The Center for Counseling & Wellness
Client Information Sheet

Client Name:_____ **Date:**_____
Last First MI

Address:_____
Street City State Zip

Social Sec. #: _____-_____-_____ **Marital Status:**M__S__D__ W__Sep__O__

Primary Phone: _____ ( ) Home ( ) Cell ( ) Work

Secondary Phone: _____ ( ) Home ( ) Cell ( ) Work

Gender: ( ) Male ( ) Female **Date of Birth:**_____-____-_____ **Age:**_____

Parent/Guardian (if Minor/Disabled):_____
Last First MI

Address _____
(If different from above)

Relationship to client: _____

Primary Phone: _____ ( ) Home ( ) Cell

Emergency Contact Name: _____
Last First MI

Phone:_____ **Relationship to Client:**_____

Primary Care Physician _____
Name Phone

Employment Status: ( ) Employed ( ) Unemployed ( ) Disabled ( ) Retired

How did you learn about us? ( ) Family ( ) Friend ( ) Church ( ) School

( ) Insurance ( ) Internet ( ) Doctor ( ) Sign/Brochure ( ) Other _____

Person Completing Form _____
Name (Relationship to Client)

The Center For Counseling & Wellness

CLIENT NAME: _____

CLIENT'S DATE OF BIRTH: _____

FINANCIAL COVENANT AGREEMENT

_____ **INSURANCE** *(Fill out this section if you are using insurance to pay for treatment)*

PRIMARY INSURANCE CARRIER:

Name of Insurance:	Policy #:
Policy Holder:	Relationship to insured:
Home Address:	City/State/Zip:
Insured's Date of Birth:	Phone #:

SECONDARY INSURANCE CARRIER:

Name of Insurance:	Policy #:
Policy Holder:	Relationship to insured:
Home Address:	City/State/Zip:
Insured's Date of Birth:	Phone #:

_____ **PRIVATE OR THIRD PARTY PAYMENT** *(Fill out this section if insurance is not applicable.*

Sliding Fee Scale: Agreed Amount _____ Staff Initials: _____	**Third Party Payor:** Name: _____ Address: _____ Contact Number:_____

AUTHORIZATION AND RELEASE

I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE. I understand I am personally responsible for payment of all insurance co-pays and deductibles regardless of any insurance payments made to The Center for Counseling & Wellness (The Center). I authorize The Center to release all information necessary to process any insurance claims or third-party payment. **I authorize payment of insurance benefits directly to The Center.** I understand the Late Cancellation fee of $25 is not covered by insurance and is accordingly my responsibility. I further understand that my account needs to remain current to continue in the counseling process.

_____ _____

Client Signature/Parent or Guardian Signature if Minor Date

_____ _____

Counselor Signature Date

THE CENTER

for Counseling & Wellness

www.thecenter4counseling.com

Credit Card Authorization Form

Credit Card Information Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX

Cardholder Name (as shown on card): _____

Card Number: _____

Expiration Date (mm/yy): _____

Cardholder Billing Address & Zip Code:

_____

_____

I, _____ (client name), authorize *The Center for Counseling & Wellness*, to charge my credit card listed above for counseling services. I understand that my information will be saved to file for future transactions on my account.

I agree to pay $_____for each individual session.

Signature of Patient/Representative _____ Date _____

Patient Printed Name _____ Date of Birth _____

Relationship to Patient_____ Witness _____

110 Ye Old Kings Highway, North Myrtle Beach | 4466 Holmestown Road, Myrtle Beach | 3505 Main Street, Loris
Phone (843) 663-0770 | Fax (843) 663-0772 | email: admin@thecenter4counseling.com

The Center for Counseling & Wellness

Client Intake Signature Form and Virtual Care Emergency Contact Information

Client Name_____

My signature below confirms that I have received, reviewed, and/or completed a copy of:

- **The Center for Counseling & Wellness' Disclosure Statement with Informed Consent to Participate in Clinical Counseling, HIPAA Rules, and Virtual Care Disclosure**
- **Notice of Privacy Practices for The Center for Counseling & Wellness**
- **The Center For Counseling & Wellness Biopsychosocial History Intake Form**
- **My counselor's personal Professional Disclosure Statement**

and have had an opportunity to discuss any questions I have about this information. I acknowledge that a copy of these documents has been made available to me at no charge and that they are available on our website at thecenter4counselingcom.

_____

Client's Signature (Parent/Guardian if client is a minor) Date

_____

Witness Signature Date

In emergency situations for Virtual Care, contact:_____at _____
Local Police Department Phone #

For disruption of service for Virtual Care, contact:_____at_____
Land line or other cell phone Phone#

My Client Support Person for Virtual Care is:_____ at_____
Name Phone #

My email address is:_____

THE CENTER

for Counseling & Wellness

www.thecenter4counseling.com

Informed Consent for Virtual Care Services

To better serve the needs of people in the community, health care services are now available by interactive video communications and/or by the electronic transmission of information. This may assist in the evaluation, diagnosis, management and treatment of a number of health care problems. This process is referred to as "distance counseling, virtual care, or telehealth." This means that you may be evaluated and treated by a counselor from a remote location. Since this may be different than the type of treatment with which you are familiar, **it is important that you understand and agree to the following statements.**

1. The counselor will be at a different location from me.
2. I will have access to and familiarity with the appropriate technology in order to participate in the service provided. My counselor and/or staff at The Center may assist me with this.
3. I will be informed if any additional personnel are to be present (via video) other than my counselor. I will give my verbal permission prior to the entry of the additional personnel.
4. It is my responsibility to maintain privacy on my end of communication and to inform my counselor of additional personnel who may be present. Insurance companies, those authorized by me, and those permitted by law may also have access to records or communication.
5. I will designate a Client Support Person and sign a Release of Information for that person to be accessible for emergency situations to ensure my safety. I will verify my location at each session.
6. Virtual services rely on technology which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches in confidentiality, theft of personal information, and disruption of service due to technical difficulties.
7. I represent that I am using my own equipment to communicate with and not equipment owned by another, specifically, not using my employer's computer or network. I am aware that information I enter into an employer's computer may be considered to legally belong to my employer and my privacy may be compromised.
8. The exchange of information may not be direct and any paperwork exchanged will likely be provided through electronic means or postal delivery.
9. My counselor and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of technologies we have agreed upon today and will modify our plan as needed.
10. My counselor will keep a record of the session in my electronic medical record.
11. I understand I, nor anyone else attending my session, are not to audio or video record any portion of my counseling session unless agreed upon in writing by all parties for each session recorded.
12. I understand that I have the option to refuse virtual care services at any time without affecting the right to future care or treatment.
13. I understand I am ordinarily guaranteed access to my records and that copies of records of counseling sessions are available to me upon my written request. Additionally, I understand that my records may be used for virtual care program evaluation, education, and/or research and that I will not be

personally identified if such as use occurs. I hereby authorize these disclosures to take place without prior written consent.

14. I acknowledge that if I am facing or think I may be facing an emergency situation that could result in harm to me or to another person, I am not to seek a virtual care counseling session. Instead, I agree to seek care immediately through my own local emergency hospital or by calling 9-1-1.
15. In an emergency, in the event of disruption of service, or for routine administrative reasons, it may be necessary to communicate by other means:

In emergency situations, please contact:_____at _____

For disruption of service, please contact:_____at_____

For other communication, please contact:_____at_____

My Client Support Person is:_____ at_____

My counselor's cell phone phone number is:_____

Assignment of Benefits and **Financial Responsibility**

I and/or my insurance carrier(s) agree to pay, in a timely manner, for health care services provided. I authorize payment directly to The Center for Counseling and Wellness all benefits payable. The benefits assigned include, but are not limited to, the following:

Primary and secondary benefits for all medical and hospitalization insurance, accident insurance, Medicare, Medicaid, and any benefits payable by alternative delivery systems such as HMOs and PPOs.

Benefits arising from any workers' compensation or occupational disease claims and proceeds to which I am, or my estate is, entitled because of any claim or cause of action for damages against any person or organization.

In consideration for the telehealth services rendered to me, I agree to pay the charges not covered by any insurer or third party payer, including any deductible or co-payment, or any charges not covered as a result of my failure to provide notification or obtain preauthorization for treatment as required by any insurer or third party payer.

Signature of Patient/Representative _____ Date _____

Patient Printed Name _____ Date of Birth _____

Relationship to Patient_____ Witness _____

The Center for Counseling & Wellness
Counseling Services Consent Agreement for Collaterals

You are participating in therapy because a spouse, member of your family, or a friend has asked you to be involved. Your paticipation is important, and is sometimes essential, to the resolution of issues. This document is to explain your rights and responsibitlities, and the limits of your rights, in your role as a collateral in therapy.

WHO IS A COLLATERAL?

A collateral is usually a spouse, family member, or friend, who participates in therapy with the "identified client" but is not identified formally as the recipient of counseling services.

THE ROLE OF COLLATERALS IN THERAPY

The role of a collateral will vary greatly. For example, a collateral might attend only one session to provide information to the therapist and never attend another session. In another case a collateral might attend all therapy sessions and be invested in the therapy process with his/her relationship with the client as a focus of the treatment.

BENEFITS AND RISKS

You may experience emotional distress as you engage therapy. Also, you may grow and benefit from the process and find your life enriched in some way. Psychotherapy is a positive experience for many, but it is not helpful to all people.

PROFESSIONAL RECORDS

No record or chart will be maintained on you in your role as a collateral. Notes about you may be entered into the identified client's chart. However, except in the case of the parent or guardian of a minor child, you have no right to access that chart without written consent of the identified client. You will not carry a diagnosis, and there is no individualized treatment plan for you.

PROFESSIONAL FEES

As a collateral you have no financial obligation to the identified client or to me unless you are financially responsible for the client. You will not be billed.

CONFIDENTIALITY

The Center will maintain your confidence. There are exceptions:

- If the counselor suspects you are abusing or neglecting a child or a vulnerable adult, he/she will file a report with the appropriate agency.
- If you are a danger to yourself (suicidal), he/she will take actions to protect your life even if he/she must reveal your identity to do so.
- If you threaten serious bodily harm to another, he/she will take necessary actions to protect that person even if he/she must reveal your identity to do so. You are expected to maintain the confidentiality of the identified client (your spouse, friend, or child) in your role as a collateral.

DO COLLATERALS EVER BECOME A FORMAL CLIENT?

Collaterals typically discuss their own issues in therapy, especially issues that interact with issues of the identified client. The therapist may recommend formal therapy for a collateral. These are some examples of when this might occur.

- It becomes evident that a collateral is in need of mental health services. In this circumstance the collateral needs to have a counselor, diagnosis, and chart records kept.
- Parents, being seen as collaterals as their child is being treated, would benefit from couples therapy to improve their relationship so they can function effectively as parents.

Most often, but not always, the counselor will refer you to another counselor for treatment in these situations. There are two reasons the referral may be necessary.

- Seeing two members of the same family, or close friends, may result in a dual role, and potentially cloud the counselor's judgment. Making a referral helps prevent this from happening.
- The counselor must keep a focus on the original primary task of treatment of the identified patient. For example, if the clinician started treating a child's behavioral problem then takes on couples therapy with mom and dad to address their relationship issues, the original focus of therapy with the child may be lost. A referral helps the counselor to stay focused. One exception to these guidelines is when a family therapy approach can be effectively and ethically used to treat all members of the family, or each member of the couple.

RELEASE OF INFORMATION

The identified client is not required to sign an authorization for release of information (ROI) to the collateral when a collateral participates in therapy. The presence of the collateral with the consent of the identified client is adequate. However, it is recommended that the client sign a ROI. This provides some assurance that full consent has been given to the counselor for the client's confidential information to be discussed with the collateral in therapy. The ROI is also helpful to the counselor on those occasions when receiving a telephone call

from a collateral or when the counselor calls a collateral for one reason or another. In most instances the counselor cannot take a call from a collateral without a ROI.

PARENTS AS COLLATERALS

Counselors specializing in the treatment of children have long recognized the need to treat children in the context of their family. Participation of parents, siblings, and sometimes extended family members, is common and often expected. Parents in particular have more rights and responsibitlies in their role as a collateral than in other treatment situations where the identified client is not a minor.

- The parent has a legal right to access the medical record of the minor child. The child may need some measure of confidentiality with the counselor. The counselor will negotiate the terms of what is best for your child with you early in the child's treatment. He/she will always inform you if it is found that your child is a danger to himself or others.
- If you are participating in therapy with your minor child you should expect your counselor to request that you examine your own attitude and behaviors to determine if you can make positive changes that will be of benefit to your child.

SUMMARY

If you have questions about therapy, our procedures, or your role in this process please discuss them with the counselor. Remember the best way to assure quality and ethical treatment is to keep communication open and direct with the counselor. By signing below you inidicate you have read and understood this document.

_____

Identified Client's Name

_____

Print Collateral's Name

_____ _____

Collateral Signature Date

_____ _____

Witness Signature Date

The Center For Counseling & Wellness Biopsychosocial History Intake Form for Minor

Client Name_____ _____DOB_____Date_____pg 1

Sources of information: ☐ Client self-report ☐ Other Sources (eg. parent, guardian, doctor, spouse, child)

_____

Presenting Problems (Identify duration of problem and any additional information that would be helpful.)

_____

_____

_____

CURRENT CHECKLIST (Rate intensity of symptoms/experiences.)

	None	Mild	Mod	Severe		None	Mild	Mod	Severe
Depressed mood	☐	☐	☐	☐	Appetite disturbance	☐	☐	☐	☐
Fatigue/Low energy	☐	☐	☐	☐	Weight gain/loss	☐	☐	☐	☐
Sleep disturbance	☐	☐	☐	☐	Bingeing/Purging	☐	☐	☐	☐
Mood swings	☐	☐	☐	☐	Food restricting/Anorexia	☐	☐	☐	☐
Emotionality	☐	☐	☐	☐	Laxative/Diuretic abuse	☐	☐	☐	☐
Irritability	☐	☐	☐	☐	Self-mutilation/injury	☐	☐	☐	☐
Agitation	☐	☐	☐	☐	Guilt	☐	☐	☐	☐
Elevated mood	☐	☐	☐	☐	Emotional trauma victim	☐	☐	☐	☐
Generalized anxiety	☐	☐	☐	☐	Physical trauma victim	☐	☐	☐	☐
Panic attacks	☐	☐	☐	☐	Sexual trauma victim	☐	☐	☐	☐
Phobias	☐	☐	☐	☐	Emotional trauma perpetrator	☐	☐	☐	☐
Obsession/compulsions	☐	☐	☐	☐	Physical trauma perpetrator	☐	☐	☐	☐
Poor concentration	☐	☐	☐	☐	Sexual trauma perpetrator	☐	☐	☐	☐
Paranoid ideation	☐	☐	☐	☐	Chronic medical condition	☐	☐	☐	☐
Delusions	☐	☐	☐	☐	Grief	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐	Hopelessness	☐	☐	☐	☐
Aggressive behaviors	☐	☐	☐	☐	Social isolation	☐	☐	☐	☐
Oppositional behaviors	☐	☐	☐	☐	Worthlessness	☐	☐	☐	☐
Substance abuse	☐	☐	☐	☐	Sexual dysfunction	☐	☐	☐	☐
Suicidal thoughts	☐	☐	☐	☐	Physical complaints	☐	☐	☐	☐
Homicidal thoughts	☐	☐	☐	☐	Other_____	☐	☐	☐	☐

PSYCHIATRIC HISTORY

Prior out-patient therapy? ( ) Yes ( ) No If Yes, on how many occasions? _____

Prior Provider Name City State Diagnosis/Reason for treatment Beneficial?

_____

_____

Has any family member had out-patient therapy? ( ) Yes ( ) No If yes, who/why (list all):_____

_____

Prior in-patient treatment for a psychiatric, emotional, or substance use disorder? ( ) Yes ( ) No If Yes, on how many occasions? _____

In-patient Facility Name City State Diagnosis/Reason for treatment Beneficial?

_____

_____

Has any family member had in-patient therapy? ( ) Yes ( ) No If yes, who/why (list all):_____

_____

Current Medication ( ) Yes ( ) No If yes, please list: (Please use back side of page for additional information)

Medication Dosage Frequency Start Date Physician Side Effects Beneficial?

_____

_____

_____

FAMILY OF ORIGIN (Please use back side of page for additional information)

	Name	Age	Occupation	Nature of Relationship	Deceased? If Yes, year died.
Mother					
Father					
Step -mother					
Step-father					
Sibling					
Sibling					
Sibling					

Extended family_____

Extended family_____

Extended family_____

Age at which you left home _____Circumstances:_____

_____

Special Circumstances in childhood:_____

_____

Describe childhood family experience:

( ) outstanding home environment
( ) normal home environment
( ) chaotic home environment
( ) witnessed physical/verbal/sexual abuse toward others
( ) experienced physical/verbal/sexual abuse from others

Describe any traumatic experiences:

Age_____ Event_____
_____
Age _____Event_____
_____
Age_____ Event_____

IMMEDIATE FAMILY:

Parent's Marital Status:

( ) single, never married
( ) live-together for ____years
( ) married for ____years
( ) divorced for ____years
( ) separated for ____ years
( )____prior marriages (father)
( )____prior marriages (mother)

Intimate Relationships:

( ) never been in a serious relationship
( ) not currently in a relationship
( ) currently in a serious relationship

Relationship Satisfaction:

( ) very satisfied with relationship
( ) satisfied with relationship
( ) dissatisfied with relationship
( ) very dissatisfied with relationship

List all persons currently living in client's household:

Name	Age	Sex	Relationship to client

List immediate family members not living in same household as client:

Name	Age	Sex	Relationship to client

Describe any past or current significant issues in family relationships:_____
_____

MEDICAL HISTORY

Describe current physical health ( ) Good ( ) Fair ( ) Poor
_____
List name of primary care physician:
_____
List name of psychiatrist (if any):
_____
List any known allergies:
_____

Is there a history of the following in the *family*:

( ) Tuberculosis ( ) heart disease
( ) birth defects ( ) high blood pressure
( ) emotional problems ( ) alcoholism/drug abuse
( ) mental retardation ( ) stroke
( ) thyroid problems ( ) diabetes
( ) cancer ( ) dementia
( ) other chronic or serious health problems:
_____

Describe any serious hospitalizations, surgeries, chronic illnesses, physical problems, eating disorders, or accidents (give age and description of health problem):

_____
_____
_____
_____
_____

SUBSTANCE USE HISTORY:

Substance Used	Age when first used	Current Use? (Yes/No)	Age when last used	Frequency	Amount

Describe Substance Use Treatment History (if any):_____
_____

Consequences of Substance Use (check all that apply):

( ) hangovers ( ) withdrawal symptoms ( ) sleep problems ( ) binges ( ) seizures
( ) assaults ( ) medical conditions ( ) blackouts ( ) arrests
( ) overdose ( ) relationship conflict ( ) suicidal impulse ( ) homicidal impulse

SOCIO-ECONOMIC HISTORY (check all that apply):

Client lives with:_____

Living situation: ( ) housing adequate ( ) homeless ( ) housing overcrowded ( ) housing dangerous

Social Support System: ( ) supportive network ( ) few friends ( ) no friends ( ) conflict in peer group

Sexual history: ( ) heterosexual orientation ( ) homosexual orientation ( ) bisexual orientation
( ) currently sexually active ( ) history of unsafe sex ( ) pornography use ( ) sexual identity issues
( ) age first sexual experience) _____

School: Name of school:_____Grade____GPA_____ Repeated any grade? ( ) Yes ( ) No
If Yes, Grade repeated _____ Reason_____
( ) Learning problems? Explain_____ 504 plan or IEP ( ) Yes ( ) No
( ) Suspensions ( ) Expulsions Reason_____
Favorite subject:_____Least favorite subject_____
( ) Extracurricular activities_____
( ) Sports_____
( ) Awards_____
Future career aspirations_____

Family financial situation: ( ) no current problems ( ) poverty ( ) impulsive spending ( ) unstable financial history

Client's legal history: ( ) no legal problems ( ) on probation ( ) court ordered treatment ( ) arrests ( ) DSS involvement
( ) incarcerations ( ) describe last legal difficulty _____

Cultural/spiritual/recreational history: Cultural identity (ethnicity)_____
( ) currently active in recreational activities ( ) formerly active in recreational activities ( ) currently engaged in hobbies
( ) currently participate in spiritual activities ( ) attends church at (name of church) _____

Describe cultural issues that may contribute to current problems:_____
_____