Healthy Pathways

Pathways to a healthier you

CLIENT INFORMATION & ~~COACHING~~/THERAPY TERMS OF AGREEMENT

Please complete the information, review the terms, sign your name on the signature line and bring these forms with you to your first appointment.

Date:			
Name:			
Home address:	City	State	Zip Code
Primary phone:	May I leave a message?		
Insured Name: (if other than yourself)			
Insurance Provider Name:	Member ID #:	Group #:	Provider Phone # (on the back of your insurance card):
Credit card Number to have on file		Exp Date	CVS
Date of birth:			
E-mail address:	May I email you?		
Current Occupation			
Emergency Contact Name and phone number:			
Name of Primary Care Physician:			
Have you ever received any type of mental health services (counseling, hospitalization, psychiatric services, etc.)?			
No Yes, please explain:			
What mental health medication are you currently taking?			
What medication(s) in the past for mental health that you're no longer taking?			
How did you hear about Healthy Pathways?	Internet search Psychology Today Directory	Referred by a friend/acquaintance Other	

*****If you are using insurance, please email a copy of your insurance card with the intake forms.**

Coaching/Therapy Agreement

Procedure: Sessions are 50 minutes each at the rate of $150. If you need to reschedule any session, please let me know at least 24 hours in advance to avoid being charged for the missed session.

FINANCIAL POLICIES I accept financial responsibility for charges I incur during the course of treatment. • You are required to pay fees at the time of service. **You must provide 24 hours' advance notice if canceling an appointment. Failure to do so results in you being charged a cancellation fee of $150.**

Preparation: I ask that you come to the session prepared with an agenda of what you want from each meeting.

Clinical Emergency: If there is an emergency or crisis during the time we are working together and I become concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, I will do whatever I can within the limits of the law, to prevent you from injuring yourself or others. For this purpose, I may also contact the person whose name you have provided for emergency situations. It is not always possible for me to respond in an emergency situation. If you cannot reach me and are experiencing an emergency, you are to call 911 or proceed to the nearest emergency room. You can also call CMC Behavioral Health 24/7 at (704) 444-2400. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact in my absence if necessary.

Treatment Outcome: While the services provided are intended to benefit you, the client, no particular treatment outcome can be guaranteed.

Termination: You have the right to discontinue treatment at any time. If possible, I ask that you let me know prior to our last session if you are thinking of stopping our work.

Confidentiality: I will comply with HIPAA guidelines relevant to the delivery of my services. I recognize that in the course of our work, you may give me the following: future plans, health information, financial information, job information, goals, personal information, and other proprietary information. I will not at any time, either directly or indirectly, use any information for my own personal benefit. I will not divulge that you and I are in a coaching/therapy relationship without your permission. In certain circumstances it is required that confidential information is disclosed without your consent which includes, but is not limited to the following: • if you are evaluated to be a danger to self or others • if you are a child, elderly, or disabled and i believe you are the victim of abuse or if you divulge information about such abuse • if a court order or other legal proceedings or statute require disclosure • your insurance company requires information in order to pay claims • at your request. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not discuss any clinical information by email or text and prefer that you do not either.

Authorization, Assignment of Benefits and Referral Medical Release:
I hereby authorize the release of medical information, including complete medical records, test results and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review payment directly to Healthy Pathways for all mental health benefits otherwise payable to me under terms of my insurance.

Client has read and agrees to the parameters of the therapy/coaching practice which have been outlined above.

Client Signature: _____ Date: _____

AREAS OF CONCERN: Please circle or highlight all items below that describe your concerns and symptoms.

- Anxiety or nervousness in general
- Loneliness
- Relationship issues
- Family issues
- Self-esteem or personal growth
- Eating issues
- Body image
- Childhood Experiences
- Drugs/Alcohol abuse
- Impulse control issues
- Managing anger
- Mood swings
- Depression or feeling low
- Cutting, hitting or burning yourself
- Thoughts of suicide or homicide
- Sleeping difficulties
- Grief in response to a loss or death
- Trouble adjusting to a recent life change
- Sexuality
- Time Management
- Feeling detached from the world
- Victim of abuse or assault
- Struggling to perform in career or school
- Career identity or planning issues
- Perfectionism or procrastination
- Difficulty concentrating/Attention
- Other:

Please respond to the following questions:

- In considering the above areas of concerns, when did they first start?
  Within the last: □ 30 days □ 6-12 months □ 2 years □ During adolescence □ During childhood

- What areas of your life have been affected because of these problems?

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

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

- Please describe any major losses or traumas you have experienced:

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

- What would you like to accomplish out of your time in therapy?

- Please list any medications, herbs, or supplements. _____

- How would you rate your current physical health? (please circle) Poor Unsatisfactory Satisfactory Good Very good

- Please list any specific health problems you are currently experiencing:
  _____

- How many times per week do you generally exercise? _____ What types of exercise to you participate in _____

- Any change in weight over the past year? □ No □ Yes:

- Are you currently experiencing any chronic pain? □ No □ Yes If yes, please describe
  _____

- Please describe current use of alcohol, cigarettes, and/or recreational drugs:
  _____