

PROVIDER _____ LOCATION _____

PLEASE FILL OUT ALL INFORMATION IN FULL

CLIENT NAME _____ SS# _____

PARENT/LEGAL GUARDIAN _____ SS# _____

PT. DATE OF BIRTH _____ AGE _____ SCHOOL _____ GRADE _____

ADDRESS _____ APT NO. _____ CITY _____ ZIP _____

HM PHONE _____ WK PHONE _____ REFERRING DR. _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

NAME _____ PHONE: HM _____ WK _____

PLEASE BRIEFLY DESCRIBE THE DIFFICULTIES FOR WHICH YOU ARE SEEKING TREATMENT:

PLEASE LIST OTHER FAMILY MEMBERS IN THE HOME AND THEIR RELATIONSHIP TO THE CLIENT:

PLEASE LIST ANY SIGNIFICANT MEDICAL HISTORY AND CURRENT CONDITIONS: _____

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? WHO PRESCRIBED THEM? _____

HAVE YOU EVER RECEIVED COUNSELING OR PSYCHOTHERAPY BEFORE? IF SO, PLEASE DESCRIBE
CONDITION AND OUTCOME. _____

WHO WAS THE TREATING PROFESSIONAL? _____

MAY WE REQUEST THOSE RECORDS? (If so, please sign the Authorization for Release of Information) _____

MAY WE LEAVE MESSAGES AT HOME? Y___ N___ MAY WE LEAVE MESSAGES AT WORK? Y___ N___

**YOU HAVE A RIGHT TO REQUEST THAT CONFIDENTIAL CORRESPONDENCE BE MAILED TO AN ALTERNATE ADDRESS.
IF THIS IS YOUR WISH, PLEASE PROVIDE THE ALTERNATE INFORMATION.**

It is our policy to send a copy of your evaluation to the referring doctor and to the client/legal guardian. Please initial here to indicate your agreement _____. If you do not wish your evaluation to be mailed either to your home or to your doctor, please provide alternate instructions (example: you may pick up the report at the office). **Note to Medicaid clients:** We are required by Alabama Medicaid to send your evaluation results to the referring doctor. There is no charge for providing your evaluation results as listed above. Additional copies will be charged a fee of \$1.00 per page, minimum charge \$5.00.

PROVIDER _____ LOCATION _____

If you do not wish for claims to be filed to your insurance company, please cross out the insurance information sections in ink and initial here: _____. Any charges incurred will be due in full at the time of service. We accept cash or checks, but are unable to process credit card payments.

PRIMARY INSURANCE:

COMPANY NAME _____ SUBSCRIBER _____
SUBSCRIBER'S DATE OF BIRTH _____ RELATIONSHIP TO CLIENT _____
CONTRACT/ID # _____ GROUP # _____
EFFECTIVE DATE _____ IF BC/BS: BS PLAN # _____ BC PLAN # _____

SECONDARY INSURANCE:

COMPANY NAME _____ SUBSCRIBER _____
SUBSCRIBER'S DATE OF BIRTH _____ RELATIONSHIP TO CLIENT _____
CONTRACT/ID # _____ GROUP # _____
EFFECTIVE DATE _____ IF BC/BS: BS PLAN # _____ BC PLAN # _____

TERTIARY INSURANCE:

COMPANY NAME _____ SUBSCRIBER _____
SUBSCRIBER'S DATE OF BIRTH _____ RELATIONSHIP TO CLIENT _____
CONTRACT/ID # _____ GROUP # _____
EFFECTIVE DATE _____ IF BC/BS: BS PLAN # _____ BC PLAN # _____

Our office will file claims to your insurance company as a courtesy to you. In the event of discontinuing this service, you will be notified in writing with an explanation of our decision. Any services rendered after the date of notice will be due in full at the time of service. Deductibles, co-pays, and services denied by insurance are due at the time of service, or upon receipt of an account statement. Deductibles and co-pays are the responsibility of the guardian who brings the client for treatment. We will be happy to provide you with a copy of the bill and receipt of payment if you are entitled to reimbursement by a third party. Failure to pay these charges in a timely manner may result in your account being turned over to a collection agency or for legal action. Any additional charges incurred in the collection of the account will also be your responsibility.

Your signature below will serve as your authorized signature for the release of protected health information required by your insurance company when filing both paper HCFA-1500 claim forms and electronic claim forms. If you have any questions concerning this release of information, please ask to speak to the office manager.

SIGNATURE _____ DATE _____

I certify that the above information is true and correct to the best of my knowledge. I understand that by law, certain protected health information may be released for the purposes of continuity of treatment, referral to another professional, and/or to gain payment from an insurance company. Alabama law provides that clients 14 years old or older have a right to keep mental health treatment information confidential from legal guardians. Please discuss this with the treating professional if you have any questions or concerns.

SIGNATURE _____ DATE _____

PARENT/LEGAL GUARDIAN _____ DATE _____

WITNESS _____ DATE _____

Keith L. Ellis, MS, LMFT



Family Counseling Center LLC

1275 James Street
Enterprise, AL 3633
Phone: 334-308-2292
FAX: 1-866-614-3263

Welcome to the Family Counseling Center. I appreciate your giving me the opportunity to assist you. This should answer some questions that clients often ask about my therapy practice. It is important to me that you know how we will work together. I believe our work will be most helpful to you when you have a clear idea of what we are trying to do. This **Orientation to Therapy** talks about the following in a general way:

- The risks and benefits of therapy.
- How much services cost, and how I handle money matters
- The goals of therapy are, and what my methods of treatment are like
- Other areas of our relationship

After you read this orientation, we can discuss, in person, how these issues apply to your own situation. You may keep a copy of this agreement and refer to it later. Please read all of it and mark any parts that are not clear to you. Write down any questions you think of; and we will discuss them. When you have read and fully understood this document, I will ask you to sign it and I will keep a copy as our contract. This Standard of Care applies to therapy done by Keith Ellis and all therapist, students and/or interns under his supervision.

I use an integrated approach to therapy. It combines individual and family system psychotherapy insights to offer clients the best possible care.

Mission:

- To help each person we serve to achieve a more satisfying quality of life.
- To provide high quality services to prevent and/or reduce the negative effects of dysfunctional family interactions.
- To promote wellness for each member of the family.

Credentials

- Licenced Marriage and Family Therapist
- B.S.W. (Social Work)
- M.S. Counseling - Marriage and Family Therapy
- Clinical Member AAMFT

Services: Marriage and Family Therapist treat individuals, couples and families.

Time: Individuals, couples, and families can expect each session to last fifty (50) minutes from the time specified. Groups will meet for ninety (90) minutes to 2 hrs. once each week.

Accessibility: Consultation is available through my office at (334) 308-2292 Monday through Friday from 8:30 am to 4:30 pm. Please note that these consultations are primarily for the purpose of arranging or changing an appointment. Only on rare occasions will I conduct therapy via telephone. Such therapy is billable at the applicable rate. I will not interrupt ongoing sessions with other clients to answer phone calls or pages. My **emergency pager number is** (334) 406-1200.

Consultations: Therapists may, at the request of the client, contact others on behalf of a client. If the client is under the care of a Psychiatrist the client must provided a current signed release for consultation with the Psychiatrist. You will be required to sign appropriate release for any such consultation.

Court Appearance: Court appearances will be billed at a rate of \$ 150 per hour from the time I leave the office until I return. This includes travel and waiting time. There will also be a milage charge of 32.50 per mile. The party who issues the subpoena accepts responsibility for payment of such charges. Normally, I do not make court appearances. All parties involved in the therapy must provide a signed release to divulge any confidential communication.

Limitations: Appointments will be set at mutually convenient times. They will not normally be available on weekends or Federal holidays.

Confidentiality: All clients have the right to expect confidentiality at all times. Records will be kept in a coded form. References to a client or his/her family will be by code numbers or letters. The standard of practice for family therapists is to consider the "client" as the entire family system. At a minimum, this includes all members living under the same roof. Therefore, before any information can be given to anyone, a signed release from all members of the family system (who are a part of the therapy) is necessary. The following exceptions to confidentiality exist: Reporting Child Abuse. Those under whose legal age parents' rights are in place. Court Orders, and court orders. Also records may be used to defend any action were brought against the therapist.

Financial Policy: Fees are paid to Family Counseling Center LLC.

Fees are:

\$80.00 per hour (45-50 minutes sessions)

\$ 45.00 per half hour (25 -30 minutes sessions.)

\$ 50.00 per half hour interactive therapy

\$ 120 per (Intake & 90 minutes sessions)

(The cost of testing is additional to the hourly rate and is the responsibility of the client.)

Payment is expected at the time of treatment. If special payment considerations are needed please discuss this with me as we begin therapy. Please let me know if there are ever any questions regarding your bill.

Insurance Information: Some insurance will pay for counseling others will not. Regardless of insurance payment, the client is ultimately responsible for payment of services.

Diagnosis: The standard of practice for marriage and family therapists is to diagnose each family as either FUNCTIONAL or DYSFUNCTIONAL. A diagnosis under the standards of DSM-IV may, when warranted, be given one or more individuals within a client family.

Referral: As per the AAMFT Code of Ethics, a therapist must withdraw from the contract any time she/he feels that the interaction is no longer beneficial to the client. If this happens, a referral to another therapist in or near the client's community will be suggested. The client is free to choose this or another therapist.

Withdrawal from therapy: The client may terminate the contract at any time. However, clients should discuss their decision to terminate with the therapist rather than simply "quitting". If the client elects to simply quit, then missing two (2) successive scheduled appointments, or failing to pay for two successive appointments, will be considered withdrawal from the contract.

Records: The following records are maintained: Attendance, client contact information, test profile(s), and coded process & assessment notes. Typically records are maintained for seven Years or in accordance with existing laws.

Duty to Warn: We will abide by the laws of the State of Alabama in regards to the duty of the therapist to warn whenever there is a reasonable probability of willful harm to self or others. Duty to preserve life takes precedence over duty to maintain confidentiality.

Mandatory Reporter of Child Abuse: Under state law I am a mandatory reporter of child abuse. If such should come up it must be reported to the state and/or law enforcement for investigation.

The Risks of Counseling: The greatest risk of counseling is that it may not by itself resolve your problem or concern. Your growth may be in unintended, or even undesired, directions. For that reason we do our best to assess progress on a week-by-week basis.

Enterprise Behavioral Health Services.: As you know, I work with a group of independent mental health professionals under the name **Enterprise Behavioral Health Services.** This group is an association of independently practicing professionals which shares certain expenses and administrative functions. While the members share a name and office space, I want you to know that I am completely independent in providing you with clinical services and I alone am fully responsible for those services. My professional records are separately maintained and no member of the group can have access to them without your specific, written permission. I will be happy to address any questions or concerns you may have.

My signature acknowledges receipt of this Standard of Care

Date

Family Counseling Center LLC
 1275 James Drive
 Enterprise Alabama 36330
 Phone 334-308-2292 FAX 1-866-614-3263
Personal History—Adult (18+)

Client's name: _____ Date: _____
 Gender: ___ F ___ M Date of birth: _____ Age: _____
 Form completed by (if someone other than client): _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone (home): _____ (work): _____ ext: _____

If you need any more space for any of the questions please use the back of the sheet.

Primary reason(s) for seeking services:

- Anger management Anxiety Coping Depression
 Eating disorder Fear/phobias Mental confusion Sexual concerns
 Sleeping problems Addictive behaviors Alcohol/drugs
 Other mental health concerns (specify): _____

Family Information

Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	No
Mother	_____	_____	___	___	___	___
Father	_____	_____	___	___	___	___
Spouse	_____	_____	___	___	___	___
Children	_____	_____	___	___	___	___
	_____	_____	___	___	___	___
	_____	_____	___	___	___	___

Significant others (e.g., brothers, sisters, grandparents, step-relatives, half-relatives. Please specify relationship.)

Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	No
_____	_____	_____	___	___	___	___
_____	_____	_____	___	___	___	___
_____	_____	_____	___	___	___	___
_____	_____	_____	___	___	___	___
_____	_____	_____	___	___	___	___

Spiritual/Religious

How important to you are spiritual matters? Not Little Moderate Much

Are you affiliated with a spiritual or religious group? Yes No

If Yes, describe: _____

Were you raised within a spiritual or religious group? Yes No

If Yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling? Yes No

If Yes, describe: _____

Legal

Current Status

Are you involved in any active cases (traffic, civil, criminal)? Yes No

If Yes, please describe and indicate the court and hearing/trial dates and charges: _____

Are you presently on probation or parole? Yes No

If Yes, please describe: _____

Past History

Traffic violations: Yes No

DWI, DUI, etc.: Yes No

Criminal involvement: Yes No

Civil involvement: Yes No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Education

Fill in all that apply: Years of education: _____ Currently enrolled in school? Yes No

High school grad/GED

Vocational: Number of years: _____ Graduated: Yes No Major: _____

College: Number of years: _____ Graduated: Yes No Major: _____

Graduate: Number of years: _____ Graduated: Yes No Major: _____

Other training: _____

Special circumstances (e.g., learning disabilities, gifted): _____

Employment

Begin with most recent job, list job history: _____

Employer	Dates	Title	Reason left the job	How often miss work?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Currently: FT PT Temp Laid-off Disabled Retired

Social Security Student Other (describe): _____

Military

Military experience? Yes No

Combat experience? Yes No

Where: _____

Branch: _____ Discharge date: _____

Date drafted: _____ Type of discharge: _____

Date enlisted: _____ Rank at discharge: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical/Physical Health

- | | | |
|--|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Sexually transmitted diseases |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eating problems | <input type="checkbox"/> Sleeping disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Smallpox |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Measles | <input type="checkbox"/> Toothache |
| <input type="checkbox"/> Colds/Coughs | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Mumps | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Menstrual pain | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Dental problems | <input type="checkbox"/> Miscarriages | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological disorders | <input type="checkbox"/> Other (describe): _____ |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Nausea | _____ |

List any current health concerns: _____

List any recent health or physical changes: _____

Current prescribed medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter meds	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you allergic to any medications or drugs? Yes No

If Yes, describe: _____

	Date	Reason	Results
Last physical exam	_____	_____	_____
Last doctor's visit	_____	_____	_____
Last dental exam	_____	_____	_____
Most recent surgery	_____	_____	_____
Other surgery	_____	_____	_____
Upcoming surgery	_____	_____	_____

Family history of medical problems: _____

Please check if there have been any recent changes in the following:

- Sleep patterns Eating patterns Behavior Energy level
 Physical activity level General disposition Weight Nervousness/tension

Describe changes in areas in which you checked above: _____

Chemical Use History

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
					_____	_____	_____	_____
Alcohol	_____	_____	_____	_____	_____	_____	_____	_____
Barbiturates	_____	_____	_____	_____	_____	_____	_____	_____
Valium/Librium	_____	_____	_____	_____	_____	_____	_____	_____
Cocaine/Crack	_____	_____	_____	_____	_____	_____	_____	_____
Heroin/Opiates	_____	_____	_____	_____	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____	_____	_____	_____	_____
PCP/LSD/Mescaline	_____	_____	_____	_____	_____	_____	_____	_____
Inhalants	_____	_____	_____	_____	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____	_____	_____	_____	_____
Nicotine	_____	_____	_____	_____	_____	_____	_____	_____
Over the counter	_____	_____	_____	_____	_____	_____	_____	_____
Prescription drugs	_____	_____	_____	_____	_____	_____	_____	_____
Other drugs	_____	_____	_____	_____	_____	_____	_____	_____

Substance of preference

1. _____
2. _____
3. _____
4. _____

Substance Abuse Questions

Describe when and where you typically use substances: _____

Describe any changes in your use patterns: _____

Describe how your use has affected your family or friends (include their perceptions of your use): _____

Reason(s) for use:

- Addicted
 Build confidence
 Escape
 Self-medication
 Socialization
 Taste
 Other (specify): _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?

Yes No If Yes, describe: _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? Yes No

If Yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? (describe): _____

Does your body temperature change when you drink? Yes No

If Yes, describe: _____

Have drugs or alcohol created a problem for your job? Yes No

If Yes, describe: _____

Counseling/Prior Treatment History

Information about client (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment	_____	_____	_____	_____	_____
Suicidal thoughts/attempts	_____	_____	_____	_____	_____
Drug/alcohol treatment	_____	_____	_____	_____	_____
Hospitalizations	_____	_____	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	_____	_____	_____	_____	_____

Information about family/significant others (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment	_____	_____	_____	_____	_____
Suicidal thoughts/attempts	_____	_____	_____	_____	_____
Drug/alcohol treatment	_____	_____	_____	_____	_____
Hospitalizations	_____	_____	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	_____	_____	_____	_____	_____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

- | | | |
|--|--|---|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Elevated mood | <input type="checkbox"/> Phobias/fears |
| <input type="checkbox"/> Alcohol dependence | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Recurring thoughts |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Gambling | <input type="checkbox"/> Sexual addiction |
| <input type="checkbox"/> Antisocial behavior | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Sick often |
| <input type="checkbox"/> Avoiding people | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Cyber addiction | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Thoughts disorganized |
| <input type="checkbox"/> Disorientation | <input type="checkbox"/> Judgment errors | <input type="checkbox"/> Trembling |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Withdrawing |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Memory impairment | <input type="checkbox"/> Worrying |
| <input type="checkbox"/> Drug dependence | <input type="checkbox"/> Mood shifts | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Panic attacks | _____ |

Briefly discuss how the above symptoms impair your ability to function effectively: _____

Any additional information that would assist us in understanding your concerns or problems: _____

What are your goals for therapy? _____

Do you feel suicidal at this time? Yes No

If Yes, explain: _____

For Staff Use

Therapist's signature/credentials: _____ Date: ____/____/____

Supervisor's comments: _____

_____ Physical exam: Required Not required

Supervisor's signature/credentials: _____ Date: ____/____/____

(Certifies case assignment, level of care and need for exam)