Client Information

(Please Print Neatly)

Today's Date: ____/____/____

Name: ____
(First) (Last) (Middle Initial)

Birth Date:_______/________/_______ Age: ____ S.S._____/_____/_____ Gender: ☐ Male ☐ Female

Address: ____
(Street) (City) (State) (Zip)

Home Phone: _________________________ Cell: ________________________ May we leave a message? ☐ Yes ☐ No

E-mail:____May we email you? ☐ Yes ☐ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Employment Status:
☐ Full Time ☐ Part Time ☐ Unemployed/Looking for work ☐ Student ☐ Retired ☐ Disabled ☐ Other: _______________

Client Employer: ____Occupation: ____

Marital Status:
☐ Never Married ☐ Unmarried/Cohabitating ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If Married, Spouse's Name: ____________________________ DOB: _____________ Phone: _______________________

Responsible Party *(If Self Please Leave Blank)*

Name: ____
(First) (Last) (MI) (Relationship)

Birth Date:_______/_______/________ S.S.:______/______/______ Insurance ID #: ______________________

Address: ____
(Street) (City) (State) (Zip)

Home Phone: _________________________ Cell: ________________________ May we leave a message? ☐ Yes ☐ No

E-mail:____ May we email you? ☐ Yes ☐ No

_______ I understand that I am financially responsible to The Counseling Network for services rendered.
Initial

Referred by (if any): ____

Do you have a Primary Care Physician? ☐ Yes ☐ No

If yes: ____
(First) (Last) (Phone)

Address: ____
(Street) (City) (State) (Zip)

Date of last visit: ____________ Current Health Concerns: ______________________________________
____

It is very important for your therapy at The Counseling Network that we are able to have contact with your primary care provider (PCP). Do you give permission for us to contact your PCP? ☐ Yes ☐ No

Have you had previous counseling or psychiatric services? ☐ Yes ☐ No

If so, Date of last appointment _________ Reason for seeking care: ________________________________
____

Provider: ____
(First) (Last) (Phone)

Address: ____
(Street) (City) (State) (Zip)

Are you currently taking any prescription medication? ☐ Yes ☐ No

What Medications do you take? (include non-prescription, herbal medicines and supplements)

Medicine	Dose	Frequency	Who prescribes
______________________	__________	________________	____________________________
______________________	__________	________________	____________________________
______________________	__________	________________	____________________________
______________________	__________	________________	____________________________

Religious Affiliation: ______________________________________

Church you attend, if applicable __________________________________ **Attendance: Regular Sometimes Rarely**
(circle one)

Pastor/Minister/Priest Name: ________________________________

Emergency Contact:

Name:________________________Phone:_________________Relationship to client:____________ OR

Name:________________________Phone:_________________Relationship to client:_____________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW CLIENT INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Counseling Network is a Not-for-Profit Corporation organized under the laws of the State of Missouri and is designated by the IRS as 501C (3) charitable, public, tax exempt organization.

Our commitment here at The Counseling Network is to serve our clients with professionalism, being sure at all times to protect the privacy and security of all Protected Health Information. During the course of serving your interests it may be necessary to share information with other Health Care Providers or Licensed Supervisors. The following are examples of instances where information may be shared:

In privileged communication, the client is protected from having communications revealed without their explicit permission to do so. For example, we will not release psychological reports about you to schools, agencies, physicians, etc., without your written approval. There are exceptions to this statement on confidentiality, which are outlined below.

- The therapist may discuss your case with a supervisor as a means of determining the most appropriate diagnosis or treatment plan.
- For the purpose of professional supervision. All cases of The Counseling Network periodically may be reviewed or discussed with one or more supervisory therapists, including professionals under independent contract. The supervising professionals are obligated to maintain and follow all of The Counseling Network; guidelines concerning confidentiality.
- If your fees are paid by a third party (such as an insurance company), certain details of your treatment (e.g. dates, treatment and diagnosis) must be revealed to obtain reimbursement. Many insurance companies now allow you to file claims directly with them so that your employer will not see this information.
- If a client reveals information that indicates a clear danger of injury to him/herself or to others, the therapist will need to contact appropriate authorities or family members.
- By Missouri law, we have a legal responsibility to notify appropriate social agencies of any suspicion or knowledge of the physical or sexual abuse or neglect of a child, a disabled person, or an elderly person.
- In the event there is an outstanding balance for which payment has not been made for a period of three months, the account will be turned over to a collection agency.
- When group therapy is provided, The Counseling Network will stress to all participants the need to respect the privacy rights of all other participants and will stress that there should be no disclosure to others of information learned or acquired during the course of a group session. However, The Counseling Network cannot control the conduct or actions of other group members, and hence makes not representation or agreement concerning their conduct.

We here at The Counseling Network are committed to obeying all Federal, State and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization maybe revoked at any time by the individual, as provided for by law.

If you have any questions or comments regarding your Protected Health Information, feel free to contact our Compliance Officer.

I have read and understand the above Notice of Privacy Practices.

Client/Parent Signature ______________________________________ Date _________________

Spouse Signature ____ Date __________________

PROFESSIONAL SERVICES AGREEMENT

I, ____, (Client OR parent/guardian of minor client, under 18)

______ **Have read and understand** the contents of the **The Counseling Network (TCN) Notice Form** which is
initial regarding the Protected Health Information (PHI) held by TCN for requested services. I understand this information will be handled in accordance with the HIPAA Privacy Rule, which affords me specific rights and responsibilities regarding my PHI. *A copy of this notice will be provided upon request.*

______ **Give Informed Consent to Treatment** and this agreement indicates a commitment to enter into treatment with
initial the understanding of the basic ideas, goals, and methods of this therapy. I consent to keep the therapist up to date about any changes in symptoms or situation that may impact the success of treatment. I understand that with periodic evaluation of these goals may change to best serve my long-term interest.

______ **Understand** that psychotherapy may arouse unpleasant feelings and emotional experiences particularly in the initial
initial phase of treatment. The relationships with significant others may also undergo substantial change during the course of treatment. If treatment is terminated, I agree to schedule a closing session with the therapist to discuss progress, outcomes of treatment, and any further clinical recommendations.

______ **Understand the Counselor Limits of Confidentiality**
initial Information discussed in the therapy setting is held confidential and will not be shared without written permission except under the following conditions:

1. The client threatens suicide or physical harm to another person(s), including murder or assault
2. The client reports suspected abuse of a minor child (under 18), a spouse, or the elderly including but not limited to physical beatings and sexual abuse.
3. The client reports sexual exploitation by a therapist.
4. The court orders the therapist to testify or release records to the court.
5. The client threatens or causes property damage to the counseling center or therapist's property.

State law mandates that mental health professionals may need to report these situations to the appropriate person and/or agencies. Further, as a registered resident/intern who is under the supervision of a licensed practitioner, therapy sessions will be discussed with a supervisor or professional colleague as deemed necessary. Communication between the counselor and client will otherwise be deemed confidential as stated under the laws of this state.

______ I understand that no organized religion or religious denomination is being promoted by my
initial therapist or by TCN in general, but he/she is working solely from a biblical worldview.

______ **It is agreed** that neither the client nor the client's attorney or anyone acting on behalf of the client will
initial call on the therapist to testify in court or any proceeding including but not limited to divorce, custody disputes, injuries or lawsuits. It is extended to no request being made to disclose psychotherapy records or any communication that took place between the therapist and the client. This is due to the fact that disclosure often includes all records and the nature of the therapeutic process and other confidential matters.

I acknowledge that I have read and understand the above policies of The Counseling Network.
(A copy of this notice will be provided upon request.)

______________________	______________________	__________
Signature of Client	Printed Name	Date

(If different from Client)

______________________	______________________	__________	__________
Financially Responsible Party	Printed Name	Relationship	Date

FINANCIAL POLICY INFORMATION

A therapeutic relationship is built on mutual trust and respect. As such, every effort will be made to be on time for your scheduled appointment, and ask that you give the same courtesy of a call when you are unable to keep your appointment. Please read and sign The Counseling Network's Financial Policy below.

1. Full payment is expected at the time service is rendered. Any other arrangements for payment are to be discussed prior to your initial session.
2. Appointment cancellations must be made at least 24 hours in advance in order to avoid being charged. Insurance will not pay for missed appointments.
3. A $50.00 charge may be applied to your account or credit card on file for all no shows and late cancelations.
4. Appointments missed because of inclement weather or illness may be excused.
5. Three (3) missed appointments – they need not be consecutive – can result in an administrative discharge from the practice.
6. To cancel or reschedule appointments, or if you need additional information, please call (314) 637-7443

______ *Initial* **Self-Pay:** Patients who do not have insurance, or with high deductibles are responsible for the cost of their care. In some cases, we do provide a discounted rate/sliding fee. The Counseling Network is not required to file a claim or submit any documentation on his/her behalf to a third party.

______ *Initial* **Methods of Payment** Our office accepts cash, checks, and major credit cards. Any unpaid balance over 60 days may be placed on your credit card on file. We will notify you prior to running this charge.

______ *Initial* **Insurance:** The therapists with The Counseling Network take several insurance policies and will file a claim on your behalf. You will be responsible for your deductible, co-pay or unpaid charges not covered by your insurance company. If we do not take your insurance, we can provide a monthly statement with codes suitable for self-filing.

I acknowledge that I have read and understand the above policies of The Counseling Network.

(A copy of this notice will be provided upon request.)

______________________	______________________	__________
Signature of Client	Printed Name	Date

(If different from Client)

______________________	______________________	__________	__________
Financially Responsible Party	Printed Name	Relationship	Date

CONSENT FOR COUNSELING FROM A CHRISTIAN WORLDVIEW

This office is openly Christian in its profession of faith and guiding principles in practice and relationship. No effort will be made to conceal our faith as this approach to life has deeply permeated all aspects of our business. As such, counseling may include references to Biblical principles and philosophies. **A Christian worldview will never be imposed upon a patient, but in the process of counseling or medical intervention, the patient may be asked to consider the principles of Christianity as part of the therapeutic process.** Patients of all faiths are welcome, but if being exposed to Christian principles, symbols, and/or discussion/consideration of such is offensive, then it may be best to find another practitioner that more closely embraces a worldview more similar to your own.

I desire psychological counseling from a holistic perspective involving assessment and interventions in the spiritual, emotional, physical, and social realms from a Christian worldview by my therapist at The Counseling Network ("TCN").

Since I embrace the Christian spiritual perspective, I desire that my therapist use the language and practices applicable to that worldview. I do not want language and practices used from other worldviews, such as secular, Humanist, New Age, Atheistic, or Eastern worldviews.

I understand that no organized religion or religious denomination is being promoted by my therapist or by TCN in general, but he/she is working solely from a biblical worldview.

I understand also that I may experience spiritual confusion or interference in my thoughts by the interplay of spiritual and psychological realities as described below:

- Distressing, unresolved memories may surface through the use of spiritual conflict procedures.
- Some clients have experienced reactions during the treatment sessions that neither they nor the administering clinician may have anticipated, including a high level of emotion or physical sensations.
- Subsequent to the treatment sessions, the process of incidents/material may continue, and other dreams, memories, flashbacks, feelings, and the like may surface.

I further understand that the spiritual dimension if focused on as a part of my overall treatment plan and is not exclusively the focus of treatment.

I understand that I will seek support from my own church and pastoral resources for questions and issues that involve specific doctrinal, religious, or personal spiritual questions and practices.

I understand that spiritual interventions are used when they are intertwined with my psychological and social issues.

I acknowledge that I have read and understand the above policies of The Counseling Network.

(A copy of this notice will be provided upon request.)

______________________	______________________	__________	
Signature of Client	Printed Name	Date	
(If different from Client)			
______________________	______________________	__________	__________
Financially Responsible Party	Printed Name	Relationship	Date

CONSENT TO CONTACT

In accordance with the HIPAA Privacy Rule, we cannot leave a message for a patient at their home or workplace either with someone or on an answering machine unless we have your consent.

_____ *Initial* — I agree to be contacted by phone or mail for purposes of quality improvement following discharge from the Counseling Network.

Please initial one of the following statements to indicate your preference

_____ **You MAY make contact** by phone to confirm appointments or notify me of cancellation by leaving a phone message at the following #'s

____________________ (home) ____________________ (work) ____________________ (cell)

_____ **You MAY NOT contact** me by phone to confirm appointments or notify me of cancellations by leaving a phone message. I will be responsible for keeping scheduled appointments and I understand that a missed appointment fee will be charged for appointments cancelled less than 24 hours in advance or for not showing up for an appointment.

Signature of Client or Responsible Party	Printed Name	Relationship	Date

SUPERVISION/INTERNSHIP

The Counseling Network has several therapists with supervising licenses. This gives students from area colleges the opportunity to participate in an Internship at our facility. Our interns have completed or are completing their practicum hours which is observation of clients, and the internship students are then able to observe, participate and facilitate sessions. You may be asked in advance of your session(s) if you are willing to have an intern "sit in" or facilitate your session.

If you are willing to have an intern observe, participate and/or facilitate those counselors in training will be provided with "clinical supervision" and "work supervision". These types of supervision are in accordance with the laws of the State of Missouri and the rules and regulations of the National Christian Counselor Association as well as, the State of Missouri's Psychology Board. Supervisors are the primary responsible persons for the clinical services you receive.

The supervisors and the counselors in training are under the same confidentiality guidelines. Please be open to these internship opportunities.

☐ Yes, I am willing to have an intern included in my session.

☐ No, I am not willing to have an intern included in my session.

Signature of Client or Responsible Party	Printed Name	Relationship	Date