There's Hope! Counseling Services
5215 E. 71st Street #1600
Tulsa, OK 74136
(918) 277-0777

Please complete the following. Thank you for your assistance.

Date_____

CLIENT INFORMATION

Client Name_____

Address _____

City_____ State_____ Zip Code_____

Home Phone_____ Cell / Wk Phone _____

Birthdate_____ Email address: _____

Occupation_____Place of Employment_____

Education (Highest Grade Completed)_____ Marital Status_____

Religious Affiliation_____

SPOUSE OR PARENT INFORMATION (If applicable)

Name_____

Address _____

City_____ State_____ Zip Code_____

Home Phone_____ Cell / Wk Phone _____

Birthdate_____ Social Security Number_____

Occupation_____Place of Employment_____

Education (Highest Grade Completed)_____ Marital Status_____

Religious Affiliation_____

CHILDREN/SIBLINGS

Name	Birthdate/Ages	Grade in School	Living at Home

Whom should we contact in case of an emergency?_____

Telephone Number_____ Relationship_____

Should we need to call to confirm appointments or gather additional information, is it acceptable to leave messages on recorder or with whomever answers the phone? Please comment. _____

Whom may we thank for referring you to us?_____

May we send the person responsible for your referral a "thank you" note? _____

1. Briefly describe the issue for which you are seeking help.

_____

_____

2. How do you think we can best assist you?

_____

_____

3. Who is your personal physician/pediatrician? _____

4. When was your last physical examination? _____

5. Please describe any physical disabilities or major health problems.

_____

_____

6. Please list any medications you or your child (whoever is being seen) are now taking.

_____

_____

7. Please describe any additional information that might be helpful in our understanding of the problem.

_____

_____

8. Have you or your child received psychiatric help or psychological counseling before? (Circle)YES NO

If yes, with whom and dates? _____

_____

Please circle any of the following symptoms/problems that pertain to you or your spouse:

Nervousness	Depression	Fears or phobias	Suicidal thoughts
Shyness	Sexual problems	Separation/divorce	Weight
Having to do things over and over	Coping with a traumatic event	Thoughts I can't get out of my mind	Need to be in control of everything
Finances	Alcohol or drug use	Career choices	Friends
My past	Stomach troubles	Dependency	Relationship problems
Anger/temper	Self-control	Unhappiness	Sleep
Stress	Children	Bowel problems	Headaches
Tiredness	Legal matters	Memory	Lack of ambition
Energy	Insomnia	Making decisions	Loneliness
Procrastination	Education	Inferiority feelings	Concentration
Unresolved grief	Loss of control	Health problems	Nightmares
Marriage	Work	Appetite	Blocked emotions
Being a parent	Unresolved grief	"Up-and-down" Feelings	Relaxation

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CONSENT FOR TREATMENT AND ACCEPTANCE OF FINANCIAL RESPONSIBILITY

I acknowledge that I have received, read, and understand the policies and procedures as described in the Client Information forms and do so indicate by affixing my initials next to each of the following points:

_____1) Confidentiality – I am aware that all information is confidential and cannot be released without my written permission. I have also been informed of exceptions when confidential information could be released including when imminent danger is a risk for self or others, child abuse, elder abuse, or when ordered by the court.

_____2) Payment and Billing Policies - I am aware that I am responsible for payment in full for any charges for services provided on my behalf . I am aware that I may terminate treatment at any time without consequence, but that I will still be responsible for payment of the services I have received. I am aware that if I have not paid for services received, my treatment may be discontinued and my account turned over for collection.

_____ 3) Client Right & Responsibilities – I acknowledge that I have been given a copy of my client rights and responsibilities.

_____ 4) Appointments and Cancellations - I am aware that any cancellations of appointments must be made at least 24 hours in advance of the appointment and if I do not cancel or do not show up I will be charged the full amount for that appointment.

_____ 5) Professional Consultation - I am aware that my therapist may consult or share information with other mental health professionals with expertise if such consultation can be expected to be beneficial in therapeutic treatment. I am also aware that these professionals are under the same confidentiality restraints as my therapist and my identity will not be disclosed and my right to privacy will remain respected.

_____ 6) Risks of Psychotherapy - I am aware that the practice of psychotherapy is not an exact science and that predictions of the effects are not precise or guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided by the therapist identified below.

_____7) Court Testimony and Custody Evaluations – I am aware that There's Hope! Counseling Services make every effort to maintain client confidentiality and therefore do not testify in court regarding custody, divorce action, or other legal matters. I agree not to contact a There's Hope! Counseling Services therapist personally or via my attorney to testify in court.

_____ 8) I do_____ do not _____ have questions about this consent for treatment/financial policy.

I do hereby seek and consent to participate in evaluation and or treatment with the therapist identified below.

_____ _____

Client Signature Date Client Signature Date

_____

Therapist Date

Business Policies

Our experience has been that counseling and psychotherapy are most effective when expectations regarding fees, billing, and cancellation policies are understood by all parties in advance. Please review the information below, and feel free to ask if there are any questions.

FEES

For individual,couples, marital, and family therapy (most sessions are 50 minutes in length. Longer or shorter sessions may be recommended in certain circumstances):

Initial 50-minute **Intake** assessment ……..……..…….$150.00
50-minute **Individual** session ……..$125.00
50-minute **Couples** or **Family** session ……..……..$150.00

Should these fees put a financial hardship on you, please consult with your therapist regarding a sliding scale fee based on income.

PAYMENT

All payments are due at the time of service. We reserve the right to retain a collection agency or attorney to collect unpaid fees after termination of therapy if the former client fails to make a reasonable effort to pay off any outstanding balance.

CANCELLATIONS AND MISSED APPOINTMENTS

If you cannot keep an appointment, please notify our office at least 24 hours in advance so that we can reschedule someone else for the time that has been reserved for you. Unless we are able to reschedule with shorter notice, the regular fee will be charged for appointments missed without notice or canceled with less than 24 hours notice. There is no charge for appointments canceled due to illness or emergency if the office is notified prior to the scheduled appointment time.

My signature below indicates that I have read, that I understand, and that I agree to the business policies outlined above. I agree to assume financial responsibility for the cost of services rendered by There's Hope Counseling Services to me or to the person whose name appears below.

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Client: _____ Client Date of Birth:_____

Responsible Party:_____

Signature of Responsible Party:_____

Date:_____ Witness:_____

There's Hope! Counseling Services

Kim Thomas, LPC, LMFT
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CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ _____ _____
(Name of patient) (date of birth) (social security number)

Hereby authorize There's Hope! Counseling Services _____ to disclose to _____ to obtain from:

_____
Person(s) Organization

_____
Address City State Zip Phone

Information pertaining to my care and treatment including psychiatric, drug abuse and /or alcoholism records. Information required:

____ Termination/Discharge Summary ____ Therapist Evaluations

____ Psychiatric/Psychological Evaluation ____ Treatment Plan / Progress Notes

____ Medical History ____ Psychological Assessment / Testing

____ Other (Specify) _____

This consent is for the period: ___ A. Beginning _____ and ending _____.

___ B. Duration of Treatment.

___ C. _____ months after patient signature.

I understand that my right to confidentiality under Federal law and regulations does not protect any information about suspected child abuse or neglect. In addition, if there is reason to suspect that I am in danger of physical or bodily harm, or that any one else is in danger of physical or bodily harm that this information is not protected under Federal Regulation. I understand this authorization is subject to revocation by me at any time except to the extent that action has already been taken in reliance on it. With this knowledge, I give consent to the release of information in my medical records including any information concerning my identity and release There's Hope! Counseling Services, its agents and employees from any liability in connection with the release of the information contained therein.

_____ _____
Signature of Client Date

_____ _____
Signature of Client Date

_____ _____
Witness Date

There's Hope! Counseling Services

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ADULT HISTORY AND GOALS QUESTIONNAIRE

Please complete this questionnaire and give to your therapist at your initial appointment. This information will help your clinician gain an understanding of the problems for which you are seeking help and other important events in your life.

YOUR NAME IN FULL	DATE OF BIRTH	AGE
SPOUSE'S NAME IN FULL	DATE OF BIRTH	AGE

WHO REFERRED YOU TO US? TODAY'S DATE

WHAT EMOTIONAL, BEHAVIORAL, OR INTERPERSONAL PROBLEMS ARE YOU EXPERIENCING THAT ARE CAUSING YOU TO SEEK THERAPY AT THIS TIME?

HOW LONG HAVE THESE PROBLEMS BEEN AFFECTING YOUR LIFE?

IF APPLICABLE, DESCRIBE HOW THE PROBLEMS ARE INTERFERING WITH WORK OR SCHOOL PERFORMANCE, FAMILY LIFE, SOCIAL LIFE, AND RELATIONSHIPS

DESCRIBE ANY STRESSFUL CIRCUMSTANCES THAT MAY BE CONTRIBUTING TO THESE PROBLEMS

WHAT HAVE YOU DONE TO SOLVE THE PROBLEM?

HAVE ANY OF THESE SOLUTIONS BEEN HELPFUL?
☐ YES ☐ NO

PREVIOUS TREATMENT

HAVE YOU RECEIVED PREVIOUS TREATMENT FOR THESE PROBLEMS? ☐ YES ☐ NO (describe below)

DATE	NAME OF FACILITY OR PROFESSIONAL WHO PROVIDED TREATMENT	TYPES OF TREATMENT	RESPONSE

WHAT DID YOU FIND MOST HELPFUL ABOUT YOUR PREVIOUS TREATMENT?

WHAT WAS LEAST HELPFUL ABOUT YOUR PREVIOUS TREATMENT?

EDUCATION AND EMPLOYMENT

LIST ANY RECENT CHANGES

DESCRIBE PLANS YOU HAVE TO MAKE CHANGES

EDUCATION:

☐ DID NOT COMPLETE HIGHSCHOOL ☐ COMPLETED HIGHSCHOOL ☐ COMPLETED BUSINESS / TECHNICAL TRAINING ☐ COMPLETED COLLEGE ☐ COMPLETED GRADUATE SCHOOL

OCCUPATION

☐ TECHNICAL / TRADE ☐ SALES ☐ CLERICAL ☐ OTHER

☐ HOMEMAKER ☐ PROFESSIONAL ☐ UNEMPLOYED YEARLY INCOME $ _____

MILITARY SERVICE: ☐ YES ☐ NO	IF YES, WHAT BRANCH?	HIGHEST RANK	TYPE OF DISCHARGE

MEANING AND SPIRITUALITY

WHAT GIVES YOUR LIFE MEANING?

IS SPIRITUALITY OR RELIGION A SIGNIFICANT PART OF YOUR LIFE? ☐ YES ☐ NO	DO YOU PARTICIPATE IN A SPIRITUAL COMMUNITY? ☐ YES ☐ NO	WHAT RELIGION OR DENOMINATION DO YOU IDENTIFY WITH?

HOW ACTIVE ARE YOU THIS COMMUNITY?

HOW CAN YOUR BELIEFS, VALUES, OR PRACTICES HELP YOU OVERCOME THE PROBLEMS THAT BRING YOU INTO TREATMENT?

OTHER IMPORTANT INFORMATION

IF APPLICABLE, DESCRIBE ANY FINANCIAL DIFFICULTIES YOU ARE HAVING

IF APPLICABLE, DESCRIBE ANY PAST OR CURRENT LEGAL PROBLEMS

LIST WHAT YOU DO FOR FUN OR RECREATION

HOW MANY CLOSE FRIENDS DO YOU HAVE?	ARE YOU SATISFIED WITH THIS NUMBER? ☐ YES ☐ NO

IS THERE ANY ADDITIONAL INFORMATION YOU WOULD LIKE ME TO KNOW REGARDING YOURREASON FOR CHOOSING TO COME INTO THERAPY?