There's Hope! Counseling Services
6931 S. 66th E. Ave. Suite #220
Tulsa, OK 74133
(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 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 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 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

There's Hope! Counseling 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 …………………………..$150.00
50-minute **Couples** or **Family** session …………..……..$180.00

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:____