CC COUNSELING SOLUTIONS LLC

CLIENT INFORMATION SHEET

Date: _____/_____/_____ CASE #: _____

CLIENT NAME: _____ M / F Date of Birth: _____/_____/_____ Home Address: _____

(Street) (City) (State) (Zip)

Marital Status: M S D W Soc. Sec. #: _____ Home Phone: _____

E-mail Address: _____ Cell Phone: _____ Employer: _____
Work Phone: _____ Emergency
Contact:_____ Cell Phone: _____
Name Relationship Home or Work Phone: _____ _

POLICY HOLDER INFORMATION (If you are not the policy holder)

Name: _____ Soc. Sec. #: _____ D.O.B. _____ Relationship to client: _____ Home Phone: _____ Address: _____

__ (Street) (City) (State) (Zip)

E-mail Address: _____ Cell Phone: _____ Employer: _____
Work Phone: _____ **RESPONSIBLE PARTY INFORMATION** (Guardian, Custodial Parent)

Name: _____ Soc. Sec. #: _____ D.O.B.: _____ Relationship to client: _____ Home Phone: _____ Address: _____

__ (Street) (City) (State) (Zip)

E-mail Address: _____ Cell Phone: _____ Employer: _____
Work Phone: _____

CLIENT TREATMENT AGREEMENT AND CONSENT TO TREAT

CLIENT REPORT OF PROBLEM

Name: _____Today's Date: _____ Case Number: _____

Client/parent statement of problem:

Briefly describe your reason(s) for seeking help:

How long have you had the problem(s)?

Why did you decide to seek help now?

What other ways have you tried to deal with this problem?

History of treatment for emotional problems and family history:

Inpatient / Outpatient counseling (Therapist name, dates, did it help):

Family history of emotional problems (Who and their relationship to you):

Check any of the following items that apply:

___ Thoughts of suicide or death
___ History of attempts to kill yourself
___ cutting or otherwise hurting yourself
___ depressed mood
___ feelings of hopelessness
___ large weight gain or loss
___ trouble getting to sleep
___ waking during the night
___ Racing thoughts
___ inability to make decisions
___ excessive guilt
___ frequent crying
___ loss of energy
___ feeling worthless

___ nervousness/anxiety
___ trouble concentrating
___ phobias
___panic attacks
___ irritability
___ feeling overwhelmed
___loss of appetite
___ mood swings
___ forgetfulness
___ excessive worry
___ feeling tense
___ reliving traumatic events
___ intrusive distressing thoughts
___ hallucination

___ thoughts of harming others
___ trouble controlling anger
___ violence toward others
___ hearing voices
___ feeling empty
___ memory problems
___ financial problems
___ problems at work
___ legal problems
___ health problems
___ family problems
___ history of sexual abuse
___ history of physical abuse
___ alcohol/drug problem

Welcome to CC Counseling Solutions. Please read this document which contains important information about our professional services and business policies. A Notice of Privacy Practices for use and disclosure of Protected Health Information (PHI) is also posted in the reception area.

The law requires that I obtain your signature acknowledging that I have provided you with this information and that you have agreed to its terms. When you sign this document, it will represent a contract between us. You may revoke this contract in writing at any time. That

revocation will be binding on me unless I have already taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or monies owed in connection with treatment.

By signing this form, you will be authorizing me to release information about you that is required by your insurance company or EAP for payment of services. Fees for other services not included in your insurance/EAP Your insurance company or EAP does not typically reimburse for activities that are not a part of direct individual, family or group counseling.

If any of these policies or procedures cause problems or seem confusing, please speak with me, so that I may clarify them for you. I make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files. I have no control over what they do with the information once it is in their hands. In some cases, they may share the information with a national medical information databank.

CLIENT RIGHTS

Our clients have the right to: 1. Be treated by a licensed mental health professional and with respect for their individual needs, preferences, feelings and requirements; 2. Confidential treatment of their treatment records. Information from those records will not be released without their prior written consent, except in an emergency, as required by law or as noted (page 2); 3. Have an individualized treatment plan and participate with their therapist in treatment planning decisions; 4. Be given the information necessary to give informed consent prior to the start of any treatment or procedure; 5. Refuse treatment and to be informed of the consequences of refusal; 6. Continuity of care. Should transfer or discharge become necessary, clients will be given the reasons and plan, as well as reasonable advance notice; 7. Participate in the formulation of a discharge plan when the termination of treatment is therapeutically indicated; 8. View their treatment and financial records. Our clients have the responsibility to: 1. Provide to the extent possible, information that their therapist needs to provide appropriate care; 2. Participate in the development of treatment plan goals; 3. Communicate openly and honestly with their therapist; 4. Ask questions so that they understand the care and instructions given; 5. Actively participate in his or her own treatment and to carry out therapeutic homework assignments; 6. Take medications prescribed as part of their treatment plan and as instructed; 7. Keep their appointments or call at least 24 hours in advance to cancel visits; 8. Inform their therapist of any changes or updates in insurance or EAP coverage; 9. Pay their co-payments, deductibles, other fees and/or bills for services rendered in a timely manner. Client Consent to exchange Information with my Primary Care Physician / Psychiatrist HIPAA policy allows collaboration between health care providers regarding your care. A space for this information is provided. You have the right to withhold this information.

Agreement

By signing this Agreement, you agree that I can provide the necessary information to your insurance carrier, employee assistance program and other designated third-party payers such as Medicare or Medicaid, to process claims and for quality assurance activities.

I am acknowledging that I have reviewed: 1) Client Agreement and Consent to Treat Policies 2) Practices to Protect the Privacy of Your Health Information displayed in the office and you may obtain a copy for yourself on request 3) Notice of Client Rights and Responsibilities (page 2) I have read these policy statements and having been informed to my satisfaction, I give consent to treatment and/or evaluation by _____ and CC

CLIENT TREATMENT AGREEMENT AND CONSENT TO TREAT

Counseling Solutions. I understand that by signing this agreement I am acknowledging that I understand the content on this form and agree to comply with all aspects of it.

_____ _____
_____

Signature of client/parent/guardian Date Print Client Name

_____
_____ Relationship of above to client

Witness Date