpful care. Supervision sessions with other professionals may occur to ensure that I am practicing ethically and competently. Every effort is made to avoid revealing the identity of my clients during consultations.
The other professionals are legally bound to keep all information discussed in consultation confidential. If you have any questions or concerns about consultations, please discuss them openly with me.

.[f you are participating in a group, couples or family counseling, reasonable attempts to ensure confidentiality will be taken but absolute confidentiality cannot be guaranteed.

Please note that if you send me a text message or email that is not secure, then your confidentiality cannot be guaranteed. **Please use telephone communications for emergencies or extremely confidential content.**

A clinical chart is maintained describing your treatment, progress in Treatment, dates of and fees for sessions, and notes (if applicable). Your records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section above. Medical records are locked and kept on premises.

For further details regarding confidentiality policies/procedures please see the **Notice of HIPAA Policy and Practices .**

Social Media Policy:

In accordance with the ethics of the counseling profession, I do not accept friend or contact requests from current or former clients on Facebook or other social media sites. Doing so has the potential to compromise your confidentiality and our respective privacy. I will not write professional endorsements for clients due to the potential for violating the ethical code on dual relationships.

I Anne Contee has a company Facebook, and other social media, page(s) where I post counseling related information that you are welcome to follow. I also have a Linkedln account where professional information is posted.

Appointments:

Appointments are usually scheduled on a weekly or bi-weekly basis and are for **50 minutes.** More frequent sessions or an intensive outpatient schedule are available if determined appropriate by you and me.

Cancellations:

I have a 24 hour cancellation policy. If **you need to cancel or reschedule your appointment, please email me at least 24 hours in advance.** I will not charge a cancellation fee if you notify me 24 hours in advance. This will free your appointment time for another client. Without such notice a fee of $75.00 will be charged for a late cancellation or missed appointment. If two sessions in a row are cancelled with less than 24 hours' notice, I may request to speak with you before continuing to reschedule appointments . Continuity is crucial to the effectiveness of therapy.

Fees:

My fees are $150.00 for 50 minute individual or couples therapy sessions
$75 .00 Late Cancellation or No Show fee
$40.00 returned check fee

Financial assistance may be available in the form of a sliding scale based on gross family income and other resources.

Payment should be made to me directly.

If you become involved in any court or legal proceedings that require my participation, you will be expected to pay for all my professional time, including preparation and transportation costs, even if they are called by another party. The fee is $250 .00 per hour for preparation, communication, travel and attendance at any legal proceeding. A one-hour minimum payment of $250.00 is due in advance for our time.

I accept cash, checks, Debit, Mastercard, Visa, American Express and Discover Card for payment.

Insurance:

I work directly with insurance companies; BlueCross, Blue Sheild, Aetna, TriCare and soon to be paneled with United Health Care.

Emergencies:

I check my voicemail daily and will respond to all messages within 2 business days during my office hours. This excludes national Holidays or days I am not in the office. If you are experiencing a mental health emergency and cannot safely await my return, please call 911 or go to your local emergency room or Crisis Center.

Every attempt will be made to schedule you as soon as possible after you receive emergency services or to offer other options. Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, attempts will be made to return calls in a timely manner. When out of town travel is planned, I will make reasonable attempts to inform you of this absence and develop a plan with you to be used during my absence .

Discontinuing Services:

You, or I, can initiate termination of services at anytime. Please discuss any plans or desire to terminate therapy, as ending is an important part of the therapeutic process.
Referral and transfers to a different Counselor are available.

Clinical Supervision:

LGPC's work under the supervision of licensed counselors. Supervisors are required to keep all information confidential.

Consent for Treatment:

By signing below, you are stating that you have read the above and understand the policy statement and that you have had your questions answered to your satisfaction.
I accept, understand and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time.

I,_____,agree to the policies, procedures, fees and payment arrangements as described above.

Client Signature: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Date: _ _ _ _ _ _ _ _

Parent/Guardian Signature:_____Date:_____

Therapist/Witness:_____Date: _ _ _ _ _ _

FINANCIAL POLICY

Thank you for choosing Anne Contee for your professional services. The following is our financial policy, which we require you to read, agree to and sign prior to any treatment. This policy is strictly enforced with all clients.

Payment Terms

Full payment of _____ is due at time services are rendered. I accept as payment:

- cash, checks, Debit, Mastercard, Visa, American Express and Discover Card for payment.
- Health Insurance Terms

If Applicable, please read and initial the following:

____I understand that my insurance company does not guarantee payment and that I am responsible for payment of series if my insurance company fails to cover the cost of therapy.

____I understand that I am responsible for finding out my own insurance benefits and authorizations as necessary and cannot rely on **Anne Contee** to have this information.

____I authorize **Anne Contee** to release pertinent information concerning my care to my insurance company or any agency necessary for payment on my account, if needed.

Court Terms

There is a $250 .00 minimum fee that needs to be paid in advance if Anne Contee is requested to be an expert witness in court for any matter involving the client. This covers travel, preparation and consulting with subject matter experts . Every hour thereafter is charged at a rate of $250.00.

Returned Checks

If a check is returned unpaid or non-sufficient funds, there will be a $40.00 returned check fee. Fees may be recovered using electronic debit through your financial institution. Checks will no longer be accepted once a check is returned unpaid or with non-sufficient funds.

Collection Terms

Any account past due 60 days will be turned over to a collection agency. All applicable collection fees will be the client's full responsibility. Fees for collection are equal to 50% of the past due amount.

Cancellation/Missed Appointments

As a courtesy, Anne Contee require a 24 hour cancellation notice prior to the scheduled appointment . Individual appointments not canceled within 24 hours will be charged a fee of $ 75 .00 which must be paid prior to next appointment.

Acknowledgement

Your signature below acknowledges you have read, understood, and agree to the terms of Anne Contee's **FINANCIAL POLICY.**

Signature:_ _

Date:_____Print Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

NOTICE OF HIPAA POLICY AND PRACTICES

For purposes of this Notice Anne Contee and (you" or (your" refers to our clients (or their legal representatives in accordance with state informed consent law).

Protected Health Information

Anne Contee must maintain patient confidentiality as required by applicable federal, state and local laws. Anne Contee is also required to establish a consistent process when there is a request for patient information from law enforcement authorities. When using, disclosing or requesting protected health information (PH I), every reasonable effort shall be utilized to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. ANNE CONTEE will take steps to ensure that the appropriate actions are taken to properly identify and secure all individual s' PHI.

The following individually identifiable health information will be designated as PHI within ANNE CONTEE to ensure compliance with the Health Insurance Portability and Accountability Act (**HIPAA**) of 1996 :

A. Information that relates to the past, present, or future physical or mental health conditions of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; specifically including such information in verbal, written, or electronic form
B. Names
C. Address information
D. Telephone numbers
E. Fax numbers
F. Social Security numbers
G. Health plan beneficiary numbers
H. Full face photographic images and any comparable images
I. Any other identifying number, characteristic, or code used to identify an individual

When you visit a health care provider, you give information about your physical and mental health. The law identifies this information as **PHI.** This information goes into your medical or health care record or file. With your written consent, the healthcare provider can use your PHI to provide treatment, process for payment, and administer healthcare operations (T PO).

Primary uses and disclosures of PHI include:
A. Treatment: Once you give consent and your treatment begins the information you give about yourself may be used by ANNE CONTEE staff members or disclosed to other health care professionals. Example: contact with past counelors, current or past physicians, or other treatment facilities, with written consent from the client.
B. Payment: The information you give ANNE CONTEE about yourself may be used to seek payment from your health plan or from other sources of coverage. Example: your health insurance company may request and receive information on date of service, the services provided, and the diagnosis and symptoms of the mental health condition being treated.

OTHER DISCLOSURES

The following are descriptions of some other possible ways in which ANNE CONTEE may be required or permitted by law to use or disclose your PHI. Law enforcement authorities are not covered entities for the purposes of HIPAA compliance . Therefore, ANNE CONTEE shall abide by disclosure restrictions as provided by law and regulation.

Mandatory Disclosure Laws

A. ANNE CONTEE shall disclose PHI to law enforcement personnel and designated protected service personnel pursuant to the mandatory disclosure laws related to victims of child or adult abuse, neglect, or domestic violence.
B. ANNE CONTEE is required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Regula tions.
C. ANNE CONTEE shall disclose PHI to law enforcement personnel or medical, hospital, or psychiatric hospitalization services in the event of a current or recent (recent defined as within 2 weeks) suicide attempt.

Court Orders or Warrants

ANNE CONTEE may disclose PHI to law enforcement in compliance with and limited by relevant requirements (the information sought is relevant and material to a legitimate law enforcement inquiry, and the request is specific and limited in scope to the extent that is reasonably practicable in the light of the purpose for which the information is sought and de-identified PHI information could not be reasonably used) of a:
1. Signed Court Order
2. Signed Court -Ordered Warrant
3. Signed Subpoena
4. Summons issued by Judicial Officer
5. Crime occurs on the premise
6. Threat to health and safety: ANNE CONTEE may disclose PHI in conformance with ethical standards, in good faith, and in compliance with applicable law, to avert serious threat to

health and safety of the person, counselor, teacher, family member, or to the public, as is necessary for law enforcement authority to identify or apprehend an individual:

a. Because of a statement of admission of violent crime that may have caused serious physical harm to a victim.

b. Because of the individual appears to be an escapee from a correctional institution or lawful custody.

c. For purposes of national security and lawful intelligence of the National Security Act.

d. As required by protective services for the President and other under Secret Service Protection.

Designated Authority:

In the event of a concern over improper disclosure, please contact me: Anne Contee, 202-681-7692.

Court Appearance and Out of the Office Consultations:

ANNE CONTEE does not provide court/custody evaluations and will not appear in court to testify in divorce/legal/custody cases unless subpoenaed . If I required to appear in court on your behalf, you are responsible to pay them an hourly rate of $250.00 and are also responsible for paying for any court/legal fees they accrue during this process. At your request, Anne Contee can attend consultations outside of therapy, such as, teacher/ school meetings, doctor meetings, etc. Please know that you will be charged your Counselor's hourly rate including travel time.

Duties of ANNE CONTEE

ANNE CONTEE is required by law to maintain the privacy of your **PHI** and to provide you with this **NOTICE OF HIPAA POLICY AND PRACTICES .** We are required to abide by the privacy policies and practices that are outlined in this notice. All members of our staff are obligated to respect your confidentiality and privacy as outlined in this notice Similarly, any of our business associates who have contact with your **PHI** (such as a third party billing company) are obligated to respect your confidentiality and privacy in accordance with this notice. As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations.

Your Rights:

You have certain rights under the federal privacy standards. These include:

Right to Request a Restriction: You have a right to request a restriction on the **PHI** we use or disclose about you for payment or healthcare operations. We will comply with the restriction unless the information is needed to provide emergency treatment to you and as long as it allows us to comply with the law. You may request a restriction by

writing. In your request tell us: 1) the information you want to limit and 2) how you want to limit our use and / or disclosure of the information.

Ri ght to Request Confidential Communications by Alternative Means: If you believe that a disclosure of all or part of your **PHI** may endanger you, you may request that we communicate with you regarding your information in an alternative manner or an alternative location. For example, you can request that we only contact you at work.

Right to Inspect and Copy: As permitted by federal regulation, we require that requests to inspect, copy, or release **PHI** be submitted in writing. You may obtain a form to request access to your records by contacting your Counselor. If you request a copy of the information, we will charge a fee for the costs of copying, mailing, or other costs associated with your request. Please note that the law does not guarantee you the right of access to, or possession of a mental health therapist's personal or psychotherapy notes. We may deny your request to inspect and copy your **PHI** in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

Right to Amend: If you believe that your **PHI** is incorrect or incomplete, you may request in writing that we amend your information. Your written request should include the reason the amendment is necessary. In certain cases, we may deny your request for the amendment. If we deny your request, you have the right to file a statement of disagreement with us. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

Right of an Accounting: You have the right to receive an accounting of most disclosures of your **PHI** for reasons other than payment, treatment, or healthcare operations. This accounting will not include disclosures for which you provided an authorization. An accounting will include the date(s) of the disclosure. We are permitted to charge you for the cost of producing the list.

Rights for Confidentiality in Substance Abuse Treatment: You may have additional rights of confidentiality under 42 CFR Part 2. Ask for a special authorization form, if needed.

Right to Receive a Printed Copy of the Notice: You have a right to receive a printed copy of this notice.

Acknowledgement

Your signature below acknowledges you have read and understand the **Notice of HIPAA Policy and Practices.** A copy is available at your request.

Client Name (printed):_____ Date:_____

Client Signature:_____ Date:_____

Printed Name of Parent/Guardian if client is a minor:

_____ **Date: _ _ _ _ _ _ _**

_____ **Date:_____**

(Signature of parent/guardian if client is a minor)

AUTHORIZATION TO RELEASE AND/OR OBTAIN INFORMATION
CONSENT FORM

I, _____, will authorize

(C LIENT NAME)

_____

(NAME OF COUSELOR)

to ___ release to and/or ____ obtain information from:

_____

TAME OF INDIVIDUAL, HOSPITAL , OR AGE1 CY WHO WILL RECEIVE/RELEASE INFORMATIO

_____

(ADDRESS)

_____

(PHONE NUMBER, FAX NUMBER, E-MAIL ADDRE)

Information to be released includes (Please INITIAL each item to be released):

__ ALL INFORMATION including medical, psychiatric, psychological, HIV/AIDS, alcohol, drug or other substances.

___ Specific information / reports, such as: (Please I ITIAL each item to be released)

__ Treatment/Discharge summary____ Physical/laboratory results

__ Clinical/psychiatric/psychological assessment____ Progress Notes

___ Verbal exchange of information. Please specify:_____

_____ Other:_____

Specific purpose for disclosure of information:_____

This information cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time (except to the extent that action has been taken) by written notification to the Counselor named above. If I DO NOT revoke this authorization, it will expire automatically in 365 days.

Client Signature: _____Date:_____

Parent/Guardian Signature: _____ Date:_____

Therapist/Witness:_____Date:_____

CLIENT INFORMATION AND WELLNESS ASSESSMENT FORM

This form collects contact and demographic information as well as general medical and mental health information. If there are any questions regarding medical or mental health information that are not relevant, or you do not feel comfortable addressing in detail on this form) please leave them blank) or write) "Not ready to share)) and your counselor will note to discuss this with you later. The more information you can give us the quicker we can get you the help you are looking for.

CLIENT REGISTRATION

___ New client_ Returning client

Therapist:_____

Name:.....Date:.....
D.O.B.: Age: Gender:_____
Marital Status:_____

Address:

_____
Street Apt#

_____
City State Zip Code

Is it ok to send mail to this address?___ yes__ no

If you marked no, please provide an alternative address that we may use for billing purposes, if
necessary:

_____
Street Apt#

_____
City State Zip Code

Best Phone#:_____ **Best E-mail:** _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Can we email you? ___
Can we text you? ___
Can we leave a message?____

Ethnicity:_____

Emergency Contact:_____ **Tel#:**_____
Relationship to you: _
Address:

_____

Street Apt #

_____

City State Zip Code

Referred by: (Nam e)_____ **Tel#:**_____
Referral/How did you hear about us?

_____

_____

Did you come here voluntarily?_____ yes _ _ _ no

Parent/Guardian Information

Name:_____ **D.O.B.:**_____ **Age:**___
Gender: .....
Relationship to Patient:_____
Employer:_____

CLIENT INFORMATION

Current Living Situation:

Marital Status: Single____ Married_____ Divorced_____ Separated_____ Other__

Composition of Present Household (check all that apply):
Alone_ _ With Parent(s)/ Guardian(s)_ _ With Spouse____ With Partner_
With Roommate(s)_ _
Other(describe):_____

Number of Children:_ _ _ _
Ages:_ _
Number of Children in Household:_____
Number of Children Living:_ _ _ _ _ _

Were you adopted? ____ yes ____ no If yes, at what age?___ _

Education:

Your highest education level attained (please check one):

Elementary School. Middle School High School.

Some College College Graduate Trade School
Master's Degree Doctorate, J.D. or MD

Are you currently in school? yes no If yes, what grade/level?

Employment:

Occupation:
Full Time Part Time Self Employed
Student Unemployed. Homemaker

Are you a veteran? yes no no
Are you currently serving in the military?
y
es
explain:

Date of Last Physical:_____

Medical Conditions (past or present):

_____

_____

_____

_____

_____

Are you currently taking any medications:____ yes____ no

If so, please list the type and dosage:

_____

_____

_____

Health and Wellness:

Please rate your overall health: _ Optimal ___ Good _ Average ___ Poor

Please indicate if you have concerns in any of the following areas related to your health/ wellness:

Sleeping____ yes____ no

Eating (Appetite)___ yes____ no

Weight (Gai n or Loss)____ yes ____ .no

Exercise_____ yes_____ no

If you consume/use any of the following, please indicate how often/much in a day/week:

Caffeine_____Alcohol_____

Tobacco_____Marijuana_____

Other----------

What activities, if any, do you engage in for relaxation or leisure:

_____

_____

_____

Please rate your support system: _ Optimal ___ Good _ Average ___ Poor

Please explain your support system (What do you find supportive? Are you lacking support?)

_____

_____

List the relationships that support your well being:

_____

_____

_____

Spirituality/Religion:

Are you affiliated with any Religion or Spirituality?____ yes _ _ _ no
If yes, please explain: _

Mental Health:

Previous mental health or emotional issues:

_____

_____

_____

Have you been to therapy in the past? ____ yes____ no
If yes, when?

_____

If yes, what brought you to therapy at that time?

_____

Have you been diagnosed with a mental health disorder (past/current):
_ _ _yes____ no
If yes, please specify:

_____

_____

_____

Is there any history of mental health disorders in your family? ____ yes _ _ _ no
If yes, please explain:

_____

_____

_____

Any special, unusual or traumatic circumstances that affected your development?
_ yes _ no
If yes, please explain:

_____

_____

_____

Have you ever been the victim of emotional, verbal, physical, or sexual abuse/ assault?
___ yes___no
If yes, please explain:

Do you have any concerns with your sexuality?____ yes_____no

Have you ever attempted suicide?____ yes_____no
Have you recently considered committing suicide? ____ yes_____.no
Are you currently considering committing suicide? ____ yes_____no

Has a family member ever committed suicide? ____ yes_____no
Have you engaged in self-injurious behavior? ____ yes_____no

Have you ever been admitted to the Hospital for psychiatric care? ____ yes_____no
If yes, please explain:

Have you ever been in an inpatient treatment program? ____ yes _____no

Have you ever been charged with a felony offense or a crime of a sexual or violent nature?
____ yes_____no
If yes, please explain:

Have you ever been diagnosed with and/or been in treatment for a substance abuse disorder?

_ _ _ yes - - no

If yes, please explain:

_____

_____

_____

Have you ever been diagnosed with and/or been in treatment for an eating disorder?

___ yes___ no

Are you concerned with your current eating habits? _ _ _ yes_____no

If yes, please explain:

_____

_____

_____

Are you currently seeing a psychiatrist? _ _ _ yes _____ no

If yes, please provide:

Name:_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Phone#_ _ _ _ _ _ _ _ _ _ _ _

*It is common for your counselor and psychiatrist to collaborate/ coordinate care. If you consent to this collaboration, please complete an **Authorization to Release/Obtain Information Consent Form.**

Reason(s) for seeking therapy at this time:

_____

_____

_____

Outcome(s) you would like to see as a result of therapy:

_____

_____

_____

Circle everything that has happened to you in the <u>past five years</u>:

Sexual Problems Bowel Troubles Stomach Problems Suicidal thought
Finances Health Problems Making Decisions Physical Abuse Inferiority Career Choices Self-Control Alcohol Use Headaches
Libido Issues Death of a spouse/partner Death of another family member
Major illness/injury (yourself) Major illness/injury (someone else)
Marriage Problems Family Problems Financial Problems
Legal Issues

Please explain any additional information that you may feel helpful:

_____

_____

_____

I certify that all information provided by me is true, accurate, and complete to the best of my knowledge.

Client Name: ..... **Date:** .....

Client Signature: **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____