HEALING WITH GRACE

Client Information

Name_____ Date_____

Gender_____ Date of Birth_____ Age_____ Marital Status_____

Address_____

City_____ State_____ Zip_____ Phone_____

Email_____ Referred By/Website _____

Highest Level of Education_____ Occupation_____ Sliding Scale/Income _____

Emergency Contact Name_____ Number_____ Relationship_____

Second Party Information (Parent, Legal Guardian, Spouse Etc.)

Name_____ Date_____

Gender_____ Date of Birth_____ Age_____ Marital Status_____

Address_____

City_____ State_____ Zip_____ Phone_____

Email_____

Highest Level of Education_____ Occupation_____ Sliding scale/Income _____

Emergency Contact Name_____ Number_____ Relationship_____

Payment Information (Credit Card)

Name as it appears on card _____Zip code (billing address) _____

Credit Card number _____Expiration_____ Vcode _____

Signature authorizing payment for each Session or cancellation without 24 hour notice to be billed on card

_____ Date _____

Background Information Immediate Family Members (Use back of sheet if space is needed)

Name	Relationship	Age	Living In Home Y/N

Have you had any treatment with a psychiatrist, psychologist or therapist in the past? _____Yes _____No

If yes, Psychiatrist/therapist/practitioner _____ Was it Helpful? _____Yes _____No

Current Prescription Medications _____

Religious Affiliations or Church_____ Do you want Spiritual/religious issues to be a part of your therapy? _____ Yes _____No

Briefly explain why you are seeking counseling today: _____

_____

Please describe any complaints associated with the problem: _____

_____

When did the problem start? _____ How long do you think it will take to resolve these problems? _____

What are your goals for therapy? _____

Are you currently at risk of harming yourself or someone else? _____Yes _____No _____Unsure

Have you attempted to harm yourself in the past? (Please list dates) _____

Following is a list of common obstacles that often lead people to seek counseling. Please check all that apply:

___Anxiety	___Communication	___Self Esteem	___Depression
___Addiction	___Grief	___Eating Problems	___Insomnia
___Alcohol	___Drugs	___Weight	___Stress
___Smoking	___Gambling	___Work Problems	___Shyness
___Relationships	___Sexuality	___Panic Attacks	___Guilt
___Phobia (Please List)	___Abuse	___Trauma	___Anger
___Suicide Attempts	___Suicidal Thoughts	___Self-Harm (Cutting)	___Pain
___Low Motivation	___Sexual Problems	___Social Withdrawal	___School

Is there a family history of any of the following? Please List Family Member in space provided (father, mother etc..)

_____Alcoholism _____Drug Use _____Depression _____Anxiety
_____Suicide _____Attempted Suicide _____Medical Problems _____Psychosis
_____OCD _____ Eating Disorder _____Domestic Violence _____Abuse

In the past 2 weeks have you engaged in any of the following?

___Alcohol Frequency_____ Your Strengths _____

___Marijuana Frequency_____ Your Weakness _____

___Drugs Frequency_____ Your pets & names _____

___Other _____ Frequency_____ Your Hobbies _____

Explain how you cope with stress: _____

What do you like to do with your free time? _____

Are you currently in a romantic Relationship? _____ If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____ If there is areas you would like improvement what are they? _____

What stressful life events have your experienced recently? _____

Is there anything else that you feel is important for me to know? _____

_____

HEALING WITH GRACE

Client Rights

1. You have the right to receive information concerning the methods of therapy employed, the techniques used, the duration of therapy and the fee structure for services provided. If services are not appropriate, referrals to other qualified professionals will be provided.
2. You have the right to refuse or terminate treatment at any time.
3. You have the right to seek a second opinion, if needed I can provide you with the names of other qualified professionals.
4. You have the right to know that in a professional psychotherapeutic relationship sexual intimacy between therapist and client is never appropriate.
5. Therapy is a professional relationship. It is extremely important that you and I both believe the relationship is the right fit in order to provide you with the greatest benefit possible. Because I value and appreciate your commitment to therapy, if at any time I believe you would greater benefit from seeking the services of another professional, I will inform you immediately and provide referrals.

_____Initials

Confidentiality

The therapeutic relationship is confidential and protected by ethical standards of practice and Nevada statutes. Any information obtained in the therapeutic setting cannot be released without your prior written consent except in the following situations according to Nevada State Regulations:

a. Cases of suspected child or elder abuse or neglect.
b. Cases of potential harm to self or others or a need for immediate hospitalization – medical/mental health concerns
c. Cases of legal claims or defense required by state of federal law or court ordered by a judge.
d. Cases under investigation by a board of examiners as part of an investigation or hearing.
e. If you are under the age of 18 in the State of Nevada, parents have access to information in regard to their child's medical records.

It is Healing with Grace Counseling Center and my therapist's policy to maintain confidentiality throughout the therapeutic process; therefore, my therapist will not acknowledge clients in a public area unless first approached by client.

_____Initials

Fees and Cancellation Policy

Sessions are 50 minutes long. The charge per session is $_____ or sliding scale fee of _____ is due at the time of service. Please give a 24-hour cancellation notice to avoid a fee for the missed appointment and to allow others to receive help in your place.

_____Initials

Emergencies

I understand that my therapist is not a 24-hour crisis intervention provider. If I am faced with a mental health emergency I agree to call 911 or go to my local emergency room.

_____Initials

Insurance

I understand that Healing with Grace Counseling Center and my therapist does not accept insurance. If you have PPO Insurance we can give you a superbill once a month to submit. It will depend on your coverage if it is reimbursable or not.

_____Initials

Court Appearances

I understand that my Therapist will not appear in court unless mandated by the court.

_____Initials

Teletherapy (Initial if this form of therapy may be utilized)

Though I do my best to protect your confidentiality of electronic messages, please note that I cannot guarantee confidentiality under circumstances that include use of Internet (VSee, Skype, Facetime), cellular phone or text message.

I understand that using this medium of teletherapy is not entirely secure and Healing with Grace Counseling Center nor my therapist is not held responsible should there be a breach in security on the Internet or phone. I understand that I am responsible for information security on my computer. _____Initials

I understand Teletherapy services are not appropriate treatment modality for everyone and should not continue if therapist and I feel it is counter-productive. My therapist will suggest other options if needed.

I understand that fees and cancellation policy is the same in teletherapy as in-person therapy. _____Initials

Electronic Communications

I authorize Healing with Grace Counseling Center or my Therapist to send Email and or text messages regarding appointments

_____Initials

I have read and fully understand the nature and limits of the above statements and agree to participate in counseling under these conditions.

Signature_____ Date_____

HIPPA Privacy Statement

I. Uses and Disclosure for Treatment, Payment, and Health Care Operations

Healing with Grace Counseling Center may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. We are required by law to maintain the privacy of health information and to provide you with our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the Revised Notice of Privacy Practices by sending you a copy in the mail upon request at your next appointment.

II. Uses and Disclosures Requiring Authorization
We may use of disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances, when we asked for information for purposes outside of treatment, payment, and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing psychotherapy notes. “Psychotherapy notes” are notes your therapist has made about your conversations during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent Nor Authorization.
We may use of disclose PHI without your consent or authorization in the following circumstances: (1) Child Abuse/Neglect; (2) Elder Abuse/Neglect; (3) Health Oversight (Nevada Licensing Board requesting records); (4) Judicial or Administrative Proceedings (Judge Court Order); (5) Serious Threat to Health or Safety to self or others; (6) Workers Compensation (if you file a claim)

Client Printed Name: _____

Signature: _____

(If a child or adolescent under age 18, parent or legal guardian must sign)