**Client Information Sheet**

**PLEASE PRINT**

FIRST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MI: \_\_\_\_ LAST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If client is under 18 years old: parent/guardian /DCS name and phone number:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_

May I contact you at the mailing address above? Yes No \_\_\_\_\_\_\_\_\_ Initials

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I contact you at this number? Yes No \_\_\_\_\_\_\_\_ Initials

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I contact you at this number? Yes No \_\_\_\_\_\_\_ Initials

Will you accept text appointment reminders? Yes No \_\_\_\_\_\_\_\_\_\_ Initials

E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May I contact you at the email address above? Yes No \_\_\_\_\_\_\_\_\_ Initials

Birth Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: Male\_\_\_\_\_\_\_\_\_ Female\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number of the Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: \_\_\_\_Minor \_\_\_\_Single \_\_\_\_Married \_\_\_\_Separated \_\_\_\_\_Divorced \_\_\_\_Widowed

Place of Employment/School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May I contact you at this number? Yes No \_\_\_\_\_\_\_\_ Initials

Student: Full-time\_\_\_\_\_\_\_\_\_\_\_ Part time\_\_\_\_\_\_\_\_\_\_\_ Non-student\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact/Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychiatric Advance Directive**

In the event that I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have a psychiatric emergency and am incapable/ incompetent to make a decision for myself regarding my psychiatric care, I designate the following person to do so:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY CARE PHYSICIAN**

For coordination of care, I ask that you provide the name of your primary care physician. I can make contact with your physician to inform them of the counseling services that you will be receiving, if you would like. By providing this information and your signature, this gives me authorization to make contact, as required, regarding your treatment.

**If you do not have a Primary Care Physician or you do not want me to make contact,**

**Initial\_\_\_\_\_\_\_\_ and Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Physician name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REFERRAL SOURCE**

I would like to thank whomever referred you to my office. By providing the following information and your signature, this gives me authorization to send a “Thank You letter” on behalf of the office. If you do not wish for me to do this, please leave this area blank**.**

Name of individual referring you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DECLARATION OF PRACTICES AND PROCEDURES**

MAI Counseling Services

115 East Main Street C-2 Lebanon, TN 37087

Fax: (615) 396-3188

Jennifer Reeves, LPC – MHSP, NCC Kristi L. Ward, MA

 maicounseling@att.net Kwardtn.lpc.emdr@gmail.com

 P: 615-969-7066 P: (615) 294-2419

**Qualifications**:

**Jennifer:** I earned a Master of Arts degree in Professional Counseling from Argosy University in Nashville, TN in 2007. I am a Licensed Professional Counselor #3005 with the Tennessee Licensed Professional Counselor Board.

**Kristi:** I earned a Master of Arts degree in Professional Counseling from Argosy University in Nashville, TN in 2011, graduating summa cum laude. I have been a practicing therapist since October, 2011.

**Areas of Focus**:

**Jennifer:** I approach counseling from a Person-Centered Approach, which recognizes that everyone is an individual with a unique history, strengths and potential. I also utilize a cognitive-behavioral approach to counseling, working with clients to identify patterns of emotions, thoughts, and behaviors to first understand problems and then develop realistic solutions. I strive to increase a client’s insight and self-awareness. I also am trained in Eye Movement Desensitization and Reprocessing (EMDR), which enables people to heal from symptoms and emotional distress which are a result from disturbing life events.

**Kristi:** I focus on individual and family counseling. Many things hold us back from reaching our full potential, and those are usually rooted in painful memories or negative beliefs about ourselves. My goal is to help you identify and reshape those memories and beliefs that have been holding you back. I use a combination of evidence-based therapies in a trauma-informed practice. I want to help you address your past so that it stops interfering with your present. Through this journey, I wish for all of my clients to have better and brighter futures. Thank you for choosing me.

**Fees**: Clients are seen by appointment only and fees vary by service type. Cancellations must be made 24 hours prior to your appointment time. **No-show appointments/Cancellations within 24 hours of appointment will be charged $75**

* Acknowledged and agreed-upon session cost is \_\_\_\_\_\_\_\_\_\_\_
* Therapy sessions are typically 50 minutes
* $25.00 per page for correspondences
* $50.00 Copying of your chart
* $150.00 per hour for court appearances – including all time spent waiting in court for your case to be heard

**\_\_\_\_\_\_\_\_ Client Initial as acknowledgement regarding appointment and no-show fees**

**Guarantee of Payment:** For value received, the client hereby unconditionally guarantees the prompt payment of all charges, hereby agreeing to pay all cost and expenses incurred in enforcing this guarantee. In the event the client/guardian fails to comply with their obligation herein, each consent to the disclosure of their identity and any other necessary information relating to service rendered to any collection agency or attorney at law, for the purpose of enforcing the client/guardian’s obligation to the therapist and the re-disclosure of such information by the collection agency or attorney. Such disclosure or re-disclosure shall not be deemed to be a breach of the patient confidentiality by MAI Counseling Services, Jennifer Reeves, LPC-MHSP, NCC or Kristi Ward, MA.

\_\_\_\_\_\_\_\_ **Client Initial as acknowledgement regarding collections reporting**

**Code of Conduct**: As a Counselor, I am required by law to adhere to the Code of Conduct that has been adopted by the Tennessee Licensing Board, a copy of these codes are available upon request.

**Snow Policy**: If Lebanon Special School District is closed due to snow the office will be closed also – unless communicated otherwise.

**Privileged Communication**: Material revealed in counseling sessions will remain strictly confidential, except under the following circumstances in accordance with state law:

a) The client signs a written release of information

b) The client expresses intent to harm him/herself or someone else

c) There is reasonable suspicion of abuse/neglect against a minor, elderly person (60 or older), or dependent adult

d) A court order is received directing the disclosure of information

**Client Responsibilities**: You, the client, are expected to be an active participant in counseling. Your honesty and effort are crucial to success. As we work together, please share with me any concerns or suggestions you have so that we can consider adjustments for improvement. If it develops that you would be better served by another mental health provider, I will assist you with the referral process. If you are currently receiving services from another mental health professional, I expect you to inform me of this and grant me permission to share information with this professional so that we may coordinate our services to you.

**Emergency Situations**: If an emergency situation arises and an immediate response is necessary, you may seek immediate assistance by reporting to the closest hospital emergency room or by calling 911.

**Physical Health**: Being physically healthy is an important factor in your emotional well-being. If you have not had a physical exam in the last year, it is recommended that you do so. Also, please discuss with me any medication you are currently taking.

**Potential Counseling Risk**: During mental health counseling, certain additional issues may surface during our sessions that you were not previously aware of. This may cause additional stress for you or your relationships. If any new concerns arise, please share these new concerns with me.

**I have read and understand the above information and agree to enter into this counseling relationship.**

Client Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Counselor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Use of Insurance**

Providers who participate in insurer contracts are obligated to verify client insurance status prior to providing services.You have the right to opt not to use your insurance coverage for any reason; however, you are required to formally document your decision.

**CLIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**By signing below** *(select the applicable agreement)***, I attest that I understand and agree to the following regarding my insurance coverage and I agree to immediately notify my provider of any changes to my insurance status in the future.**

**I have insurance and intend to use it.** I hereby authorize the release of all information necessary to secure payments from my insurance company. For in-network services I assign payments directly to my provider; for out-of-network services I will receive payments directly from my insurer if applicable. I understand my insurer will only estimate my benefits in advance of services and will not guarantee the estimate until after claims are processed. I understand that I am financially responsible for payments if my insurer denies a claim for any reason. Reasons claims may be denied include if my deductible is not met, if my benefits change in new term periods, if I exceed the number of allowed sessions in a term, or if medical necessity for treatment is denied. I understand should payment not be made by the insurance company ninety days from the date of service received I will be financially liable. Failure to do so will result in disclosure to collection agency or attorney at law shall not be deemed to be a breach of the patient confidentiality by MAI Counseling Services.

**Signed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Services Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claims Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Myself □ Spouse □ Parent □ Other

Insured’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Services Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claims Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Myself □ Spouse □ Parent □ Other

Insured’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I have IN-NETWORK insurance and DO NOT wish to use it or am aware services are NOT COVERED by my policy.** I will pay my insurer’s total allowable charge for services and waive rights to reimbursement. I cannot request retroactive billing to my insurance if I change my mind in the future.

**Signed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

**I have OUT-OF-NETWORK insurance and do not want to file out-of-network claims.** I cannot request retroactive billing to my insurance if I change my mind in the future.

**Signed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

**I do not have insurance** and understand I am responsible for my provider’s self-pay rates as set in my payment policy.

**Signed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

**Adult Comprehensive Clinical Assessment**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_ Gender: \_\_\_M \_\_\_ F

Marital Status: (circle one) *single/never married married separated divorced widowed living with someone*

Please CIRCLE ALL of the following that describe how you have been feeling lately:

*Sad anxious depressed frightened guilty angry ashamed aggressive resentful worthless tearful irritable confused extreme up extreme down jealous hopeless helpless*

Describe any other feelings you have had: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you participate in regular exercise: Yes No (circle) Hobbies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Describe your current working environment: ­

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any changes in your sleeping habits? Yes No (circle) describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you had any changes in eating habits? Yes No (circle) describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

THOUGHTS: Please check any of the following that apply to you:

\_\_\_ I sometimes hear voices, even though no one nearby is talking to me

\_\_\_ I sometimes wish I were dead

\_\_\_ I sometimes want to kill myself

\_\_\_ I sometimes feel that forces outside of me control me

\_\_\_ I sometimes feel that other people control my thoughts

\_\_\_ I sometimes have the same thought over and over and cannot control it

\_\_\_ I sometimes feel that someone is out to hurt me or to do something against me

\_\_\_ I sometimes am unable to control my behavior

Please list your Therapy Goals:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client-Informed Consent for Telehealth Counseling Services

I hereby consent to engage in online teletherapy services for myself/my child with MAI Counseling Services. I understand that teletherapy includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that online counseling/teletherapy also involves the communication of my medical/mental information, both orally and visually.

I understand that I have the following rights with respect to online counseling/teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

2. The laws that protect the confidentiality of my medical information also apply to online counseling/teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are limits and exceptions to confidentiality with teletherapy, just as there are with in-person therapy. I am in agreement with these limits/exceptions, and understand that my therapist will explain these to me in detail if I wish.

3. I understand that there are risks and consequences from online counseling/teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapist, that: the transmission of my information could be disrupted or distorted by technical failures.

\*\* I understand that if the teletherapy session does get disconnected, my therapist will call me back by phone, to complete our session.

4. In addition, I understand that online counseling/teletherapy based services and care may not be as complete as face-to-face services. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my counselor, my condition may not be improve, and in some cases may even get worse.

5. I understand that I may benefit from online counseling/teletherapy, but that results cannot be guaranteed or assured.

6. I accept that online counseling/teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911; or proceed to the nearest hospital emergency room for help; or call my primary care physician or psychiatrist. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support. I can also call the Teen to Teen Crisis Line at **1-800-454-TEEN or the Tennessee Statewide Crisis Hotline at 1.855.CRISIS.1.**

7. I understand that I am responsible for (a) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions and (b) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my online counseling/teletherapy session.

**I have read, understand and agree to the information provided above.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Client/Guardian Printed Name

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Client/Guardian Signature

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date

**CONSENT FOR DISCLOSURE**

MAI Counseling Services

115 East Main Street C-2 Lebanon, TN 37087

Fax: (615) 396-3188

Jennifer Reeves, LPC – MHSP, NCC Kristi L. Ward, MA

 maicounseling@att.net Kwardtn.lpc.emdr@gmail.com

 P: 615-969-7066 P: (615) 294-2419

My Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ My Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ My Telephone: \_\_\_\_\_\_\_\_\_\_\_\_

Person(s) I am consenting disclosure to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Their relationship to me: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Their address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason(s) for disclosure: (check all that apply)

\_\_\_\_\_\_ I would like to list this person as my Emergency Contact in the event I experience illness or injury.

\_\_\_\_\_\_ I would like MAI Counseling to consult with this person regarding my medical or behavioral health

treatment.

\_\_\_\_\_\_ I am requesting MAI Counseling to assist me with a referral to this person.

\_\_\_\_\_\_ I would like this person to send my records to MAI Counseling. (Please list any restrictions or

instructions below.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_ I would like MAI Counseling to send my records to this person. (Please list any restrictions or

instructions below.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_Other (as specified below)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*As the above-named client, I authorize MAI Counseling Services to disclose information about me to the individual(s)listed above. My consent will expire one year from today’s date, unless I otherwise specify an*

*expiration date here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Signature Today’s Date*

**Credit Card Authorization**

I require that a credit or debit card be kept in my files in order to bill for any missed appointments (*This card will only be charged with your permission OR in the event that you have not showed for an appointment and have not contacted me to settle your payment*).

*Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 *Name on Credit Card (if different from client): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 *Fee (for missed appointment/cancellation within 24 hours): $75.00*

*Method of Payment: \_\_\_\_\_ Visa \_\_\_\_ Mastercard \_\_\_\_ Amer Exp \_\_\_\_\_\_ Discover Card*

*Card #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Exp. Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CVC Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 *Billing address (must match the address the credit card company has on file): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*I authorize MAI Counseling Services to keep my credit card information confidentially filed with my session records to use as payment for a session cancelled within 24 hours or in the case of failure to show for an appointment. I understand I must provide cash or check should my credit card be declined.*

*Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*