There's Hope! Counseling Services
7146 S. Braden Ave., Suite #100
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_____ Email Address: _____

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 voice mail 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. Please describe any physical disabilities or major health problems.

_____

_____

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

_____

_____

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

_____

_____

6. 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

By initialing each section, I acknowledge I have received, read, and understand the Policies and Procedures as described in the Client Information forms:

_____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 read 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 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

_____

_____

Additional Client Signature (If more than one client is being seen) Date

There's Hope! Counseling Business Policies

Welcome to There's Hope! Counseling. Please review the following information and ask if there are any questions. 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.

FEES

Sessions are 50-60 minutes in length although longer or shorter sessions may be recommended in certain circumstances.

Individual Session……....$150.00
Couples or **Family** session ……..$180.00

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

When you make an appointment, a specific time is reserved for you. If you are late to your appointment, you will be seen for the remaining portion of your reserved time. If you need to cancel an appointment, please notify our office 24 hours in advance or else you will be charged the full fee.

My signature below indicates I understand and agree to the above business policies. 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:_____