FOUNDATION COUNSELING

_____ (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. Communications between client and counselor are confidential and will not be revealed unless required by law such as in situations of child or elderly abuse or threats of physical harm to self or others or subpoena of a court. 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) COMMUNICATION: Secure and private communication cannot be fully assured utilizing cell/smart phone or email technologies. By initialing, you are acknowledging that the use of any of these technologies to contact your counselor are considered non-secure. Any contact to your counselor by these means will be considered implied consent for your counselor to return messages via the same non-secure technology unless you present a written statement of further clarification.

_____ (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. A charge of $25.00 will be made for returned checks plus the amount of the unpaid session. Some counselors may charge a $3.00 fee for use of credit/debit cards to pay for sessions.

_____ (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. The fee for the session will be charged 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 45-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 Foundation Counseling LLC, 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.

Foundation Counseling, LLC

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, Foundation Counseling, LLC is required to secure your signature indicating you have received a copy of the Patient Notification of Privacy Rights document.

I have received a copy of the Foundation Counseling, LLC 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
_____	_____
Signature of Parent or Guardian	Date

* The signature of the parent/guardian is required for clients under 18 years of age

Identifying/Contact Information

Name: _____ Birthdate: _____ Age: _____ Sex: M F

Street Address: _____

City: _____ State: _____ ZIP: _____

Marital Status: Single ___ Married ____ (# of years ___) Divorced ____ Separated ____

Years of Education: _____

Religious Affiliation (if any): _____

Email Address: _____ OK to email messages? Yes ____ No ____

Telephone: (H)_____(C)_____(W) _____

OK to leave messages? Yes ____ No ____ OK to send texts? Yes ____ No ____

Emergency Contact: Name _____ Phone: _____

Current Situation

Briefly describe the reason you are seeking counseling:

_____

_____

When has the problem improved?

_____

_____

When has the problem worsened?

_____

_____

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

_____

_____

Family

Relationship	Name	Age	Grade in school last completed	Occupation
Spouse				
Father				
Mother				
Siblings				
Children				

Please describe your current living situation: (type of residence and with whom you live):

_____

_____

Occupation

Employer: _____ Length of Employment: _____

Total number of work hours per week:_____

Do you find your work particularly stressful? Yes ____ No ____

Do you find your work satisfying? Yes ____ No ____

Personal and Family History

Has anyone in your family ever suffered from any mental illness? Yes ____ No ____

If yes, please describe: _____

Have you ever been diagnosed with any mental illness? Yes ____ No ____

If yes, please describe:_____

Do you have any family history of problematic substance abuse or addiction? Yes ____

No ____ If yes, please describe: _____

What is your current typical alcohol/drug use? (Ex: 2 nights/week, 1 drink/night)

_____

_____

Medical

Describe any physical problems you have that require medication of physical care:

_____

_____

Are you currently taking any prescription medications? If so please list the name/dosage:

_____

_____

When did you last consult your primary care physician?

_____

Have you ever had previous counseling? If yes, please describe when, the reason for counseling and whom you were seeing:

_____

_____

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

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

_____ Abused as a child
_____ Aggression
_____ Anger or Temper
_____ Anxiety
_____ Bitterness
_____ Completing Tasks
_____ Concentration
_____ Depression
_____ Difficulty in Communication
_____ Eating Difficulties
_____ Excessive Behaviors
_____ Family Problems
_____ Fearfulness
_____ Feeling Manic
_____ Feeling Overwhelmed
_____ Fidget Frequently
_____ Finances
_____ Grief or Loss
_____ Hopelessness
_____ Irritability
_____ Isolation
_____ Marital Problems
_____ Nightmares
_____ Personality Conflicts
_____ Physical Problems
_____ Problems in Relationships
_____ Problems with Children
_____ Problems with Parents
_____ Resentment
_____ Sexual Concerns
_____ Sleep
_____ Social Withdrawal
_____ Spiritual Concerns
_____ Stress
_____ Thoughts of Hurting Yourself
_____ Thoughts of Suicide
_____ Trouble Making Decisions
_____ Unhappy Most of the Time
_____ Use of Alcohol
_____ Use of Alcohol by a Family Member
_____ Use of Drugs
_____ Use of Drugs by a Family Member
_____ Work
_____ Worry
_____ Other:_____

Please Complete the following:

1. The most important thing to me is

2. I worry about

3. What I do best is

4. Sometimes I feel guilty about

5. One of the things I'm angry about is

6. My biggest mistakes were

7. My job

8. What makes me nervous is

9. My personality would be better if

10. I often felt that mother

11. One of the things I can't forgive is

12. My temper

13. My childhood

14. My biggest disappointment

15. To me, sex is

16. I would be better liked if

17. I often felt that father

18. My children (child)

19. Women are

20. What hurts me most is

21. It is hard for me to admit

22. Men are