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 me 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. My counseling fees are $115.00 for the initial 90 minute assessment and $95.00 for each 60 minute follow-up session. 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 $200.00 per hour.

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: _____

_____

_____

_____ _____

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