

CenterPoint Counseling
ADULT Client Information

Date of Initial Session: _____

Therapist: _____

CLIENT Name _____	<input type="checkbox"/> Male	Date of Birth: _____
	<input type="checkbox"/> Female	
Address _____	City _____	State _____ Zip _____
Home Phone(____) _____	Work Phone (____) _____	
Cell Phone (____) _____	Other Phone (____) _____	
Employer _____	Email: _____	
Emergency Contact _____		
Name	Relationship	Phone

Partner/Spouse Name: _____	<input type="checkbox"/> Male	Date of Birth: _____
	<input type="checkbox"/> Female	
Address (If Different) _____	City _____	State _____ Zip _____
Home Phone(____) _____	Work Phone (____) _____	
Cell Phone (____) _____	Other Phone (____) _____	
Employer _____	Email: _____	
Emergency Contact _____		
Name	Relationship	Phone

Used for statistical analysis only. Information is compiled and anonymity of all clients is maintained.		
<u>Annual Household Income</u>	<u>How did you hear about us?</u> (please identify)	Are you a member of, or do you regularly attend Second Presbyterian Church?
<input type="checkbox"/> Under \$30,000	<input type="checkbox"/> Attorney _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> \$30,000 - \$40,000	<input type="checkbox"/> Friend _____	
<input type="checkbox"/> \$40,000 - \$50,000	<input type="checkbox"/> Family _____	Are you a member of, or do you regularly attend New Hope Presbyterian Church?
<input type="checkbox"/> \$50,000 - \$60,000	<input type="checkbox"/> Pastor _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> \$60,000 - \$70,000	<input type="checkbox"/> Physician _____	
<input type="checkbox"/> \$70,000 - \$80,000	<input type="checkbox"/> Insurance _____	If not at Second or New Hope, do you regularly attend another church?
<input type="checkbox"/> \$80,000 - \$100,000	<input type="checkbox"/> Internet _(website) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Over \$100,000	<input type="checkbox"/> Other _____	If Yes, which church? _____

Communication of Private Mental Health Information
 There may be times when CenterPoint staff needs to leave you a voicemail in regards to appointment times, account questions, or other reasons relating to your care. Please inform us if you have a preferred number for messages. When responding to client initiated contact, we will respond using the requested method you specify.

I acknowledge that the above information is correct.

Signature _____ **Date** _____

IF THE CLIENT IS A DEPENDENT MINOR (UNDER 18), PLEASE COMPLETE A "MINOR CLIENT INFORMATION FORM."

Therapeutic Disclosure CenterPoint Counseling

Welcome to CenterPoint Counseling! Entering into a therapeutic relationship is unique and is guided by professional governing ethical standards that we feel are important to share with you at this time.

1) Confidentiality:

The therapeutic relationship is a privileged relationship and the content of all discussions, testing, notes and evaluations are protected. This information can only be released by your signed consent.

2) Exceptions to Confidentiality:

While the therapeutic relationship is confidential, the professional standards and Indiana law require these exceptions:

- a) When physical harm is threatened against another person,
- b) When physical harm is threatened against one's self,
- c) When physical abuse or neglect is directed at a child or adult,
- d) When records are subpoenaed by a state or federal court,
- e) Any other provision covered under Indiana Code 25-23.6 et. Seq.

3) Fee Policy:

The standard counseling fee at CenterPoint Counseling is \$125 for Doctoral level clinicians, \$100 for Master's level clinicians, and \$70 for Intern level clinicians per 50 minutes session. Sessions that exceed the 50-minute session will be billed in 15-minute increments at ¼ of the appropriate standard 50-minute rate for each additional increment. CenterPoint does offer a fee subsidy through our Samaritan Fund in cases of financial hardship.

Payment for counseling services are your responsibility and due at the time of your counseling appointment. If filing with insurance, you are ultimately responsible for any claims not paid by your insurance company for any reason.

4) Cancellation Policy

We understand that illness and other unforeseen events are inevitable. Therefore, CenterPoint Counseling grants one missed appointment as a show of grace. After the first missed appointment, cancellations received with less than 24 hours notice will be charged a \$50 missed appointment fee. Unfortunately, because missed appointments cannot be billed to insurance, you are responsible for the full cost of this fee. Please discuss situations with your therapist that you think warrant further consideration.

I have read and understand the policies of CenterPoint Counseling provided in this document as it relates to confidentiality, exceptions to confidentiality, fees, and cancellation policies.

Client Signature _____ Date _____
(Client or Parent/Guardian if Minor/Personal Representative)

Acknowledgement-Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received the *Notice of Privacy Practices* from CenterPoint Counseling.

Client Signature _____ Date _____
(Client or Parent/Guardian if Minor/Personal Representative)

Signature of Witness _____ Date _____

Insurance for Mental Health Services CenterPoint Counseling

1) Insurance Considerations

The filing of an insurance claim usually requires that we provide a diagnosis to your insurance company. There have been occasions when a clinical diagnosis to your insurance has resulted in persons experiencing difficulty in obtaining life, medical or disability insurance.

2) Insurance Information

There are numerous insurance companies that offer mental health benefits as part of their coverage. We suggest you check with your insurance provider to determine the requirements for insurance coverage. Your insurance company will want to know the credentials of the Provider of Service. You will want to ask your insurance company about deductible requirements, authorization requirements, percentage of co-payment, number of sessions per year and “In-Network” vs. “Out-of Network” benefits. Contracting with insurance companies is the decision of each individual therapist. CenterPoint Counseling will be glad to assist you by providing and filing the necessary information for insurance reimbursement. **Be aware that if you are seeing a provider who is not licensed or out-of network, filing for insurance may not be an option. You will be responsible for any charges not covered by insurance for any reason.**

3) Insurance Pre-Certification/Authorization of Services

Many insurance companies now require pre-authorization of services. Please know that it is your responsibility to obtain authorization of services for an out-of-network provider if needed.

You will be responsible for any charges not covered by insurance due to lack of precertification/authorization for an out-of-network provider.

4) Insurance With Regards To Our Cancellation Policy

We understand that illness and other unforeseen events are inevitable. Therefore, CenterPoint Counseling grants one missed appointment as a show of grace. After the first missed appointment, cancellations received with less than 24 hours notice will be charged a \$50 missed appointment fee.

Unfortunately, because missed appointments cannot be billed to insurance, you are responsible for the full cost of this fee. Please discuss situations with your therapist that you think warrant further consideration.

5) Authorization to Release Information

If I choose to file with insurance, I authorize CenterPoint Counseling to release my clinical diagnosis, prognosis and treatment request information acquired in the course of my examination or treatment to my insurance carrier. I am also aware that payment is ultimately my responsibility and should my insurance fail to pay for services for any reason, I am required to pay CenterPoint Counseling for services and reconciling with insurance is my responsibility.

Do you plan to file for insurance reimbursement? ___ Yes ___ No

I have read and understand the policies of CenterPoint Counseling provided in this document as it relates to filing insurance for mental health services.

Client Signature _____ Date _____

(Client or Parent/Guardian if Minor/Personal Representative)

Client Name: _____

Therapist: _____

Life, Family and Relationship Questionnaire

(If a couple is coming in for relational counseling, each individual needs to fill out this form)

The purpose of this questionnaire is to help advance the therapy process by providing information about your life's journey to this point. In marriage and family therapy we are concerned with issues that impact you, your health, your family of birth, your committed relationships, your children and your work. By asking these things in questionnaire form, we can save a great deal of valuable therapy interview time. Therefore by answering these routine questions as fully and accurately as you can, it will make it possible for us to get to work on the issues that concern you the most more quickly.

All responses are strictly confidential and will not be released without your written permission. If you have any questions about this questionnaire, please feel free to call.

Birthdate: _____ Age: _____

Single Dating Living together Engaged Married Separated Divorced Widowed

Spouse's Name (if married): _____ Age: _____

Date of Marriage: _____ Length of Engagement: _____ Years Dating: _____

Previously Married: Yes No (if yes, how many times? _____)

Spouse Previously Married: Yes No (if yes, how many times? _____)

Children's Names: (Include and identify step-children)

_____ Sex: _____ Age: _____ Grade: _____ Married: _____

_____ Sex: _____ Age: _____ Grade: _____ Married: _____

_____ Sex: _____ Age: _____ Grade: _____ Married: _____

_____ Sex: _____ Age: _____ Grade: _____ Married: _____

Reason for Seeking Therapy

My reason(s) for seeking therapy is/are: _____

What solutions to your problem(s) have you found helpful? _____

When did the problem(s) begin? (Date) _____

Other personal concerns I have include:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Feeling Blue | <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Feeling Angry | <input type="checkbox"/> Anxious |
| <input type="checkbox"/> Family tension/conflict | <input type="checkbox"/> Parenting concern | <input type="checkbox"/> Financial stress | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Religious differences | <input type="checkbox"/> Addiction concerns | <input type="checkbox"/> Tired | <input type="checkbox"/> Work stress |
| <input type="checkbox"/> Infidelity Concerns | <input type="checkbox"/> Eating problems | <input type="checkbox"/> Lack of trust | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Communication Issues | <input type="checkbox"/> Custody/visitation Problems | | _____ |

Health

Do you have any physical symptoms that concern you? _____

List any medication you are taking: _____

Family Doctor: _____ Date of last physical: _____

History of Medical Condition: _____

Do you exercise? ___ Yes ___ No (if yes, how and how often?) _____

Do you: (check all that apply) ___ drink alcohol ___ use drugs ___ smoke ___ drink caffeine
 ___ want to (Gain/Lose) weight ___ have high blood pressure
 ___ have allergies ___ have trouble sleeping

Briefly describe your overall health? _____

Have you ever felt you should Cut down on your drinking? Yes No

Have people Annoyed you by criticizing your drinking? Yes No

Have you ever felt bad or Guilty about your drinking? Yes No

Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (Eye Opener)? Yes No

Source: Ewing JA. Detecting alcoholism: the CAGE questionnaire JAMA 1984;252:1905-1907. CAGE

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1. Little interest or pleasure in doing things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, or hopeless.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling or staying asleep, or sleeping too much.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Poor appetite or overeating.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself, or that you are a failure, or have let yourself or family down.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things such as reading the newspaper or watching TV.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thought that you would be better off dead, or of hurting yourself in some way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Family of Origin History

Father's Name: _____ Living? Yes No (If yes) Age: _____

Occupation: _____ Health: _____

If Deceased – His age at death: _____ Cause of Death: _____

Your age at his Death: _____ Describe Relationship: _____

Mother's Name: _____ Living? Yes No (if yes) Age: _____

Occupation: _____ Health: _____

If Deceased – Her age at death: _____ Cause of Death: _____

Your age at her Death: _____ Describe Relationship: _____

Brother/Sister: _____ Age: _____ Married: Y / N Children? # _____

Brother/Sister: _____ Age: _____ Married: Y / N Children? # _____

Brother/Sister: _____ Age: _____ Married: Y / N Children? # _____

Brother/Sister: _____ Age: _____ Married: Y / N Children? # _____

Brother/Sister: _____ Age: _____ Married: Y / N Children? # _____

Describe your father's father: _____

Describe your father's mother: _____

Describe your mother's father: _____

Describe your mother's mother: _____

Check any of the following that applied in your family during your youth:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Family Problems | <input type="checkbox"/> Separation | <input type="checkbox"/> Divorce | <input type="checkbox"/> Affairs |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Verbal Abuse | <input type="checkbox"/> Sexual Abuse |
| <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> School Problems | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Medical Illness |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Death | <input type="checkbox"/> Suicide | <input type="checkbox"/> Legal Troubles |

How did your family express care and affection: _____

How did your family express anger and manage conflict: _____

How did your family manage anxiety and stress: _____

Religious / Spiritual

I consider myself a spiritual person? ___ Yes ___ No ___ Uncertain

My religious preference is:

___ Protestant (Denomination) _____

___ Jewish

___ Agnostic (not sure about existence of God)

___ Catholic

___ Atheist (do not believe in the existence of God)

___ Orthodox

___ Other: Please specify _____

___ None

Do you pray? ___ Yes ___ No ___ Occasionally

Do you meditate? ___ Yes ___ No ___ Occasionally

Do you read the Bible? ___ Yes ___ No ___ Occasionally

How often do you attend a place of worship? _____

How important are matters of faith in your life? _____

In what church / faith tradition were you raised? _____

Employment

Occupation: _____ Employer: _____

Retired (Date): _____ Unemployed (Date): _____

Spouse's Occupation: _____ Employer: _____

Rate your job satisfaction: (Low) 1 2 3 4 5 6 7 8 9 10 (High)

What do you enjoy about your job? _____

What do you dislike about your job? _____

Therapy

Have you had previous experience with counseling? ___ Yes ___ No

If yes, when: _____ Therapist: _____

When: _____ Therapist: _____

For you, therapy will be successful when: _____

The likelihood that therapy will succeed is: ___ Very Good ___ Good ___ Poor ___ Very Poor

I expect it will take _____ sessions to complete my therapy goals.