

## CLINICIAN PATIENT AGREEMENT

### Rights and Risks:

- You may ask questions about any aspect of the counseling process.
- If you have been referred by a court or state agency, you have the right to divulge only what you want to be included in a report.
- Therapy is most effective when you are open and can speak honestly about your emotions and experiences.
- Therapy may include talking about emotionally provoking subjects and scenarios.

### Confidentiality:

- Information shared by you in session will be kept confidential.
- Information will not be released without your written consent, except for professional consultation if needed and unless required by law.
- I am required by law to disclose information pertaining to suspected child abuse, the inability to care for one's basic needs for food, clothing or shelter, and threatened harm to oneself or others.
- The court may subpoena counseling records.
- It is understood that information regarding treatment and diagnosis may be provided to an insurance company.
- You may want to discuss further limits or exceptions of confidentiality.

### Appointments:

- All office visits are by appointment and may be scheduled through your counselor directly.
- Please arrive on time, as you use up your own time when you arrive late for an appointment. The usual length of an appointment is 50 minutes.

\_\_\_\_\_  
Signature of Client (Required for Youth 13+)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Clinician

\_\_\_\_\_  
Date

### Emergencies:

The **best phone number** during business hours is 904-725-2500 x115 . If you receive the voice mail, please leave a message with your name and phone number. Your counselor may be on the phone, in therapy with someone else, or out of the office. In a crisis situation, please call 911 **or go immediately to your local hospital emergency room.**



## THERAPY FEES

Services	Licensed Mental Health Professional
Intake (45-50 min)	\$100
Individual, couple, or family session	\$100
Short session (25-30 min)	\$50
School Observation & Recommendations	\$100/Hr
No Show Fee	Full price of session

\*Fees are as of January 1, 2015 and are adjusted periodically

No Show Fee: A cancelled appointment delays our work. When you must cancel, please give me at least 24 hours notice. I am rarely able to fill a cancelled session unless I know at least 24 hours in advance. In you are unable to provide at least 24 hours notice when you cancel, you will be charged the full fee for your session unless I am able to fill it with another client. The only time I will waive this fee is in the event of serious or contagious illness or emergency.

### FINANCIAL AGREEMENT

By signing below I agree to the above fee schedule and understand payment (cash or check) is due in full at the beginning of each counseling session.

I understand the following regarding use of insurance:

If I have insurance coverage, Parkwood Counseling Center is considered Out of Network. I can

- Bill my insurance using an approved diagnostic code (in which case I would be responsible for the difference between what my insurance covers and the full amount listed above)
- Decide not to use my insurance and pay in cash to the full amount listed above

If I do not have insurance coverage I will pay the fee listed above in full.

Client: \_\_\_\_\_

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

Parent/guardian: \_\_\_\_\_

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

Clinician: \_\_\_\_\_

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

## ADULT INTAKE FORM

### **Chief Concern**

Please describe the main difficulty that has brought you to see me:

### **Your medical care** (From whom or where do you get your medical care?)

Clinic name:

Phone:

Doctor's name:

Address:

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? Yes No

### **Your current employer**

Employer:

Work phone:

Address:

Occupation:

Length of time with this employer:

Please indicate any restrictions on calls:

### **Present relationships**

How do you get along with your spouse or partner?

How do you get along with your children?

**Past Psychological/Psychiatric Treatment**

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services? Yes No

Please indicate which type of treatment (circle one): Inpatient Outpatient Both

If yes, please indicate:

**When:**

**From Whom:**

**For What:**

**Results:**

Have you ever taken medications for psychiatric or emotional problems? Yes No

If yes, please indicate:

**When**

**From Whom:**

**For What:**

**Results:**

**List of Symptoms**

Please circle any of the following that have been bothering you lately:

- |                 |                   |                      |
|-----------------|-------------------|----------------------|
| abused as child | agoraphobia       | alcohol use          |
| ambition        | anger             | anxiety              |
| appetite        | being a parent    | bowel trouble        |
| career choices  | children          | compulsions          |
| compulsivity    | concentration     | confidence           |
| depression      | divorce           | drug use/abuse       |
| eating problem  | education         | energy (hi/low)      |
| extreme fatigue | fears             | fetishes             |
| finances        | friends           | guilt                |
| headaches       | health problems   | inferiority feelings |
| insomnia        | loneliness        | making decisions     |
| marriage        | memory            | my thoughts          |
| nervousness     | nightmares        | obsessive thinking   |
| overweight      | painful thoughts  | panic attacks        |
| phobias         | relationships     | sadness              |
| self-esteem     | separation        | sexual problems      |
| short temper    | shyness           | sleep                |
| stress          | suicidal thoughts | work                 |

**Please indicate how the issue(s) are affecting the following areas of your life:**

**Marriage / Relationship:**

1 - No effect   2 - Little effect   3 - Some effect   4 - Much effect   5 - Significant effect

Not Applicable

**Family:**

1 - No effect   2 - Little effect   3 - Some effect   4 - Much effect   5 - Significant effect

Not Applicable

**Job/school performance:**

1 - No effect   2 - Little effect   3 - Some effect   4 - Much effect   5 - Significant effect

Not Applicable

**Friendships:**

1 - No effect   2 - Little effect   3 - Some effect   4 - Much effect   5 - Significant effect

Not Applicable

**Financial situation:**

1 - No effect   2 - Little effect   3 - Some effect   4 - Much effect   5 - Significant effect

Not Applicable

**Physical health:**

1 - No effect   2 - Little effect   3 - Some effect   4 - Much effect   5 - Significant effect

Not Applicable

**Anxiety level / nerves:**

1 - No effect   2 - Little effect   3 - Some effect   4 - Much effect   5 - Significant effect

Not Applicable

**Mood:**

1 - No effect   2 - Little effect   3 - Some effect   4 - Much effect   5 - Significant effect

Not Applicable

*Parkwood Counseling Center*

Clinical Counseling from a Christian Perspective

**Eating habits:**

1 - No effect   2 - Little effect   3 - Some effect   4 - Much effect   5 - Significant effect

Not Applicable

**Sleeping habits:**

1 - No effect   2 - Little effect   3 - Some effect   4 - Much effect   5 - Significant effect

Not Applicable

**Sexual functioning:**

1 - No effect   2 - Little effect   3 - Some effect   4 - Much effect   5 - Significant effect

Not Applicable

**Alcohol / drug use:**

1 - No effect   2 - Little effect   3 - Some effect   4 - Much effect   5 - Significant effect

Not Applicable

**Ability to concentrate:**

1 - No effect   2 - Little effect   3 - Some effect   4 - Much effect   5 - Significant effect

Not Applicable

**Ability to control anger:**

1 - No effect   2 - Little effect   3 - Some effect   4 - Much effect   5 - Significant effect

Not Applicable



**Substance Use**

Do you currently consume alcohol? Yes No

If yes, on average how many drinks per occasion do you consume?

How many days per week do you consume alcohol?

Do you have a history of problematic use of alcohol? Yes No

Have family members or friends expressed concern about your drinking? Yes No

Do you currently use non-prescribed drugs or street drugs? Yes No

Do you have a history of problematic use of prescription or non-prescription drugs? Yes  
No

Do you have a family history of alcohol or drug problems? Yes No

If yes, please describe:

**Other**

Is there anything else that is important for me as your therapist to know about and that you have not written about on any of these forms? Please tell me here; use the back of the paper if needed.