Tree of Life Behavioral Health

190 Lime Quarry Rd
Madison AL 35758
256-278-2802

1. Patient Registration

Today's Date:_____

Please print clearly and complete all areas. If you have any questions, please ask our front office for assistance.

Client Name: _____Preferred Name:_____
Birth Date: _____Assigned Sex: (M)☐(F)☐Gender Identity:_____
SS#:_____
Marital Status: ☐ Single ☐ Married☐Divorced☐Widowed
Spouse: _____

Physical Address (No PO Box): _____
City: _____State: _____Zip: _____Telephone Numbers:
Primary (_____) _____Secondary: (_____) _____
Email Address: _____

Referred By: _____
Emergency Contact: Name _____Telephone: (_____) _____
Relationship to Patient:_____

Parent or Guardian Information (Responsible Party) if applicable:
Parent/Guardian/Guarantor: _____Birth Date: _____Sex:☐M ☐F
SS#:_____Relationship to Patient: _____Mailing Address:
_____City:_____State: _____Zip: _____
Telephone Numbers: Primary: (_____) _____Secondary: (_____) _____

Primary INSURANCE INFORMATION*
Name of Insurance: _____
Employer: _____
Policy #: _____Group #: _____
Effective Date: _____Insured's Name: _____
DOB: _____Sex:☐M ☐ F SS# of Insured: _____
Relationship to Patient:_____

Secondary INSURANCE INFORMATION
Name of Insurance: _____
Employer: _____
Policy #: _____Group #: _____
Effective Date: _____Insured's Name: _____
DOB: _____Sex:☐M☐ F SS# of Insured: _____
Relationship to Patient:_____

*Please note that we do not file insurance for our psych testing. Speak with the front office for payment plans.

2. Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

• Make sure that protected health information ("PHI") that identifies you is kept private.

• Give you this notice of my legal duties and privacy practices with respect to health information.

• Follow the terms of the notice that is currently in effect.

• I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules and regulations allow health care providers who have direct treatment relationship with the client to use or disclose the client's personal health information without the client's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

a. For my use in treating you.

b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.

c. For my use in defending myself in legal proceedings instituted by you.

d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.

e. Required by law and the use or disclosure is limited to the requirements of such law.

f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.

g. Required by a coroner who is performing duties authorized by law.

h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.

3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AURTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.

2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone’s health or safety.

3. For health oversight activities, including audits and investigations.

4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.

5. For law enforcement purposes, including reporting crimes occurring on my premises.

6. To coroners or medical examiners, when such individuals are performing duties authorized by law.

7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.

8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.

10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say “no” if I believe it would affect your health care.

2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.

4. The Right to See and Get Copies of Your PHI. Other than “psychotherapy notes,” you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.

5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say “no” to your request, but I will tell you why in writing within 60 days of receiving your request.

7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing this document, you are acknowledging that you have received a copy of HIPPA Notice of Privacy Practices.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Client Signature (age 14 or above): _____
Date: _____

Parent or Guardian (if applicable): _____
Date: _____

3. Informed Consent For Professional Counseling Services

YOUR RIGHTS AS A CLIENT

1) You have the right to ask any questions about happenings or procedures used during counseling. Your counselor shall explain the reasons and usual methods to you.

2) You have the right to confidentiality. Within certain limits, information revealed by you during counseling will be kept strictly confidential and will not be revealed to any other person or organization without your written permission. We encourage strict confidentiality with all marital, family, couples and group therapy sessions. You should realize that other participants (i.e., spouses, siblings, group members, etc.) are not legally bound to maintain this privilege and might subpoena counselor's notes, which could compromise your privacy.

3) There are certain situations in which any licensed mental health professional is required by law and ethical code to reveal information obtained during counseling to others persons or agencies-without your permission. Your counselor is not required to inform you of any actions in these circumstances.

Such situations are as follows:.

A. If you threaten bodily harm or death to another person, your counselor is required by law to inform the intended victim and/or appropriate law enforcement and social service agencies.

B. If you threaten bodily harm or death to yourself, your counselor is required to attempt to persuade you not to do so, And if you do not convince your counselor that you will protect yourself, your counselor must inform other appropriate persons of your self-destructive intentions.

C. If a court of law issues an order or subpoena, your counselor is required to provide the information specifically described in the subpoena or court order.

D. If you are in counseling or being tested by order of a court of law or DHR, certain rights may not apply, and the results of the treatment or test ordered data must be submitted to the court or DHR.

E. If you reveal information about known or suspected physical/sexual abuse or neglect of a minor child, or mentally incapable or elderly adult, your counselor must report the data to appropriate authorities.

4. You have the right to decline participation in the use of certain therapeutic techniques, psychological test administration, or medication. Your therapist/psychiatrist shall inform you of his/her reasons to utilize these measurements and shall describe any risks that your therapist/psychiatrist is aware of and will remain open to issues that are of concern to you.

5. Permission to record electronically must be authorized by you in writing. Clients are prohibited from recording counseling sessions without prior written consent from you counselor.

6. You have the right to review documents and records in your counselor's file which is a record of your treatment and financial and/or insurance documents. The counselor also has the right to reject such requests.

7. You have the right to end counseling at any time without moral, legal or financial obligation (other than the balance due). If you wish, your counselor will provide you with names of other qualified mental health professionals. Treatment may be terminated by your counselor as a result of your failure to comply with clinical treatment plans and goals or of your failure to abide by administrative policies, including failure to pay for services.

8. Please be aware that records are not kept indefinitely at Tree of Life Behavioral Health. Records will be destroyed in a manner consistent with upholding client confidentiality.

9. I agree for Tree of Life Behavioral Health to contact me through any contact information that I have made available to them (phone, email, mail, etc).

10. Clients receiving care thorough an individual contracted to Tree of Life Behavioral Health agree that they will not hold Tree of Life Behavioral Health or its partners liable for any services performed by a contracted individual.

11. Counseling may involve the risk of recalling unpleasant memories. Intense feelings may also be aroused. These should be promptly discussed with your counselor.

12. If counseling is being provided to a child placed with a foster parent, the Department of Human Resources gives consent for all pertinent information to be provided to/shared with the foster parent while the child remains in their care.

Please note that your counselor is not a physician and cannot prescribe medication or perform any medical procedures. Please note that your counselor is not an attorney and cannot provide you with legal counsel or advice.

If you have read and fully understand all of the above information and agree to receive counseling from your therapist, please sign below.

Client Signature (age 14 or above)_____

Date:_____

Parent/Guardian:_____

Date:_____

Counselor_____

Date:_____

4. Telehealth Consent Form

TOL TELEHEALTH CONSENT

190 Lime Quarry Rd. Suite 111

Madison, Alabama 35758

(256) 278-2802

http://treeoflifebehavioral.com

Patient Name:_____Date: _____

Therapist: _____

Telehealth involves the use of electronic communications to enable mental health professionals to connect with individuals using interactive video and audio communications. Telehealth includes the practice of mental health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data. I understand that I have certain rights with respect to telehealth, as described below.

1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my session is confidential. However, the limits to confidentiality still apply, including, but not limited to, reporting child/elder abuse, expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

2. I also understand the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent, just the same as in face-to-face office visits.

3. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

4. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my therapist or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation. Tree of Life Behavioral Health takes all precautions by using HIPAA-compliant secure, encrypted audio/video transmission software to deliver telehealth.

5. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no result can be guaranteed or assured.

6. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes, and they have agreed to all confidentiality practices of Tree of Life Behavioral Health.

7. The video conferencing technology used for a session will not be the same as a direct client/therapist visit due to the fact that I will not be in the same room as my therapist.

8. Tree of Life Behavioral Health counselors will bill insurance for telehealth services as applicable, and all standard insurance co-pay rates will be applied. In the event that insurance does not cover telehealth, the client will be responsible for all charges.

By signing this form, I certify:

• That I have read or had this form explained to me, and all my questions have been answered to my satisfaction.

• I understand the risks/benefits of telehealth and agree to participate in telehealth sessions with my therapist.

• I agree that certain situations, including emergencies and crises, are inappropriate for audio/video/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 911 or seek help from a hospital or crisis-oriented health care facility in my area.

• By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Client's Printed Name: _____:

Client's Signature (if over 14)_____
Date: _____
Parent/Guardian's Signature (if applicable): _____
Date: _____

Therapist's Signature: _____Date: _____:

5. PLEASE READ THE FOLLOWING CAREFULLY AND INITIAL TO ACKNOWLEDGE YOUR AGREEMENT:

Filing your insurance is a courtesy we provide for you. Since your insurance policy is a contract between you and your insurance company, the Guarantor/Client/Guardian is sill responsible for co pays and unpaid balances or charges that are not covered by your insurance carrier.

Only initial clauses you agree to. Understand that if you do not agree to certain clauses below, we may not be able to bill your insurance and cash pay will be required. Also understand that failure to agree to certain clauses may result in an inability for Tree of Life staff to treat you.

FINANCIAL AGREEMENT:

I hereby assume full responsibility for all charges incurred for professional services rendered by my provider, unless the services are deemed "paid in full" because of contractual agreement between my provider and my insurer. Payment is due at the time of service. Initial here:_____

GROUP AND INDIVIDUAL INSURANCE, ASSIGNMENT OF BENEFITS:

I authorize my health insurance benefit plan to pay directly to my practitioner at 190 Lime Quarry Rd Suite 111 in Madison Alabama. The medical/psychiatric benefits, if any, otherwise payable to me for their services as described on the claim but not to exceed the chares for those services. I understand I am financially responsible for charges not covered by this agreement. Initial here:_____

AUTHORIZATION FOR RELEASE OF INFORMATION:

I hereby authorize my practitioner to release any medical, psychiatric, infectious disease or drug and/or alcohol related information to my referring physician, other healthcare providers within my provider and referral sources for diagnosis, treatment, consultation and professional communication. If I am an insured client, I further authorize the release of information to the insurance company with whom I have medical benefits for filing a medical claim. I acknowledge that this authorization is valid until such time as all medical bills related to my treatment have been paid. I further understand that I can withdraw this consent for release of information at any time. Initial here:_____

CONSENT FOR TREATMENT:

I authorize and request my practitioner to carry out psychological and/or medical exams, treatment and/or diagnostic procedures and tests which now, or during the course of my treatment become available. i understand the purpose of thee procedures will be explained to me upon my request and that they ae subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness and anger. I understand that is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me. Initial here:_____

STAFF CONSULTATION:

I understand and authorize staff to discuss my case with other staff within Tree of Life Behavioral Health when necessary to improve my quality of care. I understand that staff periodically presents

cases at staff meetings to gain the knowledge and expertise of the other licensed professionals on the treatment team and this is done to improve my care and to expand the knowledge of my provider, so they can better aid and help me. Initial here:_____

TELEPHONE CONSULTATIONS:

Our staff is available to you in crisis 24 hours a day. However, you may be charged for telephone consultations with your provider in excess of 5 minutes. Policies regarding phone contact after hours emergency contact are unique to your provider and should be reviewed with him/her. Your insurance company may or may not cover charges for extended phone calls. Your provider may not always be available for afterhours crisis calls and you may have to talk to on call staff if your provider is not available. Cost will vary depending on the on-call staff's policies and procedures. Initial here:_____

TEXT MESSAGE REMINDER:

Tree of Lie Behavioral Health provides clients with automated text message reminders to help clients keep up with their appointment dates and times. I understand that these messages will be sent to the phone number on file. I acknowledge that I would like these reminders sent to me. I also agree to front office staff communicating with me via text about my appointments. Initial here:_____

TEXT MESSAGE COMMUNICATION:

Text message communication is not confidential or compliant with HIPAA regulations. I understand this and would still like to communicate with my therapist via text from time to time. I understand that Tree of Life Behavioral Health can not guarantee the confidentiality of topics discussed with my therapist using this mode of communication. I would like my therapist to communicate with me this way _____I would not like my therapist to communicate with me this way _____

NO SHOW FEES:

I understand that my provider is an independent practitioner contracted under Tree of Life Behavioral Health. I understand that failure to cancel with my practitioner without 24 hours' notice will result in a No-Show Fee of $50-$150 without the sliding scale adjustment. Initial here:_____

RECEIPT OF PRIVACY PRACTICES:

My initials below indicate that I have reviewed a copy of the Privacy Practices of my provider and that I have been offered a paper copy for my further review outside the clinic upon my request. Initial here:_____

I have read this information in full and fully understand all clauses I have agreed to.

Patient (or parent/guardian of minor) _____

Date _____

6. NOTICE of POSSIBLE SUBPOENA, COURT ORDER and/or REQUEST for COURT APPEARANCE CONTRACT

Please be advised that this contract is binding if a Subpoena, Court Order and/or request for court appearance is processed and received, citing you or your child as litigant in court proceedings. Contingencies required by therapist's involvement in litigative action can be contraindicative to the therapeutic relationship.

Being sufficiently advised of this notice I,_____hereby agree/understand the following conditions in relation to TREE OF LIFE BEHAVIORAL HEALTH.

I understand that confidentiality of therapy at Tree of Life Behavioral Health is governed by the statutes set forth by AL Code 1975 34-8a-1, and the Regulations Governing Professional Counselors, Chapter 255-x-2-06 relative to Privileged Communication. This privilege is considered the same as that existing between client and attorney, and can only be waive by authorization from the client to release information, or when the client is considered dangerous to self or others, or by judicial order.

I understand that the directives of this Subpoena/Order/Request require my therapist to be unavailable for other clients who are involved in ongoing outpatient therapy, and I agree to pay the hourly court rate, or of any portion thereof, plus expenses in order for him/her to satisfy the contingencies of the Subpoena/Order.

I understand that my attorney is responsible for scheduling my therapist as a witness in theses proceedings. Whether or not my therapist testifies, in a timely fashion or not, within 48 hours from schedule, I will be billed and agree to pay the total amount for my therapists time. I also understand that I will be responsible for payment of court fees even if my attorney did not issue the Subpoena/Order due to my name or my child being listed as litigant.

I understand that my health insurance cannot be filed for any portion of the above expenses, relative to the Subpoena/Order served to my therapist.

I agree to pay an advance deposit for court testimony and related activities. The current deposit is $2,000.00 and must be paid in full one week before the court date. The amount of this deposit is subject to change, based on the standard of practice for Tree of Life Behavioral Health. The amount of the deposit required will be commensurate with the date that the Subpoena or Court Order is received. Additionally, I agree to pay the balance for court related expenses within 30 days from the time services are rendered. A portion of this amount is refundable if canceled up to 48 hours before the agreed upon date. I agree to all terms and conditions of payment and collections, and in case if default, to pay all costs of collection or attempts to collect including but not limited to reasonable attorney fees and court costs. Tree of Life reserves the right to retain a Collection Agent, to notify the Credit Bureau and to initiate proceedings in Small Claims Court. This agreement is governed by the laws of Alabama.

I understand that no civil or criminal action may be brought against my therapist, the professional or administrative staff of Tree of Life Behavioral Health or consultants for providing any records, reports, testimony, opinions, recommendations, or data, verbal or written, which resulted as consequences of a request for or response to a Subpoena, Court Order or litigative proceedings. I understand that this release does not have an expiration date and will remain active/valid even after my case is closed for services with Tree of Life Behavioral Health.

Client (or legal guardian if under age 14) _____Date: _____

Counselor _____Date_____

7. Credit / Debit Card Payment Consent

Client name:

(Card holder) Name on card if different than client:

Card Type:

Security Code:

Card Number:

Expiration Date and Zip Code:

NO SHOW FEE

PLEASE NOTE: If I do not cancel before 24 hours, I recognize that Tree of Life Behavioral Health will charge my card $50.00-$150.00 as a late cancel or no show fee if I do not show up for the appointment.

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

Client Initials:

Card holder Initials (If different than client):

Date:

Signature:

8. SLIDING SCALE FEE INFORMATION

PLEASE READ CAREFULLY if you would like to receive sliding scale payments.

I understand that TREE of LIFE BEHAVIORAL HEALTH offers sliding scale payments to help patients who are unemployed, uninsured or under insured to obtain mental health services.

I understand that my counselor's normal rate is up to $150 per session for their services and they only receive a percentage of that. I understand that lying on this form is grounds for immediate discharge and will prevent other individuals who may need this sliding scale slot from obtaining the service they need as each therapist can only offer a limited number of sliding scale slots.

I hereby certify that my HOUSEHOLD income is $_____(this includes all members of my family living in my household). I also understand that I must provide proof of income to receive sliding scale services.

I understand that, based on my income and the fees listed, my sliding scale payment will be $_____per session and this must be paid at the time of service.

If you have no income in your household, meaning you do not personally have a job, and you do not have a spouse, parent or other individual living in your home with you helping with expenses, please check box below.

☐ I certify that I have no income at this time. I understand that my payment will be $50 per session if I have no income. This is the least amount we accept for payment.

☐ I understand that if my income level changes during the time I am receiving services, I will notify my counselor and the fees will change accordingly.

☐ Less than $49,000 = $50*

☐ $50-$59,000= $60

☐ $60-$69,000= $70

☐ $70-79,000= $80

☐ $80,000-$100,000= $100

☐ $100,000+= $150

Note that if you are seeing Charles Montgomery your sliding scale begins at $60 and increases accordingly

Client Signature: _____Date:_____

Counselor's Signature: _____Date:_____

9. Standard Intake Questionnaire

Complaint

What is your major complaint?:

Have you previously suffered from this complaint?:

If Yes, enter previous therapist(s) seen for complaint, describe treatment:

Aggravating Factors:

Relieving Factors:

Current Symptoms

(check all that apply)

- [ ] Anxiety
- [ ] Appetite Issues
- [ ] Avoidance
- [ ] Crying Spells
- [ ] Depression
- [ ] Excessive Energy
- [ ] Fatigue
- [ ] Guilt
- [ ] Hallucinations
- [ ] Impulsivity
- [ ] Irritability
- [ ] Libido Changes
- [ ] Loss of Interest
- [ ] Panic Attacks
- [ ] Racing Thoughts
- [ ] Risky Activity
- [ ] Sleep Changes
- [ ] Suspiciousness

Medical History

Exercise Frequency:

Exercise Type:

Allergies:

What medications are you currently using?:

Previous diagnoses/mental health treatment:

Previously treated by:

Previous medications:

Dates treated:

Previous medical conditions:

Previous surgeries:

Family History

Were you adopted? If yes, at what age?:

How is your relationship with your mother?:

How is your relationship with your father?:

Siblings and their ages:

Are your parents married?:

Did your parents divorce? If yes, how old were you?:

Did your parents remarry? If yes, how old were you?:

Who raised you? Where did you grown up?:

Family member medical conditions:

Family member mental conditions:

Treated with medication?:

Medications:

Present Situation

Work:

Are you married? If yes, specify date of marriage:

Are you divorced? If yes, specify date of divorce:

Prior marriages? If yes, how many?:

What is your sexual orientation?:

Are you sexually active?:

How is your relationship with your partner?:

Do you have child(ren)? If yes, how is your relationship with your child(ren)?:

Are you a member of a religion/spiritual group?:

Have you ever been arrested? If yes, when and why?:

Have you ever tried the following?

(check all that apply)

- [ ] Alcohol
- [ ] Tobacco
- [ ] Marijuana
- [ ] Hallucinogens (LSD)
- [ ] Heroin
- [ ] Methamphetamines
- [ ] Cocaine
- [ ] Stimulants (Pills)

- [ ] Ecstasy
- [ ] Methadone
- [ ] Tranquilizers
- [ ] Pain Killers

If yes to any, list frequency/dates of use:

Have you ever been treated for drug/alcohol abuse? If yes, when?:

Do you smoke cigarettes? If yes, how many per day?:

Do you drink caffeinated beverages? If yes, how many per day?:

Have you ever abused prescription drugs? If yes, which ones?:

Additional

Anything else you want the doctor to know?: