<u>Adult</u> application for services

(Couples: Please complete a separate application for each party)

Legal Name: _____

Preferred Name: _____

Date of Birth: _____ Gender: _____ Ethnicity: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Mobile Phone: _____May we leave messages? Yes No

Home Phone: _____May we leave messages? Yes No

Email Address: _____
(Your email address is not required. If you provide your email address you are giving our office permission to send you a link to our client portal and email appointment reminders).

Emergency contact: _____

Emergency contact phone: _____

Emergency contact relationship: _____

Who referred you to this office? _____

Intake Information:

Name: _____ Age: _____

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

Please briefly describe the symptoms that you checked above:

Do you currently have thoughts of self-harm or thoughts of suicide?

History of present problem:

When did your symptoms begin? _____

How often do you experience your symptoms? _____

Please list any previous counseling, psychiatric care, mental health hospitalizations, or substance abuse treatment.

Doctor/Therapist /Hospital	Dates	Reason for Treatment

Do you feel safe in your current environment? If no, why not?

Do you have any history of being violent? (Please describe)

Trauma History

Have you experienced any verbal, emotional, sexual, or physical abuse? _____

Have you experienced any other traumatic event? _____

If yes, please briefly describe:

Family psychiatric history:

Has anyone in your family been diagnosed with a psychological disorder? _____

Diagnosis: _____ Relationship to you: _____

Diagnosis: _____ Relationship to you: _____

Diagnosis: _____ Relationship to you: _____

Medical conditions and history:

Current medical conditions: _____

Past medical conditions: _____

Allergies: _____

Other treatments: _____

Primary Care Physician: _____

Medications: (Please bring a full list to your appointment if you take numerous medications)

Medication: Dose: Purpose:

Medication: Dose: Purpose:

Medication: Dose: Purpose:

Prescribing physician: _____

Substance use:

Alcohol: How Often: Last use:

Marijuana: How Often: Last use:

Smoking/vaping: How Often: Last use:

Other: How Often: Last use:

Other: How Often: Last use:

Have you ever received treatment for substance abuse? _____

If yes, where was the treatment and when?

Family history:

Who lives in your home?

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Who were you raised by?

_____ Parents _____Grandparents _____Adoptive Parents _____Foster Parents

_____Other Relative Other: _____

How many siblings do you have? _____ Half Siblings? _____ Step Siblings? _____

Were your parents in a committed relationship with each other?

What was your childhood like?

Social history:

Who do you rely on for emotional support?

_____ Family _____Friends _____ Coworkers _____ Neighbors

_____ Religious/Spiritual Leader _____ No One

Any religious affiliation?

Education/Occupational history:

What is your highest level of education?

_____Some High School _____High School _____Some College

_____College Graduate _____Masters _____Doctorate

Are you currently employed? _____

Who is your employer? _____

How long have you been in this position? _____

What kind of jobs have you held in the past?

Have you served in the military? _____

If yes, which branch? _____Dates of Service _____Type of Discharge _____

Please briefly describe your time in the military, including whether or not you were in active combat:

Legal history:

Have you ever been involved in the criminal justice system? _____

If yes, please briefly describe:

Are there any pending charges against you?

Family Life Counseling and Psychological Services, LLC

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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.

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. Cancellation of 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.

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 voicemail 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.

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.

The standard fee for a 38-52 minute session is $125. The standard fee for a 53-60 minute session is $145. Our fee for court ordered psychological evaluations is $200 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.

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.

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.

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.

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. I give permission for the office to provide information necessary to my insurance company in order to file a claim.

_____

Client's Name or Guardian's Name (Please type or print)

_____ _____

Client's Signature or Guardian's Signature Date