

**ADULT COUNSELING SERVICES AGREEMENT**

Client Name \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Address \_\_\_\_\_ City, State, ZIP \_\_\_\_\_

Phone (H) \_\_\_\_\_ Phone (Mobile) \_\_\_\_\_

Education \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Relationship Status: \_\_\_\_\_ Religion/Spirituality \_\_\_\_\_

Number of Children \_\_\_\_\_ Ages \_\_\_\_\_ Sex \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Insurance Plan \_\_\_\_\_ Authorization # \_\_\_\_\_

Policy Holder's Name & Date of Birth \_\_\_\_\_

The hourly fee for all appointments not cancelled 24 hours in advance will be charged. \_\_\_\_\_ Initial

This is to certify that I consent to counseling. \_\_\_\_\_ Initial

I agree that information will be released to my insurance carrier for purposes of reimbursement where applicable. \_\_\_\_\_ Initial

**After-Hours Emergencies: Call 911, or contact your insurance company for direction regarding the most appropriate level of care. The Community Counseling Center does not provide after hours or weekend care.**  
\_\_\_\_\_ Initial

**There is a \$100 charge for completing disability, FMLA and any other paperwork. It is the responsibility of the patient to pay this fee prior to completion of the form. Our policy is to allow 7-14 days for processing the form. We require that the patient information, employer information and other personal sections be completed before accepting the form.** \_\_\_\_\_ Initial

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent's Signature (if client is under 18 years)

\_\_\_\_\_  
Counselor's Signature

# Adult Health History

The following questions are designed to be of assistance in determining your need for counseling. Please complete this questionnaire as accurately and honestly as possible.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of birth: \_\_\_\_\_

1) Did someone refer you? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, who referred you? \_\_\_\_\_  
What was the reason? \_\_\_\_\_

2) Have you ever experienced: (Indicate P for past and C for past 6 months)

_____ Depression	_____ Anger management problems
_____ Low energy	_____ Anxiety/Panic
_____ Poor concentration	_____ Job stress
_____ Low self-esteem	_____ Obsessive thoughts
_____ Feelings of hopelessness	_____ Compulsive behaviors
_____ Feelings of worthlessness	_____ Unresolved grief reaction
_____ Excessive guilt	_____ Divorce/Separation
_____ Sleep changes (too much or too little)	_____ Sexual problem
_____ Appetite changes (increase or decrease)	_____ Eating disorder
_____ Thoughts/attempts to harm yourself	_____ Traumatic experience
_____ Thoughts /attempts of harming someone else	_____ Childhood abuse
_____ Social isolation	_____ Adult abuse
_____ Communication difficulties	_____ Excessive worrying
_____ Family conflicts	_____ Excessive use of alcohol or drugs

3) What would you like to accomplish in counseling?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4) Have any of your family members experienced:

_____ Depression	_____ Alcohol or drug abuse
_____ Suicide attempts	_____ Child abuse or neglect
_____ Anxiety	_____ Anger management problems

5) Please list any medical problems you are currently receiving treatment for.  
Medical Condition: \_\_\_\_\_ Medications/Treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_

6) Have you received counseling services in the past? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please list.  
Counselor Reason for Counseling Approximate Dates

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7) Please list any medications you have taken or are taking to alleviate a mental health condition:

Medication Dosage Prescribing Physician Results (Good-fair-Poor) Side effects?

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8) (a) Have you ever been hospitalized for a psychiatric reason? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please list

Hospital/Treatment Center Reason Approximate Dates

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(b) Any history of self harm? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain

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9) Have you ever received treatment for substance abuse (including NA, AA)?

Yes \_\_\_\_\_ No \_\_\_\_\_ (If yes, please list)

Treatment Center/Support Group Dates Period of abstinence after treatment?

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10) Have family, friends or doctors told you that they were concerned about your alcohol/drug use?

Yes \_\_\_\_\_ No \_\_\_\_\_

11) Please complete:

<u>Substance</u>	<u>Yes/No</u>	<u>Previous or Current</u>	<u>Use per week</u>
Caffeine	_____	_____	_____
Alcohol	_____	_____	_____
Tobacco	_____	_____	_____
Marijuana	_____	_____	_____
Cocaine	_____	_____	_____
Others: Please List	_____	_____	_____

(12) Medical History:

Do you have a primary care physician? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list name, address and phone number: \_\_\_\_\_

\_\_\_\_\_

Please list all past and present medical issues:

<u>Medical Condition</u>	<u>Date of Diagnosis</u>	<u>Medication/Treatment</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

13) Family/Social History:

Where were you born? \_\_\_\_\_ Where did you grow up? \_\_\_\_\_

Who raised you? Parents Adopted Foster Care Grandparents Other

Number of brothers \_\_\_ sisters \_\_\_ half/stepbrother \_\_\_\_\_ half/stepsister \_\_\_\_\_

Any history of abuse? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who do you live with now? \_\_\_\_\_

Relationship History:

Current relationship situation: in a relationship married single divorced widowed

Name of partner or spouse: \_\_\_\_\_ years together/married: \_\_\_\_\_

If separated or divorced: date: \_\_\_\_\_ reason : \_\_\_\_\_

14.) How did you hear about St. Luke's Community Counseling Center?

- \_\_\_\_\_ Word of Mouth
- \_\_\_\_\_ Online Search (key words) \_\_\_\_\_
- \_\_\_\_\_ Print Ad
- \_\_\_\_\_ Worship Guide
- \_\_\_\_\_ Brochure at St. Luke's
- \_\_\_\_\_ Brochure at Event

I understand that this information is being provided to my Counselor only. It is my responsibility to share relevant medical information with my Primary Care Physician.

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

## **Patient Record of Communication**

**Patient Name:** \_\_\_\_\_

In general, the HIPAA privacy rule gives the individual the right to request confidential communications or that a communication is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

**I wish to be contacted in the following manner (check all that apply):**

- Home Telephone: \_\_\_\_\_
  - O.K. to leave message with detailed information
  - Leave message with call-back number only
  
- Written Communication
  - O.K. to mail to my home address
  - O.K. to mail to my work/office address
  - O.K. to fax to this number: \_\_\_\_\_
  
- Work Telephone: \_\_\_\_\_
  - O.K. to leave message with detailed information
  - Leave message with call-back number only
  
- Other \_\_\_\_\_

**Authorization to Disclose Information**  
**To Primary Care Physician**

If you are an insurance client, you **must** fill out this form. If you do not want your records released to your Primary Care Physician, check the third option below, sign and print your name.

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve months from the date signed.

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_  
*(Please Print Client's Name)* *(Please Print Treating Counselor's Name)*

**Please check any that apply:**

- To release any applicable information to my Primary Care Physician
- To release medication information only to my Primary Care Physician
- Not to release information to my Primary Care Physician

\_\_\_\_\_  
*(Client's or Client's Guardian Signature)* *(Date)*

\_\_\_\_\_  
*(Please Print the above Name)* *(Date)*

**Primary Care Physician:**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

**Phone:** \_\_\_\_\_

## **Notice of Health Information Practices**

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, AND SIGN INDICATING THAT YOU HAVE READ AND UNDERSTAND THE NOTICE.

### Understanding Your Health Record/Information

Each time you visit, a record of your visit is made. Typically, this record contains your symptoms, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third party payer can verify that services billed were actually provided
- a tool in educating health professionals;
- a source of information for public health officials charged with improving the health of the nation;
- a source of data for facility planning and marketing and
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy
- better understand who, what, when, where and why others may access your health information
- make more informed decisions when authorizing disclosure to others.

### **Your Health Information Rights:**

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. Privacy Rules (PR) specify that you have the right to:

- request a restriction on certain uses and disclosures of your information as provided by PR 164.522
- obtain a paper copy of the notice of information practices upon request
- inspect and copy your health record as provided for in PR 164.524
- amend your health record as provided in PR 164.528
- obtain an accounting of disclosures of your health information as provided in PR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken.

### **Our Responsibilities:**

This organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

## **For More Information or to Report a Problem**

If have questions and would like additional information, you may contact the Administrative Assistant at 407-876-4991 ext. 250

If you believe your privacy rights have been violated, you can file a complaint with the Director of The Community Counseling Center, or with St. Luke's Director of Human Services. There will be no retaliation for filing a complaint.

## ***Examples of Disclosures for Treatment, Payment and Health Operations***

*We will use your health information for treatment. For example:* Information obtained by your mental health counselor will be recorded in your record and used to determine the course of treatment that should work best for you. Your counselor will document in your record her/his expectations of your treatment.

*We will use your health information for payment. For example:* A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis.

*We will use your health information for regular health operations. For example:* Members of the counseling staff may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the counseling service we provide.

## **Other Uses or Disclosures**

*Notification:* We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

*Communication with Family:* Counselors in best judgment may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

*Marketing:* We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

*Workers Compensation:* We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

*Public Health:* As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

*Law Enforcement:* We may disclose health information for law enforcement purposes as required by law, or in response to a valid subpoena.

There are specific exceptions to confidentiality as provided in state and federal law, where a counselor can release information **without** your consent. These exceptions include possible threat of harm to self, harm to others, child abuse and neglect situations, aging adult abuse and neglect.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.



## **Client Rights and Responsibilities**

As a client of the Community Counseling Center at St. Luke's, you have certain rights and responsibilities.

### **Rights**

- You have the right to receive information about the services and providers available through the Community Counseling Center at St. Luke's. You also have the right to receive information related to standards of practice.
- You have the right to be treated with respect and dignity and understanding of your need for privacy.
- You have the right to an honest discussion of appropriate treatment options for your conditions regardless of cost or benefit coverage.
- You have the right to refuse treatment. If you refuse treatment, you have the right to ask your provider about the possible results of refusing.
- You have the right to receive information about your rights and responsibilities as a client. You may also make recommendations regarding the client's rights and responsibilities policies.

### **Responsibilities**

- It is your responsibility to actively and earnestly cooperate in your treatment.
- It is your responsibility to follow program rules.
- **It is your responsibility to keep scheduled appointments Or cancel at least 24 hours in advance or pay a flat fee.**
- It is your responsibility to pay for treatment at the time services are rendered as agreed during your initial intake.
- It is your responsibility to provide full information, to your counselor, regarding any treatment you are receiving or have received including types of counseling, medications and hospitalizations.

### **Reasons for Discontinuing Counseling**

I understand that the following are program rules and violation of any of these rules WILL result in my discharge from counseling.

- No alcohol, illegal drug possession, drug/alcohol use will be permitted on or about the Community Counseling premises.
- No violence, threats of violence or verbal abuse will be permitted on or about the Community Counseling premises.
- No weapons will be permitted on or about the Community Counseling premises.
- No act of vandalism to the property of the Community Counseling Center, its staff or patients will be permitted.
- No smoking will be permitted inside the Community Counseling Center building.
- Nonpayment of Counseling Center charges will result in termination of counseling.

**I have read and understand the Notice of Health Information Practices.**

**I have received a copy of the Client Rights and Responsibilities and have read and understand them.**

**I understand the rules of the program. I understand the policy of reporting abuse or complaints.**

**I agree to participate and abide by the stipulations in this contract.**

**Client's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent's Signature (if client is under 18)** \_\_\_\_\_ **Date** \_\_\_\_\_

**Counselor's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_