Shelby Psychological Services

Adult Patient Registration Form

PATIENT INFORMATION					
Name		Birth Date	❒ Male ❒ Female	Social Security Number	
Street Address		City		State	Zip Code
School (if applicable)	Grade	Employer		Work Phone ( )	
Email Address				Home Phone ( )	
Primary Care Physician Name:				Cell Phone ( )	
How Did you Hear About Us? ❒ Physician ❒ Internet ❒ Yellow Pages ❒ Insurance Co. ❒ Other _____					

INSURANCE INFORMATION (Please provide your insurance card for office to copy)			
Primary Insurance		Primary Policyholder's (PP's) Name	
Primary Policyholder's Social Security #	PP's Birth Date	PP's Employer	Group number
Policy Number		Patient's Relationship to Primary Policyholder	
Secondary Insurance			
Primary Policyholder's Name	PP's Birth Date	PP's Employer	Group number
Policy Number		Patient's Relationship to Primary Policyholder	
Person Responsible for Bill and address if different			

Your Signature

Acknowledges:

- Accuracy of above information and financial responsibility to pay any balance and attorney if required for account collection
- Notice of HIPAA and State of Alabama policy and practices to protect your health information
- Consent for me or my minor child to be evaluated and/or treated by Shelby Psychological Services
- Dr. Vance has a small therapy-dog-in-training at SPS – we understand it is our responsibility to inform SPS staff if we do not want to interact with the dog.

Authorizes:

- SPS to release information required to process my insurance claim and for insurance benefits to be paid to SPS
- Consent to release treatment information to SPS providers only in the event of an interoffice referral
- Consent to release requested information to the referring physician/source
- Consent to release information for insurance purposes, when required, with supervising providers.

I have read, understand and acknowledge/authorize the above.

Printed Name of Patient/Guardian_____

_____ _____

Signature of Patient/Guardian **Date**

Shelby Psychological Services
FINANCIAL AGREEMENT

Patient/Guardian/Responsible Party Name:
_____

Please remember that insurance is considered a method of reimbursing the patient for the fee paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. Testing services are not always reimbursed. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL THE COST OF BILLINGS, IT IS REQUESTED THAT THE CHARGES FOR OFFICE VISITS BE PAID AT THE TIME OF THE VISIT. **APPOINTMENTS NOT CANCELED 24 HOURS PRIOR TO THE SCHEDULED TIME WILL BE CHARGED AT THE REGULAR RATE.** Automated reminder calls are sent out as a courtesy. However, computers do sometimes malfunction and phone numbers change etc. **YOU ARE STILL RESPONSIBLE TO KEEP YOUR APPOINTMENTS OR CANCEL ON A TIMELY BASIS** even if the reminder system does not work.

_____Please initial

If a provider receives a subpoena with an order to appear for court proceedings regarding this case, it is the client/guardian's responsibility to reimburse the provider for their time. This includes preparation time, travel time and actual time at court at the cost of $200/hour. A retainer fee of $1000 is required at the time of the request. _____Please initial

If this account is assigned to an attorney for collection and/or suit, I agree to pay a reasonable attorney's fee and cost of collection. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record. I hereby assign all medical benefits, to include any major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and/or other health plans to Shelby Psychological Services.

The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Patient/Responsible Party Signature _____Date _____

LESKA MEELER, MAMFC, S-LPC

Licensed Professional Counselor | Counseling Supervisor

205-664-4010 | **leska01@mac.com**

Shelby Psychological Services

1940 Highway 33 Unit A

Pelham Alabama 35124

INFORMED CONSENT / RIGHTS & RESPONSIBILITIES

Please initial each blank next to major headings, indicating that you have read and understood that section.

_____ **Some Things You Should Know About Your Counselor & The Counseling Process:** Since counseling is conducted in a number of different ways, depending upon the counselor and his or her orientation, this description has been prepared to inform you about Leska's qualifications, the therapeutic process, and general knowledge about what to expect from counseling.

_____ **Your Counselor's Qualifications:** Leska Meeler received her master's degree in marriage and family counseling and master's degree in religious education from Southwestern Baptist Theological Seminary in Fort Worth, Texas. Additionally, she holds a bachelor's degree in psychology from Samford University. Leska has been practicing as a Licensed Professional Counselor since 1999, licensed by the Board of Examiners in Counseling of Texas until 2003 when she moved back to her home state, Alabama. At that time, she transferred her professional license to the Board of Examiners in Counseling in Alabama. She also is credentialed by the state board as a Counseling Supervisor to supervise other clinicians working towards obtaining their licensure. She has specialized training to do EMDR therapy (Pt. 1 & 2).

The majority of her experience is working with individuals both youth and adults that have experienced trauma and loss, marriage and family/relationship counseling, pre-marital counseling, parenting issues, anxiety, spiritual issues and life transitions. She also has years of experience supervising and consulting other counselors, as well as, being a consultant for workplace transitions and management.

Leska's theoretical orientation is solution-focused brief therapy, which builds off of the strengths and assets available within an individual in order to tap into creating change in the areas of their lives that have become stagnant, or problematic. This is a goal-oriented therapy model that requires openness to the process and will entail an investment of time from the client to 'experiment' with practicing new ways of being outside of the therapy sessions. Leska takes a supportive role as the clients push outside of their comfort zones, but her goal is to be a catalyst to empower you to embrace the life you want for yourself. Therapy will not always '"feel comfortable." Changing old habits, or thought patterns, can be a difficult process, but the abundant life we were created to have and you desire for yourself is worth the effort.

Leska Meeler is not a physician and cannot prescribe or provide any medication. If medical treatment is indicated, she will recommend a physician or psychiatrist to you, depending on the nature of the concerns.

_____ **The Therapeutic Process:** You have made the first step on your road to feeling better by contacting a counselor. Like every important decision you make in your life, you may want to talk to several counselors about their training, treatment approaches, fees, and so on. "Shopping" for a counselor is often vital in getting the satisfaction you want from therapy. Before you decide on a counselor, be sure to get any questions you have answered to your satisfaction.

If you decide to enter into a counseling relationship with Leska Meeler, she will initially spend some time with you exploring the problems that brought you to counseling. This informational exchange will include questions about social and family history as well as the history of the problem. Next, you will work with Leska to set specific goals which you wish to work toward in counseling. Your progress will be periodically reviewed. The length of counseling will vary depending upon the type and amount of concerns you bring. At times, changes brought about by your efforts in counseling may cause you discomfort and anxiety; your feelings should be discussed with your therapist. These feelings often accompany behavioral change and are often a sign of progress. Nevertheless, you may find it helpful to discuss these feelings in counseling.

_____ **Records and Confidentiality:** As a client, one of your most important rights is that of confidentiality. All communication between client and counselor becomes part of the record. Records are the property of the counselor. Adult client records are disposed of seven years after the file is closed. Minor client records are disposed of seven years after the client's 18th birthday. Most communication between client and counselor is confidential. However, as with most things in life, there are exceptions. The same is true with confidentiality. There are times when Leska is allowed, and even required, to break client confidentiality. Please carefully read the following **limitations of confidentiality** below.

_____ **Limitations of Confidentiality:**

(a) The counselor determines the client is a danger to himself or someone else;
(b) The client discloses abuse, neglect, or exploitation of a child, elderly, or disabled person;
(c) The client authorizes the counselor to release records;
(d) The counselor is ordered by a court (including subpoenas) to disclose information;
(e) If counselor is otherwise required by law to disclose information, he must comply. (In marriage and family counseling, the meaning of confidentiality belongs to the relationship and not the individual.)

Leska will not hesitate to contact Child Protective Services or Adult Protective Services if she becomes aware or is suspicious that abuse or neglect of a child, elderly, or disabled person is occurring or has previously occurred.

_____ **Additional Considerations:** Just as confidentiality is a staple of the therapeutic process, so is honesty. Leska believes that in order to fully be in a position to help her clients grow and progress toward their goals; she and the client should always seek to be honest with one another. Dishonesty or failure to disclose pertinent information is viewed as detrimental to the therapeutic relationship. If a client willfully or purposely tells an untruth to the therapist, then the continuation of treatment will be subject to immediate review.

To insure quality control in therapy, Leska reserves the right to consult with therapist-colleagues regarding your counseling. This is similar to a physician getting a "second opinion," and can be very helpful in the counseling process. If professional consultation occurs, identifying information, such as your surname, will not be discussed during these consultations.

_____ Marriage/Family Counseling: Because counseling requires openness and honest disclosure, it is important that both parties feel safe to process information without fear of retribution in the case of a divorce. If a decision to divorce occurs, Leska asks that you **not** have your attorney subpoena her testimony regarding divorce or child custody, in the event of such hearings.

_____ **Your Rights as a Client:**

As a client you have the right to:

1) Ask questions at any point in time regarding therapeutic or office procedures.
2) Terminate counseling at any time; you may ask Leska for a list of possible referral sources.
3) Specify and negotiate goals and be an active participant in counseling.
4) Privacy/confidentiality, as designated above.
5) Be apprised of fees and payment policies.
6) Ask about alternative procedures available for meeting your goals.

_____ **Fees:** The private pay fee for a regular 50-minute individual, family or marital session is $95.00, for a 90-minute session, $135. You may ask the front office if I am a provider for your insurance (insurance rates are different), however, there are some services (Marriage Counseling) that are usually not covered by insurance. A sliding scale fee for certain times is available for clients that have budgetary restraints. Just discuss this with your therapist before, or during the first session. Phone sessions are available to existing clients at a billable rate of $40 per 30-minute session. The fee for each session will be due and must be paid in full at the beginning of each session unless other arrangements have been made. We accept cash (exact change only), personal checks, and credit cards (Visa, MasterCard, or Discover). There will be a $30 fee for checks returned for insufficient funds. At the conclusion of each session, the client can request a receipt that will contain the information necessary for reimbursement by a third party. Client may also work out third-party payment arrangements with a church or other charitable organization. You should keep your receipts for all services in a safe place for insurance/tax purposes.

_____ **A Word About Appointments and Cancellations:** Due to the demands of her caseload, responsibilities and need to spend quality time with her own support system and family, Leska must limit her hours of availability for counseling. She usually sees people on a weekly standing appointment or sometimes a bi-weekly basis. In a professional counseling relationship, it is expected that **all appointments will be kept**, except in very limited circumstances. Client will be charged the **full fee** for missed appointments when a **24-hour** notice is not given. Additionally, please note that late arrivals will still be charged for the entire session.

Please call 205-664-4010 to schedule appointments. Leave a message that you are calling for an appointment and someone will return your call within 24-hours during the business week.

_____ **Emergencies:** During office hours (9 a.m.- 5 p.m.), the client may contact the counselor at 205-664-4010. If the client is unable to reach the counselor in a timely manner, he should contact his physician, psychiatrist, a local emergency room, or 9-1-1. You can also call the Birmingham Crisis Hotline at 205-323-7777. It is the client's responsibility to seek the appropriate resources in emergency situations.

_____ **Session Length:** The initial diagnostic assessment interview generally lasts between 50-60 minutes. Follow-up sessions, whether individual or family, are 50-60 minutes in length unless you specifically request a 90-minute session. Some family sessions, couple's counseling, or EMDR sessions may be scheduled for 90-120 minutes, but this will be agreed upon by the therapist and client when making the appointment. This allows your counselor time to complete your case records and prepare for the next client. Leska asks that clients respect this policy out of courteous regard for both her and other clients.

_____ **Childcare is Not Available:** Leska is unable to provide childcare for clients. Please make arrangements for your children, as they will not be allowed to wander around or play unsupervised at the office due to insurance liability. Failure to secure appropriate childcare will result in a re-scheduling of the appointment and **will be subject to the full fee** for the time that was set-aside for you. While Leska has a heart for children, she also realizes the impossibility of significant progress in a counseling session where a parent is trying to care for a small child at the same time. The policy regarding childcare is designed with your best interests in mind. Please do not ask for exceptions to this rule.

_____ **Referrals:** In the event that either party decides that a referral is needed, Leska will provide some alternatives including programs and/or people who may be available to be of assistance. A verbal exploration of alternatives to counseling will also be made available upon request. The client will be responsible for contacting and evaluating those referrals and/or alternatives.

_____ **Complaints:** Clients are assured that counseling services will be rendered in a professional manner consistent with accepted legal and ethical standards. If at any time for any reason you are dissatisfied with services, you will agree to let Leska know so that this issue may be appropriately addressed and adequately resolved. If your concerns are not resolved, you may report complaints to the Alabama Board of Examiners in Counseling.

By client's signature below, client is indicating that he/she has read and understood this statement, or that any questions about this statement were answered to his/her satisfaction. The client has been furnished a copy of this statement. By counselor's signature, counselor verified the accuracy of this statement and acknowledges a commitment to conform to its specifications and hereby consents to provide counseling under the terms stated on this form.

_____	_____	_____	_____
Client Signature (age 14 & up)	Date	Leska Meeler, MAMFC, LPC -CS	Date

_____	_____
Client (Printed Name)	Date

I affirm that I am the legal guardian of _____. With an understanding of the above requirements, I do grant permission for my child to participate in counseling and release the counselor from liability.

_____	_____
Guardian Signature	Date

LESKA MEELER, LICENSED PROFESSIONAL COUNSELOR
PATIENT REGISTRATION FORM

PATIENT NAME:

Patient Name: Age: Sex: Male___
DOB: Female ___

Primary Guardian/s (if child):

Address: _____
City _____State _____Zip _____
Home phone: Work phone: Cell phone:
Preferred phone number which you would like us to contact you for appointment reminders:
_____ Email: _____
Referred by _____

RESPONSIBLE PARTY:

Name: Relationship to Patient :
Address: Date of Birth:

City/State/Zip: SSN:

Home phone: Work phone: Cell phone:
Employer Name: Employer Address:

INSURANCE INFORMATION (Primary) – Please check w/ provider if you are filing insurance. Your services may not be approved under insurance.

Carrier: Subscriber's Name :

Contract/Member Number: Group Number:

Subscriber's DOB: Subsriber's SSN:

Subscriber relationship to patient: Parent___
Guardian ___
Spouse ____
Self _____

INSURANCE INFORMATION (SECONDARY)

Carrier: Subscriber's Name :

Contract/Member Number: Group Number:

Subscriber's DOB: Subsriber's SSN:

Subscriber relationship to patient: Parent___
Guardian ___
Spouse ____
Self _____

New Client Intake Form/Psychosocial Assessment
[Couples will need to fill out this portion separately]

Name: _____ **Start Date:** _____

PROBLEM ASSESSMENT
Present problem – precipitating stressors: *"In recent months, I have worried a lot about…"*
(Circle all that apply.)

Marital Issues Health Issues Job Issues Financial Issues
Parent/Child Issues Issues of past (guilt, abuse, neglect, family of origin issues, etc.)
Other:
_____

Symptoms: *Please circle all that apply:*

Change in sleep pattern	Decreased concentration	Change in appetite
Increased anxiety	Decreased energy	Suicidal feelings
Decreased motivation	Anxiety/Worry/Panic	Mood swings
Anger Problems	Relationship Issues	Feeling Stuck

Other: _____

Suicidal/Homicidal Ideation:
Have you attempted to commit suicide or homicide in the past? ❑ yes ❑ no
If yes, how? _____

Is there a history of suicide in your nuclear and/or extended family? ❑ yes ❑ no ❑ not sure
Have you ever inflicted burns or wounds to yourself? ❑ yes ❑ no
Are you presently suicidal/homicidal? ❑ yes ❑ no

What event(s) in the recent past has/have prompted you to seek counseling?
_____
_____
Describe additional problems you are experiencing:
_____
_____
When did these problems develop?
_____

Circle any recent losses you have experienced?

Family Health Disruption of lifestyle Job
Significant other Other: _____

Are there any other things that can be helpful for your counselor to know about you?
_____
_____
_____

What do you most hope to gain from the counseling experience?
_____
_____
_____

List your strengths and weaknesses:

Strengths	Weaknesses
_____	_____
_____	_____
_____	_____
_____	_____

PSYCHIATRIC HISTORY

Please list any previous outpatient counseling experiences.

Place: _____

Length of time there: _____ **Dates:** _____

Place: _____

Length of time there: _____ **Dates:** _____

Have you ever been admitted to the hospital for mental health or addiction issues? ❑ yes ❑ no

Place: _____

Length of time there: _____ **Dates:** _____

Name of current doctor and/or therapist: _____

List all medications you have taken *in the past* for anxiety, depression, and/or sleep.

_____

_____

MEDICAL INFORMATION

How would you describe your current condition of health?

_____

Are you *currently* on any medication? ❑ yes ❑ no

Name of medication/purpose	Dosage/Frequency	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has it been more than a year since your last physical exam including blood tests? ❑ yes ❑ no

Females only answer the following three questions:

Have you ever had an abortion? ❑ yes ❑ no

Have you ever suffered a miscarriage? ❑ yes ❑ no

Have you ever had other complications in pregnancy? ❑ yes ❑ no If so, what?

_____

Do you have allergies? ❑ yes ❑ no If yes, explain: _____

List any previous health problems, operative procedures, and medical hospitalizations:

Problem	Dates	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there any other medical notes or health-related conditions your therapist should be aware of?
❑ yes ❑ no If so, please explain:_____
_____
_____
_____

SUBSTANCE ABUSE HISTORY
Describe your current usage, or usage within the past year (including alcohol, caffeine, and tobacco).

Substance	Amount/Frequency	Age of 1st use	Last use
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you experienced a recent increase in the use of alcohol and/or other substances? ❑ yes ❑ no Do you see your current usage as a problem? ❑ yes ❑ no
If yes, when did it become a problem?_____
_____

Describe any significant family history of substance use/abuse.
_____
_____

NUTRITION
Have your eating habits changed recently? ❑ yes ❑ no If yes, please describe:
_____
Has your weight fluctuated more than +/- 10 lbs. over the previous year? ❑ yes ❑ no
Do you often eat out of depression, boredom or anger? ❑ yes ❑ no If yes, please describe:
_____
Do you ever self-induce vomiting? ❑ yes ❑ no
How do you feel about eating with others in a group? _____
Do you ever binge eat or feel your eating is out of control? ❑ yes ❑ no If yes, please describe:
_____
If you use laxatives, water pills (diuretics), or diet medications, how often do you use them?
_____

Do you consider your current eating habits to be healthy? ❑ yes ❑ no

LEGAL HISTORY
Please explain all that apply:

- ❑ Charges as a minor:
  _____
- ❑ Charges presently:
  _____
- ❑ Arrests: (how many)
  _____
- ❑ Incarcerations (how many):
  _____
- ❑ Parole:
  _____
- ❑ Convictions: (how many)
  _____
- ❑ Bankruptcy or Civil Suits:
  _____
- ❑ Child Custody Problems:
  _____

DEVELOPMENTAL HISTORY
List members of your family of origin and how you got along with each one.

Family Member	Comments
_____	_____
_____	_____
_____	_____
_____	_____

What was your birth order? _____ of _____ children
Who primarily raised you? _____
How would you describe your childhood? ❑ Traumatic ❑ Painful ❑Uneventful

What were you like as a child? (Include friends, school, hobbies, and personality):
_____
_____
Were there any unusual or traumatic experiences for you as a child?

Date	Age	Event
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What is your sexual orientation? ❑ Heterosexual ❑ Homosexual ❑ Bisexual

LIVING ARRANGEMENTS
❑ Satisfactory? ❑ Unsatisfactory?

Where do you currently live? _____ How long there? _____
With whom are you living?_____

SUPPORT SYSTEM
Who can you count on for support? *Circle as many as apply.*

Parents Spouse Siblings Employer Church Pastor
Therapist Ext. Family Friend Co-worker Medical Doctor
Other: _____

MARITAL HISTORY (If applicable):
Name and age of spouse:_____ Date of Marriage:_____
Previous marriage(s)? ❑ yes ❑ no If yes, date(s) of divorce(s):
_____
Any children from previous marriage(s)? ❑ yes ❑ no
What is your perception of your current marriage *(Include communication patterns, problems, & sexual relations):*
_____
_____

List names and ages of children. How do you get along with each one?

Name	Age	Comment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FINANCIAL SITUATION
Describe briefly your current financial situation:

_____
_____

RELIGIOUS/CULTURAL FACTORS
Please list any issues which are important or may have affected you in regard to religion or ethnic/cultural background.

_____
_____
_____

What is your religious background?
_____
Do you currently attend church, synagogue, or mosque? ❑ yes ❑ no

WORK ADJUSTMENT HISTORY
Describe your current job/career:

_____
_____

Would you enjoy doing this job on a long-term basis? ❑ yes ❑ no ❑ not sure
If you could have any job/career, what would you choose? _____
How many jobs have you held within the previous five years? _____

MILITARY HISTORY (If applicable):
List branch, dates, and duties.

_____
_____

EDUCATIONAL HISTORY
Highest level achieved: _____
School issues? _____
Currently in school? ❑ yes ❑ no If yes, what level? _____

FAMILY PARTICIPATION
Would it be beneficial for any members of your family to be involved in your treatment?
❑ yes ❑ no If yes, explain who and why? _____
_____

All information reported in this PSYCHOSOCIAL ASSESSMENT is true and accurate to the best of my knowledge.

_____ _____
Patient's Signature (age 14 & up) Date

_____ _____
Patient's Guardian's Signature (if patient under 18) Date