Client Information Form

GENERAL INFORMATION

TODAY'S DATE_____

NAME OF PERSON COMPLETING THE FORM_____

RELATIONSHIP TO THE MINOR_____

CLIENT'S
NAME_____
Last First Middle Initial

MINOR'S CELL PHONE (if applicable):_____ Okay to leave message: Y ❑ N ❑

Guardian 1:
NAME_____
Last First Middle Initial

MAILING ADDRESS_____
(If different from client) Street City State/ZIP

Preferred? Leave Message?
HOME PHONE:_____ ❑ Y ❑ N ❑ Email Address:_____

CELL PHONE:_____ ❑ Y ❑ N ❑ Ok to send Text Message? Y ❑ N ❑

WORK PHONE:_____ ❑ Y ❑ N ❑

Guardian 2:
NAME_____
Last First Middle Initial

MAILING ADDRESS_____
(If different from client) Street City State/ZIP

Preferred? Leave Message?
HOME PHONE:_____ ❑ Y ❑ N ❑ Email Address:_____

CELL PHONE:_____ ❑ Y ❑ N ❑ Ok to send Text Message? Y ❑ N ❑

WORK PHONE:_____ ❑ Y ❑ N ❑

Please list the names, address, and phone numbers of any other legal guardians not listed above:

_____

_____

PRESENTING PROBLEM

What brings you to counseling at this time?

_____

_____

_____

Have you (or your family members) ever been involved in counseling? ❑ Yes ❑ No

If yes, with whom?_____ When?_____

Reason(s): _____

Is the client in treatment with another counselor at this time? ❑ Yes ❑ No If yes, with whom? _____
Reason_____

MEDICAL HISTORY/HEALTH CONDITIONS

Date of Last Physical_____ Date of Last Visit_____

Please indicate if the client have now or have had any of the following conditions:

____ Arthritis	____ Asthma	____Back Problems	____ Cancer
____ Chronic Lung Problems	____ Diabetes	____Hearing Problems	____ Heart Problems
____ High Blood Pressure	____ Kidney Problems	____ Stroke	____ Thyroid Problems
____ Vision Problems	____ Weight loss/gain	____ Chronic Pain	____ Headaches
____ Stomachaches	____ Ulcer/Gastrointestinal Problems		____ Behavioral Problems
____Seizures	____ Eating Disorder	____Sleep Problems	____Anxiety
____Chronic Headaches	____Suicidal Thoughts	____Head Injury	____Changes in Appetite
____Depression	____Chronic Fatigue	____Self-Harm	____ADHD
____PMS			

____ Other _____

____ Other _____

____ Other _____

____ Other _____

____ Other _____

Please list all prescribed medications (Medication, Dosage, Frequency, & Name of Prescribing Physician)

_____

_____

Name of Psychiatrist (if applicable) _____ Phone_____

Notice of Privacy Practices

Client Name_____

This notice describes how Medical/Mental Health Information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Effective 01/01/2014, Amy Ray Counseling Services will only release information in accordance with state and federal laws and the ethics of the counseling profession. The following describes policies related to the disclosure of client's healthcare information. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality of care. State and Federal Laws allow Amy Ray Counseling Services to use and disclose health information for these purposes.

USES and DISCLOSURES

- *Help manage the health care treatment you receive* – Example: A psychiatrist sends information about your diagnosis and treatment plan so additions or changes in your care can be provided
- *Payment* – Example: Verifying your insurance coverage or processing claims to collect fees
- *Healthcare operations* – Example: Site review for compliance
- *Other uses and disclosures without your consent* – Example: Mandated reporting to a suspected crime or abuse

CLIENT RIGHTS

- Right to request where to contact or notify you

			Number or email to use:
Home	___YES	___NO	_____
Work	___YES	___NO	
Cell	___YES	___NO	_____
Email	___YES	___NO	
Voice Mail	___YES	___NO	_____

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask to limit the information shared
- Get a list of those with whom your information has been shared
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

You can complain if you feel we have violated your rights by contacting Amy Ray with Amy Ray Counseling Services, LLC. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** I will not retaliate against you for filing a complaint.
Amy Ray Counseling responsibilities include: 1. Required to maintain the privacy and security of your protected health information. 2. Let you know promptly if a breach occurs that may have compromised the privacy or security of your information. 3. Follow the duties and privacy practices described in this notice and give you a copy of it. 4. Not use or share your information other than as described here unless you inform Amy Ray Counseling Services, LLC in writing. If you inform in writing, you may change your mind at any time. Inform Amy Ray Counseling Services, LLC in writing if you change your mind.

*Client Signature (age 14 & up)*_____ Date _____/_____/_____

*Guardian Signature*_____ Date _____/_____/_____

Checklist of Concerns

(please check any relevant concerns)

THOUGHTS/FEELINGS/MOOD

- ❑Anger/frustration/hostility
- ❑Anxiety, nervousness
- ❑Attention, concentration, distractibility
- ❑Confusion
- ❑Depression
- ❑Disliking others
- ❑Emptiness
- ❑Euphoria
- ❑Excessive worry
- ❑Failure
- ❑Fatigue
- ❑Fear
- ❑Grieving (death, loss, divorce, etc)
- ❑Guilt
- ❑Hearing things other people don't
- ❑Homicidal thoughts
- ❑Intrusive thoughts
- ❑Judgment problems
- ❑Memory difficulties
- ❑Negative thoughts
- ❑Obsessive thoughts
- ❑Oversensitivity to criticism
- ❑Oversensitivity to rejection
- ❑Panic attacks
- ❑Perfectionism
- ❑Sadness
- ❑Seeing things other people don't
- ❑Self-centeredness
- ❑Self-esteem (low)
- ❑Shyness
- ❑Spiritual, religious, or moral issues
- ❑Stress
- ❑Sudden mood changes
- ❑Suicidal thoughts
- ❑Suspiciousness
- ❑Temper problems
- ❑Thoughts of hurting self or others

BEHAVIOR

- ❑Aggression, violence
- ❑Alcohol use
- ❑Argumentative
- ❑Avoidant
- ❑Compulsive behavior/rituals
- ❑Controlling
- ❑Decreased/lack of sexual interest
- ❑Dependency
- ❑Destruction of property
- ❑Drug use: prescription, over-the-counter, street
- ❑Eating problems
- ❑Financial problems, debt
- ❑Gambling
- ❑Hyperactivity
- ❑Internet problems
- ❑Irresponsibility
- ❑Isolation
- ❑Legal problems
- ❑Letting others take advantage of you
- ❑Lying
- ❑Not able to relax
- ❑Preoccupation with sex
- ❑Procrastination
- ❑Purging
- ❑History of running away
- ❑Self destruction/sabotaging
- ❑Self-neglect
- ❑Sexual dysfunction
- ❑Smoking
- ❑Stealing
- ❑Threats
- ❑Weight, gain/loss
- ❑Withdrawal from others
- ❑Loss of interest in what I used to like
- ❑Sleep difficulty
- ❑Loss of appetite
- ❑Overeating

FAMILY & RELATIONSHIPS

- ❑Affair
- ❑Childhood issues (client's childhood)
- ❑Divorce
- ❑Friendships
- ❑Housework/chores
- ❑Interpersonal conflicts
- ❑Parenting
- ❑Problems w/ child(ren)
- ❑Problems w/ parents
- ❑Problems w/ spouse/partner
- ❑Separation

ABUSE

- ❑Abuse of alcohol
- ❑Abuse of drugs
- ❑Physical abuse by another
- ❑Physical abuse of another
- ❑Sexual abuse by another
- ❑Sexual abuse of another

WORK & SCHOOL

- ❑Absenteeism
- ❑Career concerns, goals, choices
- ❑Difficulty with coworkers
- ❑Difficulty with supervisor
- ❑Performance
- ❑Tardiness
- ❑Procrastination
- ❑School problems

OTHER CONCERNS

❑_____ ❑_____ ❑_____

_____ _____ _____

❑I have no problems or concerns bringing me here.

Initial Child/Adolescent Guardian Questionnaire

Any concerns with pregnancy, delivery, or meeting developmental milestones (i.e. walking, talking, toilet training) or regression in development (i.e. was toilet trained but began urinating or having bowel movements in inappropriate places)?

_____

_____

_____

Please describe any academic concerns:_____

Has your child ever been:

Evaluated for a learning disability?	Yes	No
Placed in Special Education or Gifted Classes?	Yes	No
Does your child have current Individual Education Plan (IEP)?	Yes	No
Does your child have a current 504 plan?	Yes	No

List all persons currently living in a patient's primary household:

Name	Age	Sex	Relationship to client
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What type of discipline has been used both in the past and currently with your child? What has been ineffective and effective?

_____

_____

What would you like to see improve for your child/adolescent?_____

_____

Any further information you think would be helpful to share_____

_____

_____

Consent for Counseling

Thank you for choosing Amy Ray, LLC for your counseling needs. I am committed to giving you the best care possible. To acquaint you further with the procedures and policies, I am providing the following information regarding services and limitations.

COUNSELOR'S CREDENTIALS: I received a Master of Education with a concentration in Agency Counseling from the University of Montevallo in 2004. I am a Licensed Professional Counselor (LPC), a National Certified Counselor (NCC), and a Registered Play Therapist. Play therapy is a counseling method that can be helpful to use when children are involved in the counseling process.

PURPOSE & METHODS: My purpose is to work with you to determine what goals you have for personal growth explore possible ways to achieve those goals. The frequency and method vary depending on your individual circumstances. Counseling sessions are typically fifty-five minutes for adults and adolescents. Sessions for children may be 30 to 55 minutes depending on the individual needs of the child. With minor clients, communication with caregivers will occur as needed to help reinforce skills learned in the counseling sessions. Updates regarding concerns from caregivers are helpful as well to guide the counseling process. I use a variety of approaches and techniques in counseling and may ask caregivers to participate in the process. You always have the right to decline participation in or the use of certain therapeutic techniques. Please feel free to ask questions about any approaches or techniques used in sessions.

CONFIDENTIALITY: An essential aspect of counseling is confidentiality. I strive to maintain privacy and uphold the ethics of confidentiality. This includes all verbal, written, and recorded data concerning your treatment, which may not be released without your written consent. Limitations to these rights are: 1) I have a legal duty to warn and protect persons threatening harm to self or others; 2) I have a legal duty to report to proper authorities any indication that abuse to a child or vulnerable adult may have occurred. 3) I am required to comply with Alabama State Laws in regard to court ordered subpoenas/court testimony. 4) If you request services to be covered by your insurance company or your Employee Assistance Program, they will require the counselor provide information and may request further information about the counseling sessions to authorize reimbursement. Amy Ray, LLC is affiliated with Shelby Psychological Services and utilizes their services to manage billing and administrative needs. If you choose to keep a third-party informed of your progress in counseling, it will be necessary to complete an "Authorization to Release Information" form that will be kept on file.

Your client record is the property of Amy Ray, LLC and shall be treated as confidential. To comply with state and federal laws regarding client confidentiality, your records will not be released without properly executed written consent. Amy Ray, LLC will maintain your record for at least 7 years past the date of your last appointment at which that point in time the records will be erased. Any paper records will be scanned for electronic storage and the paper copy will be shredded. In signing this consent, you are agreeing that any electronic signatures or scanned copies of original signatures are as binding as an ink signature. In the event of my death, a custodian of records has been assigned. Currently, the assigned custodian of records is: Paul Johnson, Life Practical Counseling, 5520 Hwy 280 Suite 4 Birmingham, AL 35242, (205) 807-6645.

CONSULTATION AND SUPERVISION: It is common practice for counselors to consult with other professionals or colleagues about issues that arise within therapy. The minimum amount of information needed for consultation is given to continue to protect confidentiality.

REGARDING DIVORCE AND CUSTODY LITIGATION: If you are involved in divorce of custody litigation, my role as a counselor is not to make recommendations to the court concerning custody or parenting issues. By signing this consent form, you agree to not have me subpoenaed to court for testimony or for disclosure of treatment information in such litigation; and you agree not to request that I write any reports to the court or to your attorney making recommendations. The court can appoint professionals, who have no prior relationship with family members to conduct an investigation or evaluation and to make recommendations to the court.

RISK: Counseling comes with potential risks and benefits. Counseling can be emotionally painful at times. Counseling also involves change. Processing areas of your life and learning new ways of thinking, feeling, and behaving can cause discomfort for you and others around you. While there is hope that improvement will occur as part of the therapeutic process, this is not a guarantee. Commitment to the counseling process increases the opportunity for benefits from counseling to occur. Please ask for any clarification that may help you feel more comfortable.

REFERRALS: The counselor reserves the right to terminate the counseling relationship for any reason deemed to be in the client's best interest. If the counselor or the client believes continued counseling is needed, the counselor will provide other referrals. If a client expresses a desire to find another counselor, the counselor can provide a referral and can be contracted to provide a summary of work to the new counselor at the current hourly rate, with a minimum of one hour and a maximum of two. Summaries will be delivered within four to six weeks of payment.

EMERGENCY SERVICES AND AFTER HOURS CONTACT: Amy Ray, LLC does not provide emergency services. In the event of an emergency, call 911 or go to the closest emergency department. For urgent concerns after hours, please contact the Crisis Center at 205-323-7777.

COMMUNICATION: Phone calls are typically returned during the hours of 8:00 am to 3:00 pm Monday through Friday. Telephone sessions lasting over 20 minutes will be charged at a rate of current hourly fees. The use of emailing and texting may be used at times if you agree to this. Please be aware that emailing and texting as forms of communication may compromise confidentiality. Communication through text or email is not a requirement of this consent.

FOR CAREGIVERS OF MINOR CLIENTS: Caregivers are expected to stay on the premises of the counseling office the entire time the minor client is in session. At times, caregivers may be asked to participate in sessions with the client to help facilitate treatment plan goals for the clients. For clients under the age of 14, all custodians are requested to sign this consent for treatment for the child. Any client 14 years or older will need to sign consent for treatment as well.

I have read the preceding information. By signing below, I acknowledge my understanding and agree to all the terms discussed in this consent for treatment form.

Client Signature (Age 14 and older) Date

Guardian's Signature Date

Guardian's Signature Date

Amy Ray M.Ed., LPC Date

1940 Co Rd 33, Suite A
Pelham, AL 35124
(205) 664-4010

Shelby Psychological Services

Minor Client Registration Form

CLIENT INFORMATION					
Name		Birth Date	❒ Male ❒ Female	Social Security Number	
Street Address		City		State	Zip Code
School	Grade	Patient /Guardian Employer		Work Phone ( )	
Responsible Party's 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		Policy Holder's Name	
Policy Holder's Social Security #	Birth Date	Employer	Group number
Policy Number		Client's Relationship to Policy Holder	
Secondary Insurance			
Policy Holder's Name	Birth Date	Employer	Group number
Policy Number		Client's Relationship to Policy Holder	
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 HIPPA and State of Alabama policy and practices to protect your health information
- Consent for my minor child to be evaluated and/or treated by Shelby Psychological Services (SPS)
- 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
- I am legally authorized to consent to treatment for this minor

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.

_____	_____	_____
Signature of Client (age 14-18)	Printed Name of Client	Date
_____	_____	_____
Signature of Parent/Guardian	Printed Name of Parent/Guardian	Date
_____	_____	_____
Signature of Parent/Guardian	Printed Name of Parent/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 _____