InsideOut Counseling
4317 NC-16 Business North
Denver, NC 28037
(704) 483-5505

CONFIDENTIAL INFORMATION SHEET

Today's Date______________________ Referred by____

Client Name____________________________________ Date of Birth______________ Age______

Address____

City________________________________ State________ Zip Code_________________________

Home phone ___________________ Cell ____________________ Work ____________________

Communication: It is alright to contact me with (circle)

Home address Home Phone Cell Phone Work Phone

SS#________________________ Sex: M F Status: Single Married Divorced Widow/Widower

Name of parent/guardian if client is a minor ____

Email address: _________________________________ School(if applicable)____________________

Children: Names and Ages ____

Notify in Case of Emergency:_______________________________ Phone ______________________

Place of Employment ____

Name of Minister ______________________________ Church ______________________________

Family Physician ____________________________________ Phone _________________________

Date of Last Physical Exam __________ Allergies/Medical Conditions: _________________________

Are you currently under medical care? _________ How long? ___________________________________

Currently taking prescribed medications? Yes __ No __ If yes, please describe:

Have you been treated for any of the following:

AIDS, or acquired immune deficiency syndrome, or HIV positive ( ) Alcohol abuse ( ) Cancer ( )
Anemia ( ) Asthma ( ) Diabetes ( ) Drug abuse or addiction ( ) Venereal disease ( )
Epilepsy, seizures, or convulsions ( ) Fainting spells, feeling light-headed, or dizziness ( )
Gastrointestinal problems ( ) Glaucoma ( ) Heart murmur or disease ( ) Migraine ( )
Hepatitis, liver disease, or jaundice ( ) High blood pressure [hypertension] ( ) Stroke ( )
Kidney disease ( ) Lung disease, pneumonia ( ) Rheumatic fever ( ) Thyroid problems ( )
Serious injury or accident ( ) Tuberculosis [TB] ( ) Ulcer ( ) Uncontrolled bleeding ( )

Have you ever been under the care of a psychiatrist, psychologist, or other counselor? Yes__ No__
If yes, please list who, when, and for what presenting problem.

Has anyone in your immediate or extended family ever received treatment for a mental, emotional, or stress-related disorder, or for alcohol or chemical addiction? Yes__ No__
If yes, please indicate who, when, and kind of treatment.

Current Problem Areas: *Please check items applicable to you.*

Self Esteem __	Relationships __	Parent/Child __	Other ______________________
Marital __	Health __	Financial __	Other ______________________
Sexual __	Spiritual __	Depression __	Other ______________________
Eating Disorder __	Drug/Alcohol Abuse __	Educational/Testing/Tutoring __	

I would describe my Spiritual life now as:

In your own words, briefly describe why you are seeking counseling:

Describe briefly the history of your main problem(s) from onset to the present:

CONSENT TO TREATMENT

I acknowledge that I have been offered, read (or have had read to me), and understand the "Counselor Disclosure Statement", "Privacy Practices", and "Client Rights" forms, all related to the therapy that I am considering. I have also had all of my questions answered satisfactorily.

If the client needs a copy of either the Counselor Disclosure, Privacy Practices, and/or Client Rights sheets, please let the front office know.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active part.

I am aware that I may stop my treatment at any time. If I choose to do so, the only thing I will still be responsible for is payment for services I have already received. I understand that I may lose other services or may have other problems if I stop treatment; such as if treatment has been court-ordered, at which time I will have to answer to the court.

I know that I must call to cancel an appointment at least 24 hours before the scheduled appointment time. If I do not cancel and do not keep my appointment, **I will be charged for that appointment**. If I will be more than fifteen (15) minutes late, I understand that I need to call or the appointment will automatically be cancelled. **I understand that if payment for services I receive at InsideOut Counseling is not made, the therapist may stop treatment.**

My signature below shows that I understand and agree with all of the statements contained in this document and the three documents mentioned above and that I consent to treatment.

______________________________ ____________________
Signature of Client/Guardian Date

I, the therapist have discussed the issues above with the client and/or his/her parent/guardian. My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

______________________________ ____________________
Signature of Counselor Date

FEE STRUCTURE

I am not billing insurance at this time. However, to make counseling more affordable I only charge half the normal price for counseling services for offering The standard charge for the initial counseling session is $100.00. The standard charge for future 50 minute sessions is $85.00. If a session lasts longer than 50 minutes, an additional charge will apply. Clients are expected to pay the full amount at the time of service. Cash, personal checks, and Mastercard/Visa and Discover cards are accepted payment methods.

Court appearances and reports are not billable to insurance. The fee for a report or court appearance is $150.00 per hour.

Clients must call to cancel an appointment at least 24 hours before the scheduled appointment time. If the client does not cancel and does not keep the appointment, the client will be charged for that appointment. If the client will be more than fifteen (15) minutes late, they will need to call the office or the appointment will automatically be cancelled.

AFTER HOURS POLICY

There is not a counselor available after hours or on weekends. Therefore, if you have a emergency call 911 or go to your nearest emergency room at your local hospital.

I have read and understand the Fee Structure and After Hours Policy.

______________________________ _________________________

Signature of Client/Guardian Date

COORDINATION OF CARE: COMMUNICATION BETWEEN PROVIDERS

Client name: ____

___ I authorize my counselor to have full communication with my Primary Care Physician.

___ I do not want my counselor and Primary Care Physician to be in communication.

___ I do wish my counselor and Primary Care Physician to communicate, but only in regard to the following issues: medication, physical health, and hospital visits.

Other issues which may also be discussed: ____________________________________

____

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___________________________________ ___________________________

Signature of Client/Guardian Date

FORMS OF COMMUNICATION BETWEEN CLIENT AND COUNSELOR:

_____ Counselor/staff can leave client a detailed cell phone message using the cell phone number provided on page 1 of this form.

_____ Counselor/Staff can leave a detailed email message using the email address provided on page 1 of this form.

____ Counselor/Staff cannot leave any detailed messages via cell phone or email.

___________________________________ ___________________________

Signature of Client/Guardian Date