NEW CLIENT REGISTRATION FORM

High Expectations Counseling

Please complete the information requested based on the person/s who will be receiving counseling:

The client is here for: (please circle) **Adult** **Child/Adolescent** **Couple** **Family**

Date: _____

Please circle the form of services you are interested in: **Skype** **In office Session** **Phone** **seeesoesi Email**

Residential (Please fill out the information as it relates to the clients that will be involved in the therapeutic process. (family, couples, adolescents)

Clients First Name _____Last Name_____Email _____

Clients First Name _____Last Name_____Email_____

Home Address: _____

City: _____ State: _____ ZIP Code: _____

Home Phone: _____ Cell Phone:_____ Sex: _____ Age:_____

D.O.B: _____ Email Address: _____(for billing receipts, communication)

Referred By: _____

Provide the **best method of communicating** for appointment reminders, and confidentiality purposes.

_____

_____

_____

Informed Consent for Therapy Services

CLIENT SERVICE AGREEMENT

Welcome to HEC (High Expectations Counseling). This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. It is very important that you understand them. When you sign this document, it will also represents an agreement between us. We can discuss any questions you have when you sign them prior to services rendered.

THERAPEUTIC SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in therapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. We, as your therapists, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Therapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of therapy often requires discussing the unpleasant aspects of your life. However, therapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Therapy requires a **very active effort on your part**. In order to be most successful, **you will have to work on things we discuss outside of sessions.**

The first session will involve a comprehensive evaluation of your needs. By the end of the first session, we will be able to offer you some initial impressions of how our work will be most beneficial and include collaboratively how we will approach therapy. It is important that you make your own assessment about whether you feel comfortable working with us. If you have questions about our procedures, we should discuss them immediately.

APPOINTMENTS

Appointments run an average of 50 to 75 minutes in duration, once per week or at a frequency we agree on. Some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, we ask that you provide us with a **24 hour notice**. If you miss a session without cancelling, **my policy is to collect the amount of the session.** I will assist to schedule another time for the appointment. In addition, you are responsible for coming to your session on time. You may schedule your following appointments online at the website: www.lifecounselingorlando.com

PROFESSIONAL RECORDS

We will keep appropriate records of the therapeutic services that we provide. Your records are maintained in a secure and locked location in the office. We keep brief records noting that you were in session, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discuss, your social, and treatment history, records we receive from other providers, copies of records we send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. You also have the right to request that a copy of your file be made available to any other health care provider at your written request. Please allow 30 days to receive request.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement is essential at important times throughout treatment. It is our policy not to provide treatment to a child under age 13 unless s/he agrees that we can share whatever information we consider necessary with a parent. For children 14 and older, we request an agreement between the client and the parents allowing us to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless we feel there is a safety concern. It is our goal to work with the entire family and keep all involved and updated on progress.

CONTACTING OUTSIDE OF BUSINESS HOURS

We are often not immediately available by telephone. We will however try our best to get back to you within the end of the business day. At these times, you may leave a message on our confidential voicemail. If, for any number of unseen reasons, you do not hear from us or we are unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, please go to your Local Hospital Emergency Room, call 911 and ask to speak to the mental health worker on call. You may also reach us via email at info@highexpectationscounseling.com

CONSENT TO THERAPY Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to these terms.

_____	_____
Signature of Client	Date
_____	_____
Signature of Client	Date
_____	_____
Signature of Parent/Guardian	Date
_____	_____
Signature of Mental Health Practitioner	Date

PROFESSIONAL FEES AND INSURANCE POLICY

In Office Session 50 min-75 minutes $120/$160

Online Face to Face Sessions 50 minutes $100

Telephone Sessions 30 min-50 min $40/$90

Leadership Coaching 60 min-95 min $90/$130

Psychiatric Evaluation 95 min $300

-Please initial if we have agreed upon a different price: Price: _____ Initial _____

You will receive the day of your session a text from our online card processing system IVY. Please follow the instructions. This allows us to bill you for services without holding onto sensitive card information. Each session book will be processed for payment the day of services.
Please note that we require 24 hours advance notice if you cannot attend session. We hold that spot for you. If your unable to attend or do not cancel in time you will be charged the full amount of the session cost.

Between Session we may text you videos and helpful resources that we recommend you watch. These are just recommendations. There is no fee for you should you have questions via text throughout the week. Any checks returned to the office are subject to an additional fee of up to $25.00 to cover the bank fee that we incur.

In addition to weekly appointments, it is our practice to charge this amount on a prorated basis (we will break down the hourly cost) for other professional services that you may require such as report writing, consultations which you have requested, or the time required to perform any other service which may be requested of me. If you anticipate becoming involved in a court case, we recommend that we discuss this fully before you waive your right to confidentiality.

If your case requires our participation, you will be expected to pay for the professional time required even if another party compels us to testify. Court appearance cost starts at $300 per hour.

We are not an in network provider for insurance plans. If you are trying to get reimbursed via third party you will be emailed a receipt of payment for services. This will include the clinical diagnostic requirements which you can submit to your insurance company for third party reimbursement.

_____ _____
Signature of Client/Date Date

_____ _____
Signature of Client/Date Date

_____ _____
Signature of Therapist

HIGH EXPECTATIONS COUNSELING

Client Intake Questionnaire

Please fill in the information below and bring it with you to your first session.

Please note: information provided on this form is protected as confidential information.

Name: _____

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

History
Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No □ Yes, previous therapist/practitioner: _____
Outcome of therapy: _____

Are you currently taking any prescription medication?
□ Yes □ No
If yes, please list:
_____
_____

Have you ever been prescribed psychiatric medication? □ Yes □ No
If yes, please list and provide dates:
_____
_____

General and Mental Health Information
1. How would you rate your current physical health? (Please circle one)
Poor / Unsatisfactory / Satisfactory / Good / Very good

Please list any specific health problems you are currently experiencing:
_____
_____
May we leave a message? □ Yes □ No

2. How would you rate your current sleeping habits? (Please circle one)
Poor/ Unsatisfactory/ Satisfactory / Good/ Very good

Please list any specific sleep problems you are currently experiencing:
_____
_____

3. How many times per week do you generally exercise?

_____

What types of exercise do you participate in? _____

4. Please list any difficulties you experience with your appetite or eating problems:

_____

5. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes
If yes, for approximately how
long?_____

6. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes
If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
□ No □ Yes
If yes, please describe:

_____
_____

8. Do you drink alcohol more than once a week?
□ No □ Yes how much : _____

9. How often do you engage in recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No
If yes, for how long?

_____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

_____

11. What significant life changes or stressful events have you experienced recently?

_____
_____
_____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

Alcohol/Substance Abuse Anxiety □ Yes □ Never □ No

Depression □ Yes □ Never □ No

Domestic Violence Eating Disorders □ Yes □ Never □ No

Obesity □ Yes □ Never □ No

Obsessive Compulsive Behavior □ Yes □ Never □ No

Anxiety □ Yes □ Never □ No

Schizophrenia □ Yes □ Never □ No

Suicide Attempts □ Yes □ Never □ No
other: _____

1. Are you currently employed? Please Circle
□ No □ Yes

If yes, what is your current employment situation? _____
_____

Do you enjoy your work? Is there anything stressful about your current work? _____
_____

Do you consider yourself to be spiritual or religious?
□ No □ Yes
If yes, describe your faith or belief:
_____

3. What do you consider to be some of your strengths?
_____
_____

4. What do you consider to be some of your weaknesses?
_____

5. What would you like to accomplish in therapy?
_____
_____

Any other relevant info: