New Client Information

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently in counseling elsewhere? \_\_\_Yes \_\_\_ No

Are you currently under probation and/or parole? \_\_\_Yes \_\_\_No

Are you currently thinking about suicide or harming yourself in anyways? \_\_\_Yes \_\_\_ No

Are you having thoughts about harming anyone else in any way? \_\_\_ Yes \_\_\_ No

Are you currently using alcohol and/ or drugs? \_\_\_ Yes \_\_\_ No

**Part I. Client Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/ Legal Guardian’s Name (s) (under 18yrs.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which number would you like us to leave a message? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you authorize text messages for communication? \_\_\_\_\_\_ Yes \_\_\_\_\_\_ No

\*\* ***The following information is optional, but will assist us in providing you the best-individualized services\*\****

Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Religion: \_\_\_\_\_\_\_\_\_\_\_

Sexual Orientation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Highest Level of Education Completed: \_\_\_\_\_\_\_\_\_

**Emergency Contact**:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Part II. Individual Financial Responsible For This Account**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_

Sliding Scale Rate: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all other individuals living in the client’s home.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Age** | **Relationship to Client** | **Sex** |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |
| 6. |  |  |  |

**Part III. Employment/ School Information**

Employment Status: \_\_\_ F/T \_\_\_ P/T \_\_\_ Student \_\_ Retired \_\_ Disabled \_\_ Unemployed

Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School Attending: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Part IV. Reasons for Seeking Services** (please circle all that apply):

Emotional Health Relationship Issues Self- Esteem/ Body Image

Life Improvement/ Personal Growth Family Issues Substance Abuse/ CD

School/ Work-related Issues Child/ Adolescent Issues Grief/ Bereavement

Depression/ Anxiety Trauma/ PTSD Marital/ Couples Conflict

Adoption Issues Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please briefly explain how the above issues are currently affecting your life: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are you hoping to accomplish by receiving services (counseling and/or coaching) at this time:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Disclosure Statement and Informed Consent**

Please carefully read and **initial or mark N/A** on each line on the space provided.

\_\_\_\_ I understand that Meka Allen, LCSW with Nevertheless Counseling and Consulting is licensed in the state of Arizona.

\_\_\_\_ I understand that Nevertheless Counseling and Consulting does not provide 24-hour crisis counseling or services. If I experience a mental health emergency or crisis, I will immediately contact the crisis line at 602-222-9444 or if life threatening, I will immediately contact 911 for assistance.

\_\_\_\_ I understand that our contact will be limited to services provided during scheduled sessions except in cases of emergency. In cases of emergency, after I have contacted the crisis line and/or 911, I will leave a message for Meka Allen, LCSW at (602) 920-5088 and can expect to receive a return call within 24 business hours.

\_\_\_\_ I understand that if I do not show up for a scheduled appointment and have not called and cancelled, I will be charged a $25 fee for the missed appointment.

**FEES**

\_\_\_\_ I understand that the rate for an initial assessment is $125/hr., and the time of the initial assessment may vary according to client needs but will be no longer than 2 hours. I also understand that all subsequent office-based sessions are $100 for Individual, $125 for Family/Couples, and $40 per group session, or based on sliding scale rate. Home and/or facility based individual sessions are $175 for initial evaluation, $ 150 for Individual, and $175 for Family/ Couples. All fees are based on a 50-minute session (excluding group), and if I go over more, I will be charged for additional time in 15-minute increments.

\_\_\_\_ I understand my rate based on the Sliding Fee Schedule is $\_\_\_\_\_ per session and I am responsible for this payment.

\_\_\_ I understand Meka Allen, LCSW does not accept insurance or EAP plans.

\_\_\_\_ I understand I will be charged $125 per hour for other professional services I may need including: report writing and treatment summaries, telephone conversations lasting longer than 7 minutes, attendance at meetings with other professionals and any other professional services per your request.

\_\_\_\_ I agree that I am seeking services to provide life or career improvement and not for court testimony or to seek evaluation reports. If I request evaluation reports, I will be charged the private pay- professional services rate of $185/hr.

\_\_\_\_ I understand that all fees for services are due at the end of each session. Appointments for future sessions cannot be made until I have paid my balance in full or I have made other approved payment arrangements.

\_\_\_\_ I understand that my records and all my communication with Meka Allen, LCSW and Nevertheless Counseling and Consulting becomes part of the clinical record. Records are the property of Nevertheless Counseling and Consulting. Adult records are disposed of seven (7) years after the client has stopped receiving services, and minor records are kept until the minor child reaches age 18 or three (3) years after the minor child’s 18th birthday, whichever is longer.

\_\_\_\_ I understand that if Nevertheless Counseling and Consulting is sold, moves or goes out of business, I will be notified in writing where to locate and request a copy of my clinical record.

**MINOR CHILDREN**

\_\_\_\_ I understand that children under the age of 18yrs. who are not emancipated, on leave from military duty, and/ or married, their parents should be aware that the law gives client rights to the parent. Therefore, the parents have access to the minor’s treatment records. If there is concern that abuse or neglect of the child is taking place by a caregiver, the appropriate reports will be made and will attempt to involve parents/guardians as much as possible.

\_\_\_\_ I understand that if parent’s share joint custody, both parents must sign a written consent to treatment and services.

**HIPAA/PROTECTED HEALTH INFORMATION**

\_\_\_\_ I understand that all my communication with Meka Allen, LCSW and Nevertheless Counseling and Consulting is kept confidential and cannot be released without my written consent. However, the following are examples of circumstances or situations, according to HIPAA in which my information may be disclosed without my consent:

* I am a danger to myself or to someone else
* In situations where my treating professional suspects child, elder or spouse abuse
* I disclose sexual contact with another mental health professional
* If I am involved in legal action/proceedings, my records are subject to subpoena from the court.
* Meka Allen, LCSW is ordered by court to disclose information.
* I request and sign a written authorization to release my records.
* Nevertheless Counseling and Consulting and/your treating professional is required by law to disclose information.
* Coordination of care as deemed necessary with other treating health professionals

**CLIENT EMAIL/TEXTING**

1. Risk of using email/texting

The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

* 1. Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
	2. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
	3. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
	4. Employers and on-line services have a right to inspect emails sent through their company systems.
	5. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
	6. Email and texts can be used as evidence in court.
	7. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.
1. Conditions for the use of email and texts

Therapist cannot guarantee but will use reasonable means to maintain security and

confidentiality of email and text information sent and received. Therapist is not liable for

improper disclosure of confidential information that is not caused by Therapist’s intentional

misconduct. Clients/Parent’s/Legal Guardians must acknowledge and consent to the following

conditions:

* 1. Email and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
	2. Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
	3. All email will usually be printed and filed into the client’s medical record. Texts may be printed and filed as well.
	4. Provider will not forward client’s/parent’s/legal guardian’s identifiable emails and/or texts without the client’s/parent’s/legal guardian’s written consent, except as authorized by law.
	5. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
	6. Provider is not liable for breaches of confidentiality caused by the client or any third party.
	7. It is the client’s/parent’s/legal guardian’s responsibility to follow up and/or schedule an appointment if warranted.

I acknowledge that I have read and fully understand this consent form. I understand the risks

associated with the communication of email and/or texts between my therapist and me, and

consent to the conditions and instructions outlined, as well as any other instructions that my therapist may impose to communicate with me by email or text.

I have read the professional disclosure statement and informed consent above carefully and understand the nature of the service providers and the limits of confidentiality outlined above. I have received and understand a copy of the Notice of Privacy Practices for this office. I solemnly swear that all of the above information is true to the best of my knowledge and I agree with all terms above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Parent/Guardian Signature Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Provider’s Statement**

I have reviewed and verified patient understands of the Professional Disclosure Statement and Informed Consent, and Limits of Confidentiality.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treating Professional Signature and Credentials Date