HEALING WITH GRACE COUNSELING CENTER

Client Information

Name _____ Date _____

Gender _____ Date of Birth _____ Age _____ Marital Status _____

Address _____

City _____ State _____ Zip _____ Phone _____

Email _____ Referred By/Website _____

Highest Level of Education _____ Occupation _____ Sliding scale/Income _____

Emergency Contact Name _____ Number _____ Relationship _____

Second Party Information (Spouse, Significant Other, Parent, Legal Guardian Etc.)

Name _____ Date _____

Gender _____ Date of Birth _____ Age _____ Marital Status _____

Address _____

City _____ State _____ Zip _____ Phone _____

Email _____ Referred By/Website _____

Highest Level of Education _____ Occupation _____ Sliding scale/Income _____

Emergency Contact Name _____ Number _____ Relationship _____

Payment Information (Credit Card)

Name as it appears on card _____Zip code (billing address) _____

Credit Card number _____ Exp Date _____/_____ Vcode _____

Your card will automatically be billed for each session & for cancellation fees (without 24-hour notice). Sign to accept:

Signature _____ Date _____

Background Information on Immediate Family Members (use back of sheet if space is needed)

Name	Relationship	Age	Living In Home Y/N

Have you had any treatment with a Neurofeedback coach, psychiatrist or therapist in the past? ☐ Yes ☐ No

If yes, name of psychiatrist/therapist/practitioner _____ Was it helpful? ☐ Yes ☐ No

Current Prescriptions/Medications _____

Religious Affiliation/Church _____ Do you want spiritual/religious issues to be a part of treatment? ☐ Yes ☐ No

Briefly explain why you are seeking counseling _____

_____

Please describe any complaints associated with the problem _____

_____

When did the problem start? _____ How long do you think it will take to resolve the problem(s)? _____

What are your goals for therapy? _____

Are you currently at risk of harming yourself or someone else? ☐ Yes ☐ No ☐ Unsure

Have you attempted to harm yourself in the past? (Please list dates) _____

Following is a list of common obstacles that often lead people to seek counseling. Please check all that apply:

☐ Anxiety	☐ Communication	☐ Self Esteem	☐ Depression
☐ Addiction	☐ Grief	☐ Eating Problems	☐ Insomnia
☐ Alcohol	☐ Drugs	☐ Weight	☐ Stress
☐ Smoking	☐ Gambling	☐ Work Problems	☐ Shyness
☐ Relationships	☐ Sexuality	☐ Panic Attacks	☐ Guilt
☐ Phobia	☐ Abuse	☐ Trauma	☐ Anger
☐ Suicide Attempts	☐ Suicidal Thoughts	☐ Self-Harm (Cutting)	☐ Pain
☐ Low Motivation	☐ Sexual Problems	☐ Social Withdrawal	☐ School

Is there a family history of any of the following? Please list family member in space provided (grandparent, father, sister, etc.)

_____Alcoholism _____Drug Use _____Depression _____Anxiety
_____Suicide _____Attempted Suicide _____Medical Problems _____Psychosis
_____OCD _____ Eating Disorder _____Domestic Violence _____Abuse

In the past 2 weeks have you engaged in any of the following?

☐ Alcohol Frequency_____ Your strengths _____

☐ Marijuana Frequency_____ Your weakness _____

☐ Drugs Frequency_____ Your pets & names _____

☐ Other _____ Frequency_____ Your hobbies _____

Explain how you cope with stress _____

What do you like to do with your free time? _____

Are you currently in a romantic relationship? _____ If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____ List any areas you would like to improve:

_____

_____

What stressful life events have you experienced recently? _____

Is there anything else you feel is important for me to know about you? _____

_____

HEALING WITH GRACE COUNSELING CENTER

Client Rights

1. You have the right to receive information concerning the methods of therapy employed, the techniques used, the duration of therapy and the fee structure for services provided. If services are not appropriate, referrals to other qualified professionals will be provided.
2. You have the right to refuse or terminate treatment at any time.
3. You have the right to seek a second opinion, if needed I can provide you with the names of other qualified professionals.
4. You have the right to know that in a professional psychotherapeutic relationship sexual intimacy between therapist and client is never appropriate.
5. Therapy is a professional relationship. It is extremely important that you and I both believe the relationship is the right fit in order to provide you with the greatest benefit possible. Because I value and appreciate your commitment to therapy, if at any time I believe you would more greatly benefit from seeking the services of another professional, I will inform you immediately and provide referrals.

_____Initials

Confidentiality

The therapeutic relationship is confidential and protected by ethical standards of practice and Nevada statutes. Any information obtained in the therapeutic setting cannot be released without your prior written consent except in the following situations according to Nevada State Regulations and HWG regulations:

a. Cases of suspected child or elder abuse or neglect.
b. Cases of potential harm to self or others or a need for immediate hospitalization – medical/mental health concerns
c. Cases of legal claims or defense required by state of federal law or court ordered by a judge.
d. Cases under investigation by a board of examiners as part of an investigation or hearing.
e. If you are under the age of 18 in the State of Nevada, parents have access to information in regard to their child's medical records.
f. HWG's clinical director and administration have access to information for supervision of interns and administrative purposes.

It is Healing with Grace Counseling Center and my therapist's policy to maintain confidentiality throughout the therapeutic process; therefore, my therapist will not acknowledge clients in a public area unless first approached by client.

_____Initials

Fees, Missed Appointments and Cancellation Policies

All sessions are 50 minutes long. The charge per session is _____ which is due at the time of service. Fees for in-person sessions can be paid with cash, check or major debit/credit card. Fees for teletherapy can be paid with major debit/credit card. We value your time and ask you to value ours. For the initial session, a $25 fee will be charged if cancellation is not given to your therapist within 24-hours of the session start time. After the initial session, your therapist allows one (1) free missed session PER YEAR without the 24-hour notice. Please give a 24-hour cancellation notice to avoid being charged a FULL SESSION FEE for subsequent missed appointments. _____Initials

Emergencies

I understand that my therapist is not a 24-hour crisis intervention provider. If I am faced with a mental health emergency, I agree to call 911 or go to my local emergency room.

_____Initials

Security

I understand that there are cameras facing the front and back doors to the center for surveillance for client and staff protection.

_____Initials

Insurance

I understand that Healing with Grace Counseling Center and my therapist does not accept insurance.

_____Initials

Documents, Letters & Reports

I understand there is an hourly fee of $75, with a minimum charge of one hour per request, for documents, letters or reports that I require from my therapist. Your therapist requires 10 business days' notice with a prepayment of fee. Prepayments are non-refundable and are valid for one (1) calendar year from date of payment.

_____Initials

Court Appearances

*Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that, should there be legal proceedings (such as, but not limited to divorce, custody disputes, injuries, lawsuits, etc.) neither you nor your attorney (s) nor anyone else acting on your behalf will call on Healing with Grace Counseling Center and/or any of its clinicians to testify in court or at any other proceeding, nor will a disclosure of records be requested or provided. By signing this document, you agree not to call Healing with Grace Counseling Center or its clinicians as a witness in any such litigation or any third-party matter or request records for such matter. Only court-appointed experts, investigators, or evaluators can make recommendations to the court on disputed issues. Should you encounter legal proceedings HWGCC clinicians will provide you with referrals for continued services. HWGCC Clinicians are not Court Involved Therapists (CIT) or Court Approved Therapists (CAT).

*Should a HWGCC clinician be subpoenaed or ordered by a judge in a court of law to appear as a witness in an action involving client(s), client(s) agrees to pay directly the HWGCC clinician for any time spent for preparation, travel, or other time in which the HWGCC clinician has made himself or herself available for such an appearance at the HWGCC clinician's usual and customary hourly rate of $450 per hour, paid in advance, for a minimum of eight (8) hours totaling $3600. Additionally, client will be responsible for any other fees incurred by HWGCC clinicians relative to the legal matter including but not limited to HWGCC attorney fees, consulting fees, etc.

*HWGCC clinicians do not engage with any third parties with the exception of other medical and/or mental health service providers that are identified as part of your treatment team and will only do so with a signed release of information.

*HWGCC clinicians do not complete legal forms including FMLA, Workman's Compensation, Disability, etc. I understand and agree with the above mentioned disclosure _____Initials

Telecoaching (Initial if this form of coaching may be utilized)

Though I do my best to protect your confidentiality of electronic messages, please note that I cannot guarantee confidentiality under circumstances that include use of Internet programs (Doxy.Me, VSee, Skype, Facetime), cellular phone or text message.

I understand that using this medium of telecoaching is not entirely secure. I will not hold Healing with Grace Counseling Center nor my coach responsible should there be a breach in security on the Internet or phone. I understand that I am responsible for information security on my computer. _____Initials

I understand telecoaching services are not an appropriate treatment modality for everyone and should not continue if my coach and I feel it is counter-productive. My coach will suggest other options if needed. I understand that fees and cancellation policy is the same in telecoaching as in-person coaching. _____Initials

Electronic Communications

I authorize Healing with Grace Counseling Center and my therapist to send email and or text messages regarding appointments. _____Initials

I have read and fully understand the nature and limits of the above statements and agree to participate in counseling under these conditions.

Signature _____ Date _____

HIPPA Privacy Statement

I. Uses and Disclosure for Treatment, Payment, and Health Care Operations

Healing with Grace Counseling Center may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. We are required by law to maintain the privacy of health nformation and to provide you with our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new notice of Privacy Practices will be effective for all PHI that we maintain at that time. Will will provide you with a copy of the Revised Notice of Privacy Practices by sending you a copy in the mail upon request at your next appointment.

II. Uses and Disclosures Requiring Authorization

We may use of disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances, when we asked for information for purposes outside of treatment, payment, and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing psychotherapy notes. "Psychotherapy notes" are notes your therapist has made about your conversations during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

III. Uses and Disclosures with Neither Consent Nor Authorization.

We may use of disclose PHI without your consent or authorization in the following circumstances: (1) Child Abuse/Neglect; (2) Elder Abuse/Neglect; (3) Health Oversight (Nevada Licensing Board requesting records); (4) Judicial or Administrative Proceedings (Judge Court Order); (5) Serious Threat to Health or Safety to self or others; (6) Workers Compensation (if you file a claim)

Client Printed Name: _____

Signature: _____ (If a child or adolescent under age 18, parent or legal guardian must sign.)

INFORMED CONSENT

This agreement supplements the general informed consent that we agreed to at the start of our work together.

By signing below, you agree to all of the above conditions.

_____	_____
Written Name of Client	Date
_____	_____
Signature of Client	Date
_____	_____
Signature of Therapist	Date