South County Christian Counseling

Professional Christian Counseling, Training and Education

4167Crescent Dr., Suite 201 • St. Louis, MO 63129 • (314)729-0481

Client Information

(Please Print Neatly)

Name _____**Today's Date** _____
First **Last** **MI**

Address_____
Street **City** **State** **ZIP**

Home Phone _____ **Cell**_____ **Work Phone** _____

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

Occupation _____**Employer** _____

Email Address_____

Current Marital Status *(check one)* ☐ Single (Never Married) ☐ Married Years Married:
☐ Widowed ☐ Separated ☐ Divorced ☐ Unmarried/Cohabitating Couple

If Married, Spouse _____**Age**_____ **Phone** _____

Spouse's Address_____

RESPONSIBLE PARTY (If Self Please Leave Blank)

Relationship to Client: ☐ Spouse ☐ Parent ☐ Other _____

Name _____
First **Last** **MI**

Address_____
Street **City** **State** **ZIP**

Home Phone _____ **Cell**_____ **Work Phone** _____

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

Email Address_____

Please check any of the following problems that pertain to you:

___Nervousness	___Depression	___Fears	___Shyness
___Sexual Problems	___Suicidal Thoughts	___Separation	___Divorce
___Finances	___Drug Use	___Alcohol Use	___Friends
___Anger	___Self-Control	___Unhappiness	___Sleep
___Stress	___Work	___Relaxation	___Headaches
___Legal Matters	___Memory	___Ambition	___Energy
___Insomnia	___Tiredness	___Making Decisions	___Loneliness
___Inferiority Feelings	___Insomnia	___Education	___Career Choices
___Health Problems	___Temper	___Nightmares	___Marriage
___Children	___Appetite	___My Thoughts	___Being a Parent

HEALTH HISTORY

Primary Care Physician_____ **Phone** _____

Address _____

Date of last visit _____ **Current Health Problems** _____

List all current medications and dosages _____
_____

In the past 2 weeks were your sleep patterns *(Check one)* ___ Typical or ___ Unusual

Check all that apply: __ Nightmares __ Insomnia __ Early morning waking __ Difficulty falling asleep

In the past 2 weeks were your daily eating habits (*Check one)* ___ Typical or ___ Unusual

Check all that apply: ___ 1-2 meals ___ 2-3 meals ___ snacks

Do you have any current or past eating disorders? ___ No ___ Yes **If yes, explain**_____
_____

Are you presently experiencing emotions and/or moods that affect your day to day functioning?
(Check one) ____ Never ____ Seldom ____ Often (6 times a year)
(Check all that apply) ____ Anxiety ____ Frustration ____ Manic states ____ Depression

COUNSELING HISTORY

Previous Psychiatric or Psychological Services: ____Yes ___ No
Treatment Provider: _____ **Phone:** _____
Address: _____
Reason you were seeking care: _____
List any support groups you attend _____

Is there a family history of *(Check all that apply)* ___ Alcoholism ____ Substance Abuse ____ Mental Illness

Has anyone in your family been treated for a psychiatric disorder? ____ No ____ Yes **If yes, explain**___

INSURANCE INFORMATION (please show all insurance cards to receptionist.)

Primary Insurance Carrier:_____
Secondary Insurance Carrier:_____

_____ I hereby authorize South County Christian Counseling to release to my insurance company or its
Initial representative, any information regarding my treatment, including diagnosis, necessary to process my insurance claim.

_____ I hereby assign all my rights to benefits payable by my insurance company to South County Christian Counseling and thereby authorize and request my insurance company to pay my benefits directly to The Counseling Network.

_____ All insurance information has been listed correctly. I understand that if I have any other health *Initial* insurance coverage, including an HMO that is not listed above, any charges not covered by the listed insurance will be my responsibility.

_____ A Self-Pay Patient is one who does not have insurance, pays in full at the time of visit
Initial for our services and we are not required to file claim or submit any documentation on his/her behalf to a third party.

CANCELLATION & MISSED APPOINTMENT POLICY

A therapeutic relationship is built on mutual trust and respect. As such, every effort will be made to be on time for your scheduled appointment, and ask that you give the same courtesy of a call when you are unable to keep your appointment. Please read, sign, and date the cancellation & missed appointment policy below.

1. If you are unable to keep a scheduled appointment, you must contact the office via telephone at least 24 hours in advance.
2. If you fail to notify the office of your cancellation within the time stated above, and miss your scheduled appointment, a **$75.00 fee** for the session you have missed or cancelled will be charged.
3. At the time of cancellation, another appointment will be offered to you that may work better for your schedule.
4. Three (3) missed appointments – they need not be consecutive – can result in an administrative discharge from the practice.
5. To cancel or reschedule appointments, or if you need additional information, please call (314) 729-0481

I acknowledge that I have read and understand the above policies of South County Christian Counseling.

(A copy of this notice will be provided upon request.)

_____	_____	_____	_____
Signature of Client or Responsible Party	Printed Name	Relationship	Date

Letter of Policies & Procedures:

Please carefully read the information provided below. It contains important information you need to know regarding the counseling process. First, we are honored that you have chosen SCCC for therapy, and we are pleased to serve you. SCCC takes your situation very seriously with a deep commitment to help you in every way we can. In order to help the counseling process proceed most smoothly, let us suggest certain "process guidelines" which if followed, will result in an effective therapeutic relationship and the best use of the counseling services.

SCCC serves everyone according to ability to pay. We will not turn people away because of a lack of funds. It is important for you to remember, however, that the SCCC counselor whom you see will be paid only a portion of what you pay. SCCC counselors are not on salary. They are dependent upon how much you, and the other clients they see, are able to pay. Therefore, we ask you to evaluate your financial situation carefully and prayerfully and do the very best you can.

Remember SCCC has a necessary policy which requires a person to notify the office at least ***twenty-four (24) hours*** in advance to cancel your scheduled appointment in order to avoid having to be charged for your session (***48 hours for Monday appointments***). If we receive such advance notice we will have the opportunity to offer that time slot to others in need of counseling. If you do not give sufficient notice, not only will *you* not be receiving the counseling for that hour, but you will (unintentionally, of course) be preventing other clients from receiving services during that scheduled time as well. The SCCC Board of Managers requires payment for such missed sessions.

It is fair and reasonable to allow a "grace" period of lateness for either counselor or client. Fifteen minutes should be adequate for waiting. It would be courteous that after the fifteen minutes lapsed, the one who is departing leave notice indicating his/her having been there and the time he/she left. It is possible that there was a misunderstanding of the agreed to appointment time, although we wish to avoid all possible misunderstandings. We will always treat you with dignity and respect and part of that is to try to be on time for our consultations.

All services are provided in strict confidentiality. We will not release your records to anyone without your written and signed permission. See our Privacy Statement. It is necessary that we remind you that the law requires us to report any previously unreported child abuse. If we observe these guidelines, the counseling process will flow smoothly. We look forward to serving you.

Thank you,

ACKNOWLEDGEMENT

I, _____, hereby acknowledge that I have read and understand the above Statement of Policies and procedures, including that I will be charged if my scheduled appointment is not cancelled in the appropriate time as mentioned.

Signature: _____ Date: _____

Professional Services Agreement

I, _____, (Client OR parent/guardian of minor client, under 18)

_____ **Have read and understand** the contents of the **South County Christian Counseling Notice Form** which is
initial posted in the waiting area regarding the Protected Health Information (PHI) held by CCN for requested services. I understand this information will be handled in accordance with the HIPAA Privacy Rule, which affords me specific rights and responsibilities regarding my PHI. *A copy of this notice will be provided upon request.*

_____ **Give Informed Consent to Treatment** and this agreement indicates a commitment to enter into treatment with
initial the understanding of the basic ideas, goals, and methods of this therapy. I consent to keep the therapist up to date about any changes in symptoms or situation that may impact the success of treatment. I understand that with periodic evaluation of these goals may change to best serve my long-term interest.

_____ **Understand** that psychotherapy may arouse unpleasant feelings and emotional experiences particularly in the initial
initial phase of treatment. The relationships with significant others may also undergo substantial change during the course of treatment. If treatment is terminated, I agree to schedule a closing session with the therapist to discuss progress, outcomes of treatment, and any further clinical recommendations.

_____ **Understand the Counselor Limits of Confidentiality**
initial Information discussed in the therapy setting is held confidential and will not be shared without written permission except under the following conditions:

1. The client threatens suicide or physical harm to another person(s), including murder or assault
2. The client reports suspected abuse of a minor child (under 18), a spouse, or the elderly including but not limited to physical beatings and sexual abuse.
3. The client reports sexual exploitation by a therapist.
4. The court orders the therapist to testify or release records to the court.
5. The client threatens or causes property damage to the counseling center or therapist's property.

State law mandates that mental health professionals may need to report these situations to the appropriate person and/or agencies. Further, as a registered resident/intern who is under the supervision of a licensed practitioner, therapy sessions will be discussed with a supervisor or professional colleague as deemed necessary. Communication between the counselor and client will otherwise be deemed confidential as stated under the laws of this state.

CONSENT TO CONTACT

In accordance with the HIPAA Privacy Rule, we cannot leave a message for a patient at their home or workplace either with someone or on an answering machine unless we have your consent.

Please initial <u>one</u> of the following statements to indicate your preference

_____ **You MAY make contact** by phone to confirm appointments or notify me of cancellation by leaving a phone message at the following #'s

_____ _____ _____
(home) (work) (cell)

_____ **You MAY NOT contact** me by phone to confirm appointments or notify me of cancellations by leaving a phone message. I will be responsible for keeping scheduled appointments and I understand that a missed appointment fee will be charged for appointments cancelled less than 24 hours in advance or for not showing up for an appointment.

_____ _____ _____ _____
Signature of Client or Responsible Party Printed Name Relationship Date

Statement of Confidentiality

Consent for Limited Release of Information

South County Christian Counseling is a Not-for-Profit Corporation organized under the laws of the State of Missouri and is designated by the IRS as 501C(3) charitable, public, tax exempt organization.

It is the policy of South County Christian Counseling to protect to the maximum extent possible the privacy of every client. Generally, no one will be given any information about either you or services furnished to you without your prior written authorization or consent. There are, however, some circumstances which require the disclosure of information without your consent. Briefly, these are:

- When mandated by state or federal law (ie: suspicion or knowledge of child abuse/neglect, elder abuse, or abuse of the developmentally disabled, and proceedings to terminate parental rights).
- When there is an imminent risk or serious threat of physical harm to self or others (including suicidal or homicidal thoughts).
- For the purpose of professional supervision. All cases of South County Christian Counseling periodically may be reviewed or discussed with one or more supervisory therapists, including professionals under independent contract. The supervising professionals are obligated to maintain and follow all of South County Christian Counseling; guidelines concerning confidentiality.
- In cases where there is a third party pay, such as Health Insurance, an HMO, Medicare, Medicaid, etc., the client by agreeing to services under such a plan is deemed to have given authorization for the disclosure of any information reasonably required by such insurer, HMO, or other third party entity including diagnosis, treatment plans, etc., to determine whether or not coverage is provided.
- In the event there is an outstanding balance for which payment has not been made for a period of three months, the account will be turned over to a collection agency.
- When group therapy is provided, will stress to all participants of South County Christian Counseling the need to respect the privacy rights of all other participants and will stress that there should be no disclosure to others of information learned or acquired during the course of a group session. However, South County Christian Counseling cannot control the conduct or actions of other group members, and hence makes not representation or agreement concerning their conduct.

ACKNOWLEDGEMENTS

I, _____, hereby acknowledge that I have read and understand the above Statement of Confidentiality, including the provisions of the statement addressing the extent to which my counselor is permitted to disclose information about me. I give consent for my case to be reviewed in professional supervision.

Client/Parent Signature _____ Date _____
Spouse Signature _____ Date _____