



Date: _____

Referred By: _____

Personal

Full Name: _____

Date of Birth: _____ Cell Phone #: _____

Email Address: _____

Address: _____

City _____ State _____ Zip _____

Occupation: _____ Employer: _____

Current Family

Marital Status: Single/Never Married _____ Married _____ Divorced _____ Remarried _____

Spouse's Name: _____ Date of Birth: _____

Spouse's Occupation: _____ Employer _____

Children (please list names and ages):

Previous Marriage(s): Name(s) _____

Duration _____

Family of Origin

What number child were you in your family? _____ of how many? _____

What number child was your current spouse? _____ of how many? _____

Do you or anyone in your family of origin or anyone in your immediate family misuse alcohol or drugs? If yes, please give brief history.

Is there anything else you'd like to write here about you or your family history?

Health

Your current health: Very good _____ Good _____ Average _____ Declining _____

Approximate date of your last comprehensive exam: _____

Current medical problems:

Current medication(s) and dosage(s):

Please list any sleep disturbances.

Have you previously sought clinical or psychiatric help? ____ Yes ____ No

Therapist/Dr. _____ Profession _____

From _____ To _____

CONSENT

An Introduction to Counseling

The counseling process provides an opportunity for us to form an alliance in order to explore the nature of the problem that brings you to counseling. Because the complexity and intensity of our difficulties are so profoundly affected by other people, we will look closely at the nature of the significant relationships in your life. I will respectfully work with you to better understand the roots of your problem, encourage your exploration and growth, challenge unhealthy or destructive patterns of behavior, seek to support change, restore relationships, and empower you toward healthful decision-making.

Together, we will determine the course and duration of therapy. The counseling process will require effort on your part, and a commitment to change that may sometimes involve significant discomfort.

Remembering and resolving unpleasant events can arouse fear, anger, depression, frustration, and other powerful emotions that may seem foreign but are a normal part of the process of growth. Please remember that, at times, a situation can become more difficult before improvement is noticed.

It is important to have a framework of clearly defined rights and responsibilities in the counseling relationship. *Please initial/sign only after you have read everything carefully and discussed any questions.*

Confidentiality & Treatment

Your rights to confidentiality are one of the most important policies in the provision of mental health services. Confidentiality means that the information that you discuss with your therapist/counselor will not, except as below, be shared with anyone without your specific permission. Confidentiality of personal information is vital for building a solid therapeutic relationship, and allows you to feel free to explore problems and work toward solutions. There are some very important exceptions to confidentiality that require the disclosure of personal information without your consent.

The following are exceptions to confidentiality: I am legally obliged to take action to protect others from harm, even if I have to reveal some information about your treatment/evaluation/consultation.

- If I believe that a child, elderly person, or person with a disability is being abused or neglected, I must file a report with the appropriate state agency.
- If I believe that a client is threatening serious bodily harm to another, or to himself/herself, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client.
- Information subpoenaed in a legal proceeding might not be regarded by the Court as confidential.
- In most judicial proceedings, you have the right to prevent me from providing any information about your treatment. However, in some circumstances a judge may require my testimony if s/he determines that resolution of the issues before him/her demands it.
- I may occasionally find it helpful to consult with other professionals about a case. During a consultation, I make every effort to avoid revealing identifying information about my clients. The person with whom I am consulting is also legally bound to keep the information confidential.
- When insurance coverage is utilized it is considered consent on the insured's part (client) that diagnosis and treatment plans and issues may be discussed by the therapist with your insurance company in order to facilitate insurance claim filing or case management with your insurance company.

Please note that breaking confidentiality because of issues of abuse/neglect, threat of serious bodily harm to oneself or others, subpoenas, Court order, and collection of outstanding payment are highly unusual in my clinical practice. If such a situation occurs, I will attempt to fully discuss it with you before taking any action. If it becomes necessary to release information, it will be made in such a way as to protect as much confidentiality as possible. I have a strong commitment to maintaining confidentiality and handling your personal information with the highest degree of confidentiality possible. If you have any questions or concerns about confidentiality it is important that we discuss them at our next meeting.

Understanding the above, I give permission for Susan S Wolfe, MA, LPC, NCC to provide counseling to me.

Signature of Client _____ Date _____

Printed Name of Client _____

Signature of Counselor _____ Date _____

Contact

In the event of any medical or life-threatening emergency, I grant permission for any employee of Green Door Counseling to contact the following person(s).

Name _____ Contact # _____

Name _____ Contact # _____

Client Signature _____

Please INITIAL each statement to which you consent.

____ I grant permission for information (billing, events, and other information) to be sent to my home address.

____ I grant permission for my therapist to contact me at my cell phone # with possibility of leaving a message.

____ I grant permission for Green Door Counseling to thank the person who referred me.

I recognize that email and other forms of Internet communication are not a secure/confidential means to transmit data. By initialing any statement below pertaining to Internet communication, I voluntarily wave my rights provided by the HIPAA law, and any other federal or state laws regarding confidentiality and the transmission of information via the Internet. I voluntarily give my permission and will not hold Green Door Counseling and/or my therapist, Susan S Wolfe, MA, LPC, NCC, legally responsible for the transmission of this data.

Client Signature _____ Date _____

____ I grant permission to send and receive communication from my therapist at my email address.

Finances & Appointments

Please INITIAL all statements.

____ I understand that Green Door Counseling has a **24-HOUR CANCELLATION POLICY**. I will be charged the full rate of my session if I do not call at least 24 hours in advance to cancel unless I have a serious physical illness. If there are extenuating circumstances that I believe should affect this policy, I will discuss those with my therapist.

____ I understand that Susan S Wolfe's current rate is \$130 per session and agree to be personally responsible for this rate. Should this rate change in the future, Green Door Counseling will inform me a minimum of 30 days in advance.

____ I understand that counseling sessions last approximately 50 minutes including any time needed to schedule next appointments.

____ I understand that Green Door Counseling only bills United Healthcare (UHC), Optum, and Anthem/Blue Cross Blue Shield insurance and I am responsible for my co-pay and deductible if I choose to utilize my UHC, Optum or Anthem/BCBS insurance. Should I want to submit my counseling for insurance reimbursement other than UHC, Optum or Anthem/BCBS, Green Door Counseling will issue a diagnostic receipt that I will submit to insurance and have the insurance company reimburse me.

____ I understand that Green Door Counseling accepts cash, checks, HSAs, credit and debit cards.

____ I agree to make payment at the beginning of each session. I understand that my counselor receives a percentage of the fee I pay to Green Door Counseling for our time together. I understand my counselor is not compensated for his/her time with me unless and until I make payment for a session.

____ I understand that if I become involved in legal proceedings that may require Susan S Wolfe's participation, I will be expected to pay for her professional time even if she is called to testify by another party. Because of the complexity of legal involvement, the charge for such services is \$325 per hour for preparation, travel, and attendance at any legal proceeding, with a minimum three-hour charge.

Policies

Please INITIAL all statements.

____ I acknowledge that I have received Green Door Counseling attached, written explanation of their compliance with HIPAA entitled "Notice of Privacy Practices."

____ I understand that both the law and the standards of the clinical profession require that my therapist keep appropriate treatment records. I am entitled to receive a copy of the records upon written request, unless my therapist believes that seeing them would be emotionally damaging, in which case, my therapist will be happy to provide them to an appropriate mental health professional. Because these are professional records, they can be misinterpreted and/or can be upsetting, so Green Door Counseling strongly recommends that I review them with my therapist so that you can discuss what they contain. Clients will be charged an appropriate fee for any preparation time that is required to comply with an information request.