The Center for Counseling & Wellness
Client Information Sheet

Client Legal Name: _____
First Middle Last

Client Preferred Name: _____
First Middle Last

Address: _____
Street City State Zip

Social Sec #: _____ **Marital Status:** ☐ **S** ☐ **D** ☐ **W** ☐ **Sep** ☐ **O**

Primary Phone: _____ **Type:**_____ **Secondary Phone:** _____ **Type:**_____

Gender Assigned at Birth: _____ **Identified Gender:** _____

Preferred Pronouns: _____ **DOB:** _____ **Age:** _____

Email Address: _____

Parent/Guardian (If Minor/Disabled):_____
First Middle Last

Relationship to Client: _____ **Phone #:** _____**: Type:**_____

Emergency Contact Name: _____
First Middle Last

Relationship to Client: _____ **Phone #:** _____**: Type:**_____

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: _____
Relationship to Client

THE CENTER

For Counseling and Wellness

www.thecenter4counseling.com

The Center for Counseling & Wellness

Client Intake Signature Form and Virtual Care Emergency Contact Information

Client Legal Name_____

Client Preferred 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 thecenter4counseling.com.

_____

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

Updated 10/14/2022

110 Ye Old Kings Highway, North Myrtle Beach | 4466 Holmestown Road, Myrtle Beach
3505 Main Street, Loris | 602 Main Street, Conway
Phone (843) 663-0770 | Fax (843) 663-0772 I Email: admin@thecenter4counseling

CLIENT LEGAL NAME AS SHOWN ON INSURANCE CARD: _____

CLIENT PREFERRED NAME: _____CLIENT'S DATE OF BIRTH: _____

FINANCIAL COVENANT AGREEMENT

The Center for Counseling & Wellness

_____ 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 client:
Home Address:	City, State, Zip:
Policy Holder's Date of Birth:	Phone #

_____ SECONDARY INSURANCE CARRIER:

Name of Insurance:	Policy #
Policy Holder:	Relationship to client:
Home Address:	City, State, Zip:
Policy Holder'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 $50** is not covered by insurance and is accordingly my responsibility (*does not apply to Medicaid clients*). **I understand if I am a self-pay client, I have the right to a good faith estimate of the cost of each visit and the agreed amount above is such an estimate.** I further understand my account needs to remain current to continue in the counseling process.

_____ _____

Client Signature/Parent or Guardian Signature if Minor 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 legal 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 Client/Representative _____ Date _____

Client Printed Name _____ Date of Birth _____

Relationship to Client_____

ALL CREDIT CARDS WILL BE SUBJECT TO A 3.5% PROCESSING FEE EFFECTIVE 1/1/2023*

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THE CENTER

for Counseling & Wellness

AUTHORIZATION FOR RELEASE OF INFORMATION

I _____ DOB: _____ hereby authorize *The Center for Counseling & Wellness* to release this form letter to my primary care physician for continuity of care.

_____ _____
(Name of Primary Care Physician or Facility) (Telephone Number)

_____ _____
(Street Address, City, State, Zip Code) (Fax Number)

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke the authorization at any time. The revocation must be in writing and will not affect information that has already been used or disclosed.
- I am signing this authorization voluntarily. I may refuse to do so and my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits.
- This authorization will remain in effect for one year from the date signed unless revoked in writing.
- If my records contain documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable diseases, this information will be released as part of my record.
- I further understand that if a person or entity to whom records and information are disclosed pursuant to this authorization are not covered by federal privacy regulations, this information will no longer be protected and may be disclosed.

_____ _____ _____
(Signature of Client/Personal Representative) (Relationship to Client) (Date)

For office use only

The above client was seen in our office on _____ and was diagnosed with _____ _____. A follow up appointment is scheduled for _____. Please do not hesitate to contact us if you require anything further.

_____
(Counselor Signature and Date)

Notice: This fax message is {or the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure, or distribution is prohibited- If you are not the intended recipient, please contact the sender and destroy all copies of the original message.

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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 participation is important, and is sometimes essential, to the resolution of issues. This document is to explain your rights and responsibilities, 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 collateral 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 responsibilities 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 indicate you have read and understood this document.

_____ _____

Identified Client's Name Print Collateral's Name

_____ _____

Collateral Signature Date

REVOCATION OF CONSENT

I hereby revoke my previous consent to share health information with the participating care providers who may provide treatment or health care services to the above.

_____ _____ _____

(Signature of Client/Personal Representative) (Relationship to Client) (Date)

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

Client Legal Name_____ Preferred Name _____DOB_____Date_____pg 1

Person completing form: ☐ Client ☐ Other (eg. parent, guardian, doctor, sibling, teacher) If other print name and relationship to client_____

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	☐	☐	☐	☐	Binging/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 problems	☐	☐	☐	☐
Suicidal thoughts	☐	☐	☐	☐	Physical complaints	☐	☐	☐	☐
Homicidal thoughts	☐	☐	☐	☐	Other_____	☐	☐	☐	☐
Bedwetting	☐	☐	☐	☐	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.

Parent _____

Parent _____

Step-parent _____

Step-parent _____

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
- ☐ witnessed hate crimes toward others
- ☐ experience hate crimes directed at self

Describe any traumatic experiences:

Age_____ Event_____
Age_____ Event_____
Age _____Event_____
Age_____ Event_____
Age_____ Event_____
Age_____ Event_____
Age_____ Event_____

IMMEDIATE FAMILY:

Parent's Marital Status:

Marital Status:

- ☐ single, never married
- ☐ engaged ____months
- ☐ married for ____years
- ☐ divorced for ____years
- ☐ partnered, not living together
- ☐ domestic partnership, living with partner
- ☐ civil union
- ☐ polyamourous/non-monogamous
- ☐ widowed/grieving loss of partner
- ☐ separated for ____ years
- ☐ live-in for ____years
- ☐ ____prior marriages (parent 1)
- ☐ ____prior marriages (parent 2)

Intimate Relationship

- ☐ 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 Identified Gender Relationship to client

_____
_____
_____
_____

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

Name Age Identified Gender 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
- ☐ birth defects
- ☐ emotional problems
- ☐ mental retardation
- ☐ thyroid problems
- ☐ cancer
- ☐ heart disease
- ☐ high blood pressure
- ☐ alcoholism/drug abuse
- ☐ stroke
- ☐ diabetes
- ☐ 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: ***Please leave the following areas blank if you prefer not to answer***
Current Gender Identity: _____ Sexual Orientation: _____
Sex Assigned at Birth: _____ Preferred Pronouns: _____
☐ sexually dissatisfied ☐ currently sexually active ☐ sexually satisfied ☐ history of unsafe sex ☐ pornography use
age of 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:_____
_____