<u>ADULT</u> application for services

(Couples: Please complete a separate application for each party)
(Please complete all sections that are applicable to you)

Client's Name: _____Today's Date: _____

Social Security Number: _____

Address: _____

_____

Phone: (Home) _____ Phone (Work) _____

Phone: (Cell) _____

Emergency Contact Name: _____ Phone: _____

Client's Date of Birth: _____ Age: _____ Gender: _____

Client's Ethnicity:_____

Client's Employer (or School): _____

Occupation: _____

Who referred you to this office? _____

Briefly describe your reasons for requesting services:_____

_____

List any previous mental health services you have received: _____

_____

Please list any medications you are taking: _____

Family Life Counseling and Psychological Services, LLC
4142 Keaton Crossing Blvd, Suite 101, O'Fallon, MO 63368
Phone: (636) 300-9333 Fax (636) 300-8761

OUTPATIENT SERVICES CONTRACT

Welcome to Family Life Counseling and Psychological Services. We are pleased to have the opportunity to work with you. This document contains important information about our professional services and business policies. Please read it carefully. When you sign this document, it will represent an agreement between us.

APPOINTMENTS AND CANCELLATION POLICY:

The length of time of the appointment varies based on the services provided. Psychological evaluations generally take three to four hours of your time. While most are completed in one day, a second appointment may be necessary, particularly with children who tire easily. Therapy sessions are generally scheduled for 45 minutes or 55 minutes, one time a week, although some sessions may be longer or more frequent**. Because the appointment time is reserved for you, it is necessary to charge our full rate for appointments that are not cancelled 24 hours in advance. This includes office visits, court appearances, depositions, DFS evaluations etc. Court ordered psychological evaluations require 7 days' notice. Court ordered evaluations cancelled with less than 7 days' notice will be billed for four hours at our regular evaluation rate.** However, no fee is charged for late cancellations due to inclement weather.

CONTACTING US:

We are often not immediately available by telephone. While we are generally in the office Monday through Friday, we probably will not answer the phone when we are with a client. When we are unavailable, the phone is answered by our receptionist or voice mail that we monitor frequently. We will make every effort to return your call within 24 hours, with the exception of weekends and holidays. In case of emergency, call 911or go to your local emergency room and ask for the psychologist on call or call Behavioral Health Response at 1-800-811-4760. After business hours, for urgent but non-emergency matters, you may call our office manager, David, on his cell phone at 314-276-7566. He will contact the therapist on call for the evening.

CONFIDENTIALITY

In general, law protects the privacy of all communications between a client and a psychologist or counselor, and we can only release information about our work to others with your written permission. However, there are a few exceptions.

There are some situations in which we are legally obligated to take action to protect others from harm, even if we have to reveal some information about a client's treatment. For example, if we believe that a child, elderly person, or person with a disability is being abused, we must file a report with the appropriate state agency.

If we believe that a client is threatening serious bodily harm to another, or to himself/herself, we are 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.

We may occasionally find it helpful to consult other professionals about a case. The consultant is also legally bound to keep the information confidential.

Please read our **Notice of Privacy Practices.**

PROFESSIONAL FEES:

The standard fee for a 38-52 minute session is $115. The standard fee for a 53-60 minute session is $135. Our fee for psychological evaluations is $150 per hour. In addition to our appointments, we charge this amount for other professional services you may need. For example, the fee for psychological evaluations also includes test scoring, interpretation, and preparation of the report. Brief telephone conversations to discuss changes in appointment times are free of charge. Phone calls over five minutes in length are billed in five-minute increments, prorated at your session rate.

If you become involved in legal proceedings that may require our participation, you will be expected to pay for our professional time even if we are called to testify by another party. Because of the complexity of legal involvement, we charge $200.00 per hour for preparation, travel, and attendance at any legal proceeding. We charge this same fee for all matters that we determine as legal in nature including, divorce mediation, responding to subpoenas, phone calls, letters and faxes to attorneys, disruption of practice, etc.

BILLING AND PAYMENTS:

Your co-pay is due at the time of your session. Payment for psychological evaluations is due in full before the results of the evaluation will be made available. You are responsible for all collection fees incurred as a result of late or non-payment including the hiring of a collection agency or use of small claims court. All invoices over 90 days old are automatically turned over to collections and currently incur a 35% collection charge. A bounced check fee of $25 will be charged for all returned checks.

INSURANCE REIMBURSEMENT:

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We can provide you with a detailed receipt for you to submit to your insurance company for reimbursement. We will also be happy to submit an insurance claim for you. However, you (not your insurance company) are responsible for full payment of our fees. It is very important that you find out exactly what mental health services your insurance policy covers. Once we have all the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions.

CLIENT'S RIGHTS:

At any time, you may question and/or refuse any procedures or services, or gain whatever information you wish to know about the process and course of therapy and testing. We encourage you to ask us questions concerning the services provided. You are never obligated to continue services at any time.

CONSENT TO TREAT:

By signing below, I consent for a therapist of Family Life Counseling and Psychological Services, LLC to provide evaluation and/or treatment services for _____ (client's name). I understand that I may terminate services at any time without penalty. I understand and agree to all of the policies and procedures noted on page one and page two of the Family Life Counseling and Psychological Services, LLC Outpatient Services Contract and I have received and read a copy of Family Life Counseling and Psychological Services' Notice Of Privacy Practices.

_____

Client's Name (Please Print)

_____ _____

Client's Signature Date

ADULT DEVELOPMENTAL HISTORY

Please complete the following questionnaire as thoroughly as possible. If more space is needed, use the back of any page. Your answers will help your therapist assess your history more quickly , so that the time during your session can focus more on your specific concerns.

Name:_____ **Today's Date:** _____

Presenting Circumstances

How were you referred to our office? _____
Relationship Status: _____Single _____Engaged _____Married _____Re-married
_____Separated _____Divorced _____Widowed _____Long-Term Relationship
List the people with whom you currently live, and their relationships to you:

_____
_____
_____

Please list others whom you feel have a significant impact on you and your life:

_____
_____

What is the last grade of schooling you completed?_____
What type of work are you doing now? _____
How long have you been in this position? _____
What kinds of jobs have you held in the past? _____
_____

Please check all of the following that concern you and are related to why you came to our office:

___Aggressive, angry feelings, temper
___Relationship problems
___Thoughts about hurting myself
___Difficulty making decisions
___Anxiety
___Medical problems
___Lack of self-confidence
___Poor concentration
___Nervous habits
___Crying spells
___Use of alcohol or drugs
___Financial problems
___Eating problems/Stomach trouble
___Family problems
___Sexual Concerns
___Memory Problems
___Headaches
___Religious/spiritual concerns
___Sleep difficulties
___Fidgety/restless, can't sit still
___Feelings of sadness or hopelessness
___Guilt feelings
___Problems with energy levels
___Preoccupation with gambling

When did these problems first appear?_____
_____

Briefly describe your goals for therapy. What benefits do you hope to gain from therapy? What behaviors and/or feelings would you like to change?

_____
_____
_____
_____

Medical/Mental Health History
Please list any previous counseling, psychiatric care, mental health hospitalizations, or substance abuse treatment.

Doctor/Therapist /Hospital	Dates	Reason for Treatment

Please list all medications you are currently taking.

Medication	Dose	When Taken	For What Condition

What psychiatric medications have you taken in the past? _____
_____
Please list any chronic health conditions. _____

Have you had any significant medical problems, accidents, injuries, surgeries, or hospitalizations? if yes, briefly describe: _____
_____
_____

Are you allergic to any medications? If yes, which medication, and what type of reaction did you have?
_____
_____

Who is your primary care physician? _____
Who is your psychiatrist (or clinician who prescribes your psychiatric medications)?
_____

Substance Use History
Nicotine: ____yes ____No _____Yes, but in the past
If yes, What type? _____cigarettes ____Cigars ____Chewing Tobacco ____Pipe
Amount used per day: _____How long have you been using tobacco?_____
Any related health problems? _____

Alcohol: ____ Yes ____ No ____ Yes, but in the past
If yes:
What type of alcohol do you usually drink?_____
How frequently? ____Rare ____Occasional ____Moderate ____ Frequent
How much do you typically drink at a time? _____
Type of alcohol use: ____ Social ____ Recreational ____ Problematic ____ Dependent
Pattern of use: ____ Daily ____On weekends ____ Only at social events
Most recent use of alcohol: _____
Longest period of sobriety: _____ When was this: _____
Any related health problems? _____
Any previous treatment for alcohol abuse? If yes, when and where?
_____
_____

Drugs: ____ Yes ____ No ____ Yes, but in the past
If yes:
What type(s)? _____
Amount typically used: _____
How frequently? ____ Rare ____ Occasional ____ Moderate ____ Frequent
How long have you/did you use? _____
Method (e.g., smoked, snorted, injected, etc.) _____
Most recent use of drugs: _____
Longest period of sobriety: _____ When was this? _____
Any related health problems? _____
Any previous treatment for drug abuse? If yes, when and where?
_____
_____

Family/Social/Legal/Vocational History

Briefly describe your childhood family: Who were you raised by? ___parents ___grandparents ____adoptive parents ____foster parents _____other relative

Were your parents in a committed relationship with each other?_____

How many siblings do you have? _____

What was your childhood like? _____

_____

_____

_____

Have you ever been involved with the criminal justice system? If yes, briefly describe:

_____

_____

Have you ever served in the military? If yes, what branch and when? _____

_____

Please list the types of leisure activities you most enjoy: _____

_____

Who do you rely on for emotional support? _____ Family _____ Friends _____ No one
_____ Co-workers _____ Neighbors _____ Religious/spiritual leader

Religious affiliation: _____

Please list any groups or agencies you are involve with that may help you with your problems (e.g., church groups, AA, Al-Anon, Children's Division, Department of Mental Health, etc.):

_____

_____