Information Form

Welcome to Angela Hayes Counseling! To provide you with the best care possible, we ask that you please fill out these forms COMPLETELY and LEGIBLY. If you have any questions, please feel free to contact us at any point.

GENERAL INFORMATION

Name: _____ Name Preferred: _____

Date of Birth: _____/_____/_____ Age: _____ (If under 18, please see below)

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email Address: _____

Occupation: _____ Employer: _____

Emergency Contact : _____ Phone: _____ Relationship: _____

INSURANCE INFORMATION

Insurance Company: _____ Policy Number: _____

Contract Number: _____

UNDER 18 INFORMATION

**If the person completing this is under the age of 18, please answer the following.*

Parent or Legal Guardian's Name: _____ Phone: _____

Who has primary custody? ☐ Mother ☐ Father ☐ Both ☐ Other: _____

Mother's Phone: _____ Father's Phone: _____

Other: _____

(For Office Use Only) Custody Papers Received: ☐ YES

Office Notes: _____

Client Intake Form

Welcome! As part of beginning the therapy process it is important to gather information. This information will help me better understand your situation, and will help us both find situations that are creating difficulties. Please note that this information is confidential.

GENERAL INFORMATION

Date: _____ Services Sought: ☐ Individual ☐ Child/Teen ☐ Marital ☐ Family

Name of Person Filling Out Form with Therapist: _____

Name of Primary Patient (if different): _____

STRESSOR INFORMATION

Names of Individuals Living in the Primary Household *(Check who will be attending counseling):*

First & Last Name	*Relation*	*Birthdate*	*Employer/School*	*Position/Grade in School*

Sources of Stress (What are some of the primary issues for which you are seeking therapy?):

1.) _____

2.) _____

3.) _____

What are the most important things you think I should know about these issues?

_____

_____

_____

_____

In what ways have you attempted to cope with these issues?

_____

_____

_____

_____

Client Intake Form Con't

THERAPY EXPECTATIONS

Do you have any particular concerns or fears regarding therapy?

_____

_____

What are your goals for therapy?

_____

_____

MENTAL HEALTH & SOCIAL HISTORY

Have you or anyone in the family attended therapy previously, or are currently in treatment? Any psychiatric hospitalizations? ☐ No ☐ Yes *If yes, please indicate:*

Name	*Type of Problem/Condition*	*Therapist/Program*	*Dates of Treatment*

Have you or anyone in the family been a victim of, or perpetrator of child abuse (physical, sexual, emotional, neglect, domestic violence, rape, or other violent acts)?

_____

_____

_____

Have you or anyone in the family had trouble with alcohol or substances, now or in the past?

☐ No ☐ Yes *If yes, please indicate:*

Name	*Substance Used*	*Frequency/Amount*	*Still Using?*

Have you or anyone in the family been involved with the legal system (probation, parole, jail, Prison, DUI)? Any present or pending Civil lawsuits? ☐ No ☐ Yes *If yes, please indicate:*

Name	*Reason*	*Outcome*

Client Intake Form Con't

MENTAL HEALTH & SOCIAL HISTORY

Religious or Spiritual Preference: _____

Importance of religion to you/your family: ☐ Not Important ☐ Somewhat Important ☐ Very Important

Were you adopted? ☐ No ☐ Yes

If yes, do you have a relationship with your biological parent(s)? ☐ No ☐ Yes

MEDICAL HISTORY

Physician(s) currently treating self/family members:

_____

_____

_____

Is anyone in the family being treated for a medical problem(s) and/or disability?

☐ No ☐ Yes *If yes, please indicate:*

Name	*Briefly Describe*

Current Medications (for Primary Patient):

Name	*Medication/Dosage*	*Prescribing Doctor*	*Reason*

Please check any past, present, or impending issues for your or your family:
(check all that apply and circle primary concerns)

- ☐ Suicidal Thoughts/Attempts
- ☐ Cutting or Other Self Harm
- ☐ Depression/Hopelessness
- ☐ Anxiety/Worry
- ☐ Anger Issues
- ☐ Chronic Pain or Illness
- ☐ Sleep Problems
- ☐ Eating Problems
- ☐ Loss/Grief
- ☐ Legal Issues
- ☐ Job Issues/Financial
- ☐ Partner Violence/Abuse
- ☐ Sexual Abuse/Rape
- ☐ Alcohol/Drug Concerns
- ☐ Other Addiction Issues
- ☐ Couple Concerns
- ☐ Marital Affairs/Infidelity
- ☐ Communication Issues
- ☐ Sexuality/Intimacy Issues
- ☐ Divorce Adjustment
- ☐ Remarriage Adjustment
- ☐ Major Life Changes

For Children

- ☐ Adjustment to Divorce
- ☐ School Failure
- ☐ Truancy/Runaway
- ☐ Fighting with Peers
- ☐ Hyperactivity
- ☐ Wetting/Soiling Clothes/Bed
- ☐ Isolation/Withdrawl
- ☐ Child Abuse/Neglect
- ☐ Parent/Child Conflict
- ☐ Adjustment to Remarriage

Client Intake Form Con't

PERSONAL & FAMILY STRENGTHS & RESOURCES

Indicate the strengths that you and others in your family have:

Strength/Resource	*Self*	*Others*	*Other's Name or Notes*
Is willing to seek help.			
Gets along well with other family members.			
Is physically healthy.			
Is generally liked and respected at work/school.			
Is a hard worker.			
Has supportive family and friends.			
Copes well with disappointment.			
Uses anger constructively.			

List the people, activities, groups and hobbies that are supportive to you/your family:

ADDITIONAL OR CONTINUED NOTES:

Client-Counselor Service Agreement

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

Counseling is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in counseling, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your counselor, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

GOALS OF COUNSELING

There can be many goals for the counseling relationship. Some of these will be long-term goals such as improving the quality of your life, learning to live with mindfulness and self- actualization. Others may be more immediate goals such as decreasing anxiety and depression symptoms, developing healthy relationships, changing behavior or decreasing/ending drug use. Whatever the goals for counseling, they will be set by the clients according to what they want to work on in counseling. The counselor may make suggestions on how to reach that goal but you decide where you want to go.

RISK/BENEFITS OF COUNSELING

Counseling is an intensely personal process, which can bring unpleasant memories or emotions to the surface. There are no guarantees that counseling will work for you. Clients can sometimes make improvements only to go backwards after a time. Progress may happen slowly. Counseling requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

However, there are many benefits to counseling. Counseling can help you develop coping skills, make behavioral changes, reduce symptoms of mental health disorders, improve the quality of your life, learn to manage anger, learn to live in the present and many other advantages.

APPOINTMENTS

Appointments will ordinarily be 55-60 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours' notice.

CONFIDENTIALITY

Your counselor will make every effort to keep your personal information private. If you wish to have information released, you will be required to sign a consent form before such information will be released. There are some limitations to confidentiality to which you need to be aware. Your counselor may consult with a supervisor or other professional counselor in order to give you the best service. In the event that your counselor consults with another counselor, no identifying information such as your name would be released. Counselors are required by law to release information when the client poses a risk to themselves or others and in cases of abuse to children or the elderly. If your counselor receives a court order or subpoena, she may be required to release some information. In such a case, your counselor will consult with other professionals and limit the release to only what is necessary by law.

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Client-Counselor Service Agreement Con't

CONFIDENTIALITY AND GROUP THERAPY

The nature of group counseling makes it difficult to maintain confidentiality. If you choose to participate in group therapy, be aware that your counselor cannot guarantee that other group members will maintain your confidentiality. However, your counselor will make every effort to maintain your confidentiality by reminding group members frequently of the importance of keeping what is said in-group confidential. Your counselor also has the right to remove any group member from the group should she discover that a group member has violated the confidentiality rule.

CONFIDENTIALITY AND TECHNOLOGY

Some clients may choose to use technology in their counseling sessions. This includes but is not limited to online counseling via Skype, telephone, email, text or chat. Due to the nature of online counseling, there is always the possibility that unauthorized persons may attempt to discover your personal information. Your counselor will take every precaution to safeguard your information but cannot guarantee that unauthorized access to electronic communications could not occur. Please be advised to take precautions with regard to authorized and unauthorized access to any technology used in counseling sessions. Be aware of any friends, family members, significant others or co-workers who may have access to your computer, phone or other technology used in your counseling sessions. Should a client have concerns about the safety of their email, your counselor can arrange to encrypt email communication with you.

RECORD KEEPING

Your counselor may keep records of your counseling sessions and a treatment plan, which includes goals for your counseling. These records are kept to ensure a direction to your sessions and continuity in service. They will not be shared except with respect to the limits to confidentiality discussed in the Confidentiality section. Should the client wish to have their records released, they are required to sign a release of information which specifies what information is to be released and to whom. Records will be kept for at least 7 years but may be kept for longer. Records will be kept either electronically on a USB flash drive or in a paper file and stored in a locked cabinet in the counselor's office.

PROFESSIONAL FEES

You are responsible for paying at the time of your session. Payment must be made by cash, visa, MasterCard or PayPal.

The fee is a sliding scale based on your income. The sessions range from $50.00 - $75.00. Each session is 55 minutes to one hour.

If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required.

CONTACTING ME

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible.

The best number to reach me is 205-222-9574, you can also text me or email AngelaMHayes@icloud.com

I look forward to working with you as clients.

CONSENT TO COUNSELING

Your signature below indicates that you have read this Agreement and agree to its terms.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Informed Consent for Treatment

You have rights and responsibilities as a client seeking to engage in counseling with me. Furthermore, the federal Health Insurance Privacy and Portability Act (HIPPA) entitles you to certain protections of confidentiality. Please ask me if you are interested in a more detailed explanation of HIPPA.

YOUR RIGHTS

1. You have the right to be informed of the terms under which treatment will be provided.
2. You have a right to know my qualifications and training.
3. You have the right to refuse or terminate treatment at any time and for any reason.
4. You have the right to know that sometimes you can feel worse at the beginning of treatment instead of better. This is possibly a result of opening up old wounds and discussing painful topics that you may have been avoiding, and it should ease over time, if it happens at all.
5. You have the right to confidentiality as specified by state and federal law. This means that anything you tell me and /or that I write down in your file will not be repeated or released to anyone else without your written permission. You, of course, may discuss your treatment with anyone you choose, including another therapist.
6. If you choose to communicate with me via email, you should understand that confidentiality cannot be guaranteed due to the nature of Internet security as well as the possibility that others in your household or place of employment could access your emails. There are certain situations in which the law requires that confidentiality be broken, even if it is against your wishes. These include:
    - Child or elder abuse or neglect: I am required by law to report any suspicion of abuse to the Department of Human Resoures (DHR).
    - Violence: If I have reason to believe that you intend to harm someone else, I am required by law to attempt to notify that person
    - Suicide: If I believe you are in danger of killing yourself, I will break confidentiality to ensure your safety.
    - Consultation: At times , it might be helpful for me to consult with colleagues regarding your best treatment options. If this is necessary, consultation will be done without the use of your name or identifying information unless you have provided written permission
    - If you are under the age of 14 your parents have the right to be involved in your treatment. I would strongly advise that they are made aware of only what is necessary and helpful. Individuals 14 and up will need to sign a release of information for parents to receive information. No release is needed for parents to provide information.

YOUR RESPONSIBILITIES

1. Once we schedule an appointment, you will be responsible for paying unless you provide a 24 hours' advance notice of cancellation.
2. *YOU ARE RESPONSIBLE FOR PAYING FOR SESSIONS AT THE BEGINNING OF OUR COUNSELING SESSIONS.* A standard session is 55 minutes to one hour in length unless otherwise arranged in advance. If we both determine and agree that longer sessions are necessary your fee will be agreed upon and adjusted.
3. You are responsible for keeping me informed regarding changes in your contact information. You are responsible for letting me know if you are dissatisfied with your treatment in any way. I cannot address the problem if I do not know that there is one.
4. You are responsible for working at least as hard as I am to address the concerns that brought you, your child, or family to therapy. You will have to be willing to work on the things we talk about both during sessions and at home if you want to change.

CONSENT TO COUNSELING

I/We, _____have read the above rights and responsibilities and have had any questions answered. I/we understand and agree to these policies.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____