Intake Packet for New Clients

Address: 7220 N 16th St Suite G ⬩ Phoenix, AZ 85020 ⬩ Tel (480) 707-8172
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Informed Consent for Treatment

Welcome! I look forward to working with you. I know that starting counseling is a major decision and you may have many questions. The purpose of this document is to inform you about what you can expect from counseling and to give you the opportunity to give consent to proceed with the counseling process. We will discuss this during our first session.

My name is Kelly Hurley. I have a master's degree in counseling; I am licensed by the state of Arizona BBHE (Board of Behavioral Health Examiners). I am a Cognitive-Behavior (CBT) therapist, with a special interest and expertise in Dialectical Behavior Therapy (DBT). I help people meet their goals by examining the connection between how they think, feel (emotionally and physically), behave, and interact with their surroundings. I facilitate growth and change in my clients by teaching mindfulness, thought defusion, emotion regulation, distress tolerance, and interpersonal effectiveness; and, I am EMDRIA Certified in Eye Movement Desensitization & Reprocessing (EMDR) for work with disturbing memories and trauma. I provide counseling, skills training, and consultation to individuals, couples, and groups.

Please read this document carefully and mark each applicable box. We will discuss this document during our first session.

☐ I am completing this consent for treatment for individual/couple counseling.
Name____ **OR**

☐ I am completing this consent for treatment for a minor child.
Child's Name _________________________________

☐ I choose to participate in therapy services with Cedar & Oaks Counseling PLC, **AND/OR**

☐ I give permission to Cedar & Oaks Counseling PLC to provide therapy services to my minor child.

Initials

_______I understand that participating in these services is voluntary and collaborative, and that I may end services for myself or my child at any time. I agree to verbally advise Cedar & Oaks Counseling PLC when I decide to terminate services. I understand that, unless otherwise contracted, no contact for 30 days will result in file closure; my file may be reopened upon agreement by both parties.

_______I understand that I will be participating in individual, couples, or family therapy services to address the issues and concerns that I share with my therapist. I understand that the focus of counseling services is on helping me reach my individual/couple/family goals. I understand that there are no guarantees that these services will make me or my partner/family members feel better or resolve my problems, issues, or concerns. Further, although I understand that counseling often results in positive outcomes, I also understand that the counseling process can open up levels of awareness that are painful (e.g. I could feel upset, anxious, angry, and/or uncomfortable).

_______I understand that my client record will be kept confidential, and that confidentiality includes all aspects of the topics discussed within the therapeutic setting. I also understand that, by law, there are limitations to confidentiality in cases when one or more of the following occur: **Intent to commit suicide; Intent to commit homicide; Any other act or intention to act in a way that may be a danger to self or others; Information regarding child or elder abuse that mental health providers are mandated by law to report; A court subpoena for records; Information regarding unprofessional conduct by another behavioral health professional. In addition, I understand that my therapist is justified in informing an identifiable third party of risk of contagious/fatal disease.**

_______ I understand that my therapist may consult or seek supervision from a colleague when it is required or deemed necessary, in order to ensure quality care.

_______ I understand that I have a right to request a copy of my record in writing. I understand that I also have the right to sign a written authorization that will allow Cedar & Oaks Counseling PLC to give and/or receive information verbally and in writing with individuals or entities that I designate. When in couple or family therapy all adults must sign the authorization/release of information form(s).

_______ I understand that I have the right to participate in treatment decisions, including the development of my treatment plan. My therapist will work with me to determine the recommended services based on my situation; however, I have the right to refuse treatment and to withdraw my informed consent for treatment by providing a written request. I understand that if I submit this request, Cedar & Oaks Counseling PLC will no longer be able to provide me with services.

_______ I understand that Cedar & Oaks Counseling PLC has the right to terminate services with me, whether for therapeutic or personal reasons. I understand that should this occur, I will be provided with information on how to obtain alternative therapy services (i.e. referral to another therapist or treatment provider).

_______ I understand that the therapy relationship is exclusively therapeutic (e.g. It is inappropriate for a client and a counselor to spend time together socially, to bestow gifts, or to attend family or religious functions). I understand that the purpose of these boundaries is to ensure that you (client) and I (therapist) are clear in our roles for treatment and that my confidentiality is maintained.

_______ Kelly Hurley may be out of the office several times a year for several weeks at a time. I understand that she will provide me with ample notice and referral to a covering therapist during those times.

I/We have read and understand the above information and have discussed all aspects of informed consent with my/our therapist, Kelly Hurley. I/We hereby consent to receive counseling services from Cedar & Oaks Counseling PLC.

____

Print Name Signature Date

____

Kelly Hurley, LPC Date
A Member of Cedar & Oaks Counseling PLC

Minor or Individual With A Guardian

I/We, the parent(s) or guardian(s) of ______________________________ have read and understand the above information and have discussed all aspects of informed consent with Kelly Hurley. I/We consent that ______________________________ may be treated as a client by Cedar & Oaks Counseling PLC.

______________________________________ ______________________________

Signature(s) of parent(s)/guardian(s) Date

Kelly Hurley, LPC Date
A Member of Cedar & Oaks Counseling PLC

Financial Responsibility

Address: 7220 N 16th St Suite G ⬩ Phoenix, AZ 85020 ⬩ Tel (480) 707-8172
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I. Information Pertaining to Person Financially Responsible

Person financially responsible:

Name:____________________ SSN:________________ Date of Birth:____________

Address:____

City/State:____________________ Zip:____________________

Home Phone:____________________ Work Phone: ____________________

Present employer: ____

Employer's address: ____

II. Office Policy and Financial Responsibility Statement

I understand:

- Initial/intake Assessment session fee for services is $185
- Subsequent sessions are 60 minutes long and $150 (including counseling, individual skills training, therapist or client consultation). Longer or shorter sessions are billed as follows:
  - up to 29 min - $75.00
  - 30-59 min - $150.00
  - 60-74 min - $187.50
  - 75-89 min - $225.00
  - 90-120 min - $300.00
- Insurance: My insurance company will be billed for the session and I will be responsible for all co-pays or deductibles that the insurance company does not pay. (see No Show/Late Cancel below)
- Other professional services (e.g. telephone sessions or coaching sessions lasting longer than 10 minutes, report writing, coordination with other professionals, preparation of records or treatment summaries) will be billed at $150/hr. in 15 minute increments. In-home sessions and legal services plus associated travel time will be billed at $150/hr. Cedar & Oaks Counseling PLC reserves the right to change its fees with 30 days verbal notice.
- Payment is due at the end of each session. I may pay by cash, check, or debit/credit card.
- No Show or Late Cancel: Regardless of how I pay for regular sessions, I will provide Cedar & Oaks Counseling PLC with credit card information to be kept in a secure file. In the event of a returned check, missed session, or cancellation (with less than 24-hour notice), I understand that my credit card will be charged the full fee of $150 for the missed appointment.

Credit Card Information

Card type: ☐ M/C ☐ Visa ☐ HSA Card

Name on Card ____________________________

Address of Cardholder ____
Street City State Zip

Card #____________________________ 3 digit card security code ____________

Expiration Date ________________

- A pattern of canceled /missed sessions or late arrivals may be indicative of problems committing to therapy and will be addressed in session. Missing, canceling, or arriving late to three sessions within a 90 day period may result in termination of services.
- Cedar & Oaks Counseling PLC office line is NOT an emergency number. In the event of a psychological emergency, I may call the **Crisis line at (800) 631-1314**. In the event of a medical emergency, I should call **911** or to go to the closest emergency room. Otherwise I may leave a message and Kelly will get back to me as soon as possible. I understand that this may take 24 - 48 hours.
- I am financially responsible for any and all charges incurred for the treatment of the above-named client. I understand that I am held liable for any balance due on this account and that this balance will be due and payable on demand. I further understand that overdue accounts, with my name on them, may be submitted to a collection agency.

I have read and understand the above office policy regarding length of sessions, late arrivals, charges, returned checks, etc. **I agree to the stated terms.**

____ __________________________

Signature of Client Date

____ __________________________

Signature of Person Financially Responsible Date

Cedar & Oaks COUNSELING PLC

Therapist's Use Only

Dx__________________ ❑ N/A
Insurance Receipt ❑ Yes ❑ No

Intake Assessment

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Please complete this form to the best of your ability. Please note "NA" when an item is not applicable to you.

A. Identification and Contact Information

Name____ Date_________________________

Gender F M Date of Birth__________________ Age: _________

Address____

City/State/Zip____

All calls/e-mails will be discrete.

Home Phone_______________________________May I leave a message? ☐ Yes ☐ No

Cell Phone________________________________May I leave a message? ☐ Yes ☐ No

Work Phone_______________________________May I leave a message? ☐ Yes ☐ No

E-mail____________________________________May I e-mail you? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Living Together

Sexual Orientation: ☐ Heterosexual ☐ Gay/ Lesbian ☐ Other

Whom should I contact in an emergency?

Name_______________________________Relationship__________________Phone_______________

B. Referral

How did you come by my name? ____

If applicable, who suggested that you contact me? ____

May I have your permission to thank this person for the referral? ☐ Yes ☐ No

How did this person explain how I might be of help to you?

C. Reasons for Seeking Counseling. Please describe the main difficulty that has brought you to see me. Is there a particular reason why you have decided to seek therapy now?

Have you been diagnosed by another mental health professional, either recently or in the past? If so, please note the diagnosis (and code if you know it) here.

What have you done to try to fix your problem? (e.g. other types of therapy, medication, self-help)

What was helpful? What wasn't helpful?

Circle any problem that pertains to you at the present:

☐ Nervousness	☐ Relaxation	☐ Making Decisions	☐ Stress
☐ Shyness	☐ Legal Matters	☐ Self Control	☐ Memory
☐ Separation	☐ Energy	☐ Inferiority	☐ Appetite
☐ Drug Use	☐ Loneliness	☐ Bowel Troubles	☐ Marriage
☐ Anger	☐ Education	☐ Sexual Problems	☐ Work
☐ Sleep	☐ Undereating	☐ Alcohol Use	☐ Overeating
☐ Friends	☐ Concentration	☐ Nightmares	☐ Temper
☐ Fatigue	☐ Ambition	☐ Stomach Problems	☐ Divorce
☐ My thoughts	☐ Parenthood	☐ Health Problems	☐ Age
☐ Finances	☐ My Appearance	☐ Suicidal Thoughts	☐ Future
☐ Sexual Abuse	☐ Children	☐ Career Choices	☐ Weight
☐ Unhappiness	☐ Depression	☐ Headaches	☐ Fears
☐ Self-esteem	☐ Sexual Orientation	☐ Physical Abuse	

Anything else that you don't see listed here?

Circle everything that has happened to you in the past three years:

☐ Death of a spouse/partner	☐ Marriage Problems	☐ Changes in marital status
☐ Death of another family member	☐ Family Problems (Children, in-laws)	☐ Loss of Job
☐ Major illness or injury–yourself	☐ Financial Problems	☐ Move to another city or state
☐ Major illness or injury–family member	☐ Legal Problems	☐ Other: ____________________

Please list any additional information that you believe may be helpful or that you want me to know:

What are your interests and hobbies?

What emotions do you have trouble with? How do you deal with them?

What relationships do you struggle with? How do you deal with those difficult relationships?

Who in your life do you consider supportive?

What kinds of skills do you think you might need help with; skills that will help you meet your counseling goals?

D. Education, Work, Military

If you are currently going to school, where? What are you studying?

High School degree? Year graduated________________ OR GED? Year obtained __________________

Other education and degrees including trade schools:

School/Degree	Focus of Study	Year Completed/Graduated

Occupation:______________________________________How Long? ____________________

Place of Employment:________________________________How Long? ____________________

Address:_______________________________City/State:_________________Zip: __________

If not employed, how long has it been since you worked? ________________________________

What kind of job did you have? ____

What caused you to stop working? ____

What other types of work have you done in the past?

Have you ever been or are you now in the military? ☐ Yes ☐ No

E. Relationships

Please list current and past marriages or significant romantic relationships.

To Whom	Length of Relationship (approximate dates)	Children From Relationship? (names & ages)	Reason Relationship Ended

If currently in a relationship:

Briefly describe nature of relationship ______________________________

____

Partner's Age: ____________ Religion: ______________________________

Education, degrees? ____________________ Occupation: ____________________

Is partner currently employed? ☐ Yes ☐ No How Long? ______________________________

Has your partner been previously married? ☐ Yes ☐ No Number of times: ____________________

How long since partner's last marriage? ____________________

Number of children from partner's previous marriages: __________ Ages of partner's children: ____________________

With whom are you currently living? Include pets!

Name	Relationship	Age	How do you get along? Are they supportive of you?	Use of Alcohol/Drugs Mental Illness or Other Problems (note here if person is no longer living)

Siblings, Parents, Extended Family, Friends, Children & Step Children (not already listed)

Name	Relationship	Age	How do you get along? Are they supportive of you?	Use of Alcohol/Drugs Mental Illness or Other Problems (note here if person is no longer living)

Where did you grow up? If not in Phoenix, when and why did you move to the Phoenix area? How was it to grow up in your family?

F. Medical/Physical Information

From whom or where do you get your medical care?

Clinic/Doctor's Name ____________________ Phone__________

Address____________________

When was your last physical exam? ____________

Has your doctor ruled out any medical cause for the symptoms you are here about? ☐ Yes ☐ No

List any health problems for which you currently receive treatment: ____________________

____

List any past health problems including accidents: ____________________

____

List any non-psychiatric medications you currently take and for what reason:____________________

____

Women only:

How many pregnancies have you had?__________Are you pregnant now? ☐ Yes ☐ No

How many live births? __________

Any miscarriages? ☐ Yes ☐ No How many? __________

Any changes in your menstrual cycle? ____________________

Men and women:

Are you sexually active? ☐ Yes ☐ No __________

Do you use birth control methods? ☐ Yes ☐ No

Do you practice safe sex? ☐ Yes ☐ No

Have you ever been concerned about your eating habits? ☐ Yes ☐ No If yes, briefly describe your concerns:

Do you exercise? ☐ Yes ☐ No If yes, how often?__________What do you do?

How do you sleep? Any concerns?

Is there anything else about your physical health that you want me to know?

G. Mental Health

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?
☐ Yes ☐ No If yes, please indicate:

When?	From Whom?	For What?	With What Results?

Do you now or have you ever taken medications for psychiatric or emotional problems? ☐ Yes ☐ No

If yes, please indicate:

When	Prescriber	Medication	For What?	Results

Are you thinking about suicide now? ☐ **Yes** ☐ **No**

Have you thought about suicide in the past? ☐ **Yes** ☐ **No**

Have you ever attempted suicide? ☐ **Yes** ☐ **No**

If yes for any of the above 3 questions, please indicate: when, why, how (how did you try to kill yourself), and what happened (treatment, hospitalization, consequences, etc.) (use a separate piece of paper if needed)

Do you now, or have you ever engaged in self-harm (e.g. cutting, burning, or hurting yourself in any way) or other potentially damaging or impulsive behaviors (e.g. unsafe sex practices, gambling, impulsive spending)?

☐ Yes ☐ No If yes, please describe. Include history, frequency, the last time you engaged in the behavior(s), and anything else you think it would be important for me to know. (use a separate piece of paper if needed)

Are you now, or have you ever been, the victim of any kind of abuse (emotional, physical, sexual)? ☐ Yes ☐ No If yes, please explain: (use a separate piece of paper if needed)

H. Spiritual/Religious Beliefs/Practices. Please answer any or all of the following questions:

Is religion or spirituality important to you?

Do you consider yourself a spiritual person?

Do you believe in a higher power?

Are you affiliated with any particular religion or place of worship? If so, what is it? What gets you through difficult periods in your life?

What brings you hope and joy?

I. Substance Use

Do you believe you have a drug or alcohol problem? Currently ☐ Yes ☐ No

In the past ☐ Yes ☐ No

List all tobacco, marijuana, non-prescribed drugs, and alcohol, that you currently use or have used in the past (indicate frequency and amount):

Type	First Used	Last Used	Amount/Frequency

J. Legal

Please list and describe any arrests or legal problems: