ASHENFELTER
COUNSELING

CLIENT INFORMATION

Identification Information

Name:_____**Date:**_____

Gender: Female ☐ Male ☐ **Date of Birth:**_____**Age:**_____**SS#:**_____

Address:_____**City:**_____**Zip:**_____

Home Phone:_____**Mobile Phone:**_____**Work Phone:** _____

Email:_____**School:**_____**Grade:**_____

Emergency Contact: _____

How did you hear about us? ☐Internet ☐Friend/Family ☐School ☐Church ☐Doctor

Other, please specify_____

Please describe the main concerns that prompted you to seek counseling?

_____

_____

How have these concerns developed over time? _____

_____

_____

Please indicate what major stressors you have had in the last 12 months:

☐Serious Illness ☐Death of a Friend/Family Member ☐Divorce/Separation

☐School Change ☐Major Illness in Family ☐Relationship Change

What would you like to be different in your life when therapy concludes?

_____

_____

Family Information

Is there a family history of: Depression ☐ Suicide Attempts ☐ Anxiety☐ Eating Disorders ☐

Mental Illness☐ Emotional Abuse ☐ Physical Abuse☐ Sexual Abuse☐ Addiction☐

Chronic Illness☐ Other, please specify _____

Please explain any chronic illness _____

Medical Information

Primary Physician:_____Phone: _____

Date of Last Exam: _____ Major or Chronic Illnesses/Injuries: _____

_____

Operations: _____

_____

Current Medications	Dosage	Frequency	Effectiveness	Prescribing Physician

Have there been any recent changes in the following areas?

Sleep☐ Eating/Appetite☐ Exercise☐ Weight ☐ Concentration☐

Behaviors, please specify_____

Substance Use Information

Tobacco

Do you smoke? Yes ☐ No ☐

If no, did you smoke in the past? Yes ☐ No ☐

If yes: Cigarettes/Day_____Began at what age? _____

If you no longer smoke when did you quit? _____

Alcohol

Do you consume alcohol? Yes ☐ No ☐

If so, how much? 1x/month ☐ 3x/month ☐ 1x/week ☐ daily ☐

Check all that apply: Beer ☐ Wine ☐ Hard Liquor ☐

Drugs

Do you use any street drugs and/or misuse prescription drugs? Yes ☐ No ☐

If yes, please list below:

Name of Drug	Frequency of Use

Have you ever received counseling from a mental health profession or religious leader before? Yes ☐ No ☐

If so, please describe:

When?	From Whom?	Purpose?	Results?

Have you ever been prescribed medication for psychiatric or emotional problems?

Yes☐ No☐ **If yes, please describe the following:**

When?	Prescribing Doctor	Prescription	Reason for Rx	Effects

Have you ever been hospitalized for a psychiatric or emotional health reason?

Yes☐ No☐ **If yes, please describe the following:**

When	Hospital	Reason	Results

Have you ever been in a drug or alcohol treatment program? Yes ☐ No ☐

If yes, please specify: Inpatient☐ Outpatient☐ **When:_____How long: _____**

Outcome:_____

_____

Please indicate if you have experienced any of the following:

Physical Abuse ☐ Sexual Abuse ☐ Emotional Abuse ☐
Self Harm ☐ Violent Behaviors ☐ Legal Problems ☐

Spiritual Resources

How significant of a role does spirituality play in your life?

None ☐ Somewhat Significant ☐ Significant ☐ Very Significant ☐

Other

Is there anything else your mental health provider should know prior to beginning counseling?_____

_____

_____

_____

_____

_____

_____

_____

_____

Honesty Declaration:

I,_____, attest that the answers provided throughout this client information form have been answered truthfully and completely to the best of my recall. I attest that I have not deliberately or intentionally misrepresented my medical, social or psychological history in any way with my responses.

_____ _____

Signature Date

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the therapist has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Signature of Patient /Guardian Date

INFORMED CONSENT

THERAPIST

THE UNDERSIGNED THERAPIST IS A LICENSED PROFESSIONAL COUNSELOR (LPC) WITH ASHENFELTER & ASSOCIATES THAT TREATS A DIVERSE RANGE OF MENTAL HEALTH CONDITIONS. WE WORK WITH BOTH ADULTS AND ADOLESCENTS.

NATURE OF COUNSELING

OUR APPROACH TO COUNSELING TAKES INTO ACCOUNT THE SPIRITUAL, PYSCHOLOGICAL, SOCIAL AND BIOLOGICAL DIMENSIONS OF THE CLIENT. THE RELATIONSHIP ESTABLISHED WILL BE CHARACTERIZED BY MUTUAL RESPECT AND COOPERATION. OUR MUTUAL GOAL WILL BE THAT YOU WILL GROW, DEVELOP, AND BE COMMITTED TO WORKING ON THINGS WE TALK ABOUT BOTH DURING OUR SESSIONS AND AT HOME. THE ULTIMATE GOAL IS THAT YOU COME TO A PLACE OF BEING ABLE TO RESOLVE YOUR OWN ISSUES WITHOUT OUR

ASSISTANCE OR INTERVENTION.

PSYCHOTHERAPY CAN HAVE BENEFITS AND RISKS. SINCE THERAPY OFTEN INVOLVES DISCUSSING UNPLEASANT ASPECTS OF YOUR LIFE, YOU MAY EXPERIENCE UNCOMFORTABLE FEELINGS LIKE SADNESS, ANGER, GUILT, FRUSTRATION, LONELINESS, AND HELPLESSNESS. ON THE OTHER HAND, PSYCHOTHERAPY HAS BEEN SHOWN TO HAVE MANY BENEFITS. THERAPY OFTEN LEADS TO HAVING BETTER RELATIONSHIPS, SOLUTIONS TO SPECIFIC PROBLEMS, AND SIGNIFICANT REDUCTIONS IN FEELINGS OF DISTRESS. PLEASE NOTE, HOWEVER, THAT IT IS IMPOSSIBLE TO GUARANTEE ANY SPECIFIC RESULTS REGARDING YOUR THERAPEUTIC GOALS. TOGETHER WE WILL WORK TO ACHIEVE THE BEST RESULTS POSSIBLE.

APPOINTMENTS/CANCELLATIONS

APPOINTMENTS CAN BE MADE BY CALLING YOUR THERAPIST OR THROUGH EMAIL CORRESPONDANCE (INCLUDED ON THE THERAPIST'S CONTACT INFORMATION PROVIDED AT THE VISIT). PLEASE CALL TO CANCEL OR RESCHEDULE AT LEAST 24 HOURS IN ADVANCE OR YOU WILL BE CHARGED FOR THE MISSED APPOINTMENT. YOU ARE RESPONSIBLE FOR CALLING TO CANCEL OR RESCHEDULE YOUR APPOINTMENT.

PAYMENT FOR SERVICES

THE TYPICAL CHARGE FOR A SESSION WITH YOUR THERAPIST IS:

- $150.00 / 45 min. Individual Sessions
- $200.00 / 45 min. Couples & Family Sessions
- $295.00 / 45 min. Joint Couples & Family Sessions (2 therapist present)

PAYMENT IS DUE AT THE BEGINNING OF EACH SESSION. WE ACCEPT CASH, CHECK, AND MAJOR CREDIT CARDS.

CONFIDENTIALITY

DISCUSSIONS BETWEEN A THERAPIST AND A CLIENT ARE CONFIDENTIAL. NO INFORMATION WILL BE RELEASED WITHOUT YOUR WRITTEN CONSENT OR UNLESS MANDATED BY LAW. POSSIBLE EXCEPTIONS TO CONFIDENTIALITY INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING SITUATIONS: CHILD ABUSE; ABUSE OF THE ELDERLY OR DISABLED; SEXUAL EXPLOITATION; COURT ORDERED DISCLOSURE OF INFORMATION; AND/OR IDS/HIV INFECTION AND POSSIBLE TRANSMISSION. IF YOU HAVE ANY QUESTIONS REGARDING CONFIDENTIALITY, YOU SHOULD BRING THEM TO THE ATTENTION OF THE THERAPIST.

DUTY TO WARN

IN THE EVENT THAT THE UNDERSIGNED THERAPIST REASONABLY BELIEVES THAT I AM A DANGER, PHYSICALLY OR EMOTIONALLY, TO MYSELF OR TO ANOTHER PERSON, I SPECIFICALLY CONSENT FOR THE THERAPIST TO WARN THE PERSON IN DANGER AND TO CONTACT ANY PERSON IN A POSITION TO PREVENT HARM TO MYSELF OR ANOTHER PERSON, IN ADDITION TO MEDICAL AND LAW ENFORCEMENT PERSONNEL, AND THE FOLLOWING PERSONS:

NAME TELEPHONE NUMBER

_____

_____

_____

THIS INFORMATION IS TO BE PROVIDED AT MY REQUEST FOR USE BY SAID PERSONS ONLY TO PREVENT HARM TO MYSELF OR ANOTHER PERSON. THIS AUTHORIZATION SHALL EXPIRE UPON THE TERMINATION OF MY THERAPY WITH THE UNDERSIGNED THERAPIST.

AFTER-HOUR EMERGENCIES

EMERGENCIES ARE URGENT ISSUES REQUIRING IMMEDIATE ACTION. IF THERE IS A MEDICAL EMERGENCY, IMMEDIATEDLY CALL 911. YOU MAY ALSO CONTACT YOUR THERAPIST AT THE NUMBER YOU WERE PROVIDED AT THE INITIAL VISIT. DUE TO THE NATURE OF OUR WORK, YOUR THERAPIST MAY NOT ALWAYS BE IMMIDEATELY AVAILABLE.

CONSENT TO TREATMENT

I, VOLUNTARILY, AGREE TO RECEIVE MENTAL HEALTH ASSESSMENT, CARE, TREATMENT, OR SERVICES AND AUTHORIZE THE UNDERSIGNED THERAPIST TO PROVIDE SUCH CARE, TREATMENT, OR SERVICES AS ARE CONSIDERED NECESSARY AND ADVISABLE. I UNDERSTAND AND AGREE THAT I WILL PARTICIPATE IN THE PLANNING OF MY CARE, TREATMENT OR SERVICES AND THAT I MAY STOP SUCH CARE, TREATMENT, OR SERVICES THAT I RECEIVE THROUGH THE UNDERSIGNED THERAPIST AT ANY TIME. BY SIGNING THIS INFORMED CONSENT FORM, I, THE UNDERSIGNED CLIENT, ACKNOWLEDGE THAT I HAVE BOTH READ AND UNDERSTOOD ALL THE TERMS AND INFORMATION CONTAINED HEREIN. AMPLE OPPORTUNITY HAS BEEN OFFERED TO ME TO ASK QUESTIONS AND SEEK CLARIFICATION OF ANYTHING UNCLEAR TO ME.

_____ _____

Client/Parent Date

_____ _____

Therapist Date

Ashenfelter & Associates
12740 Hillcrest Rd Ste 270

Dallas TX 75230. 214.563.8980

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices. The notice states how we may use and/or disclose your health information. The Notice of Privacy Practices can be found on our website at www.ashenfeltercounseling.com or can be printed upon request.

Please sign this form to acknowledge receipt of the Notice.

You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____
Please print your name here

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

□ The patient refused to sign.

□ Due to an emergency situation, it was not possible to obtain an acknowledgment.

□ We weren't able to communicate with the patient.

□ Other (please provide specific details) _____

_____

_____ _____
Employee Signature Date