Client Information

To make our first meeting more productive, please provide complete and accurate responses to the following. All information will be treated confidentially. If you have a question about an area, put a check mark by it and your counselor will discuss it with you during the session.

Date: _____ Client's Full Name _____ Sex _____

Nickname _____ Age _____ Birthdate _____

Home Phone: ( )_____ Other Phone (cell, pager, etc.): ( )_____

Address _____ City/Zip_____

Parents'/Guardian's Names (if under 18) _____

Employer _____ How long? _____ Type of work _____

Work phone: ( )_____ Ext. _____ OK to call at work? _____

Circle last year of school completed: 6 7 8 9 10 11 12 GED College: 1 2 3 4 Other:_____

Person not living with you to contact in case of emergency: Name: _____

Phone: ( )_____ Relationship: _____

Marital Status: (circle current status)

Never married Engaged Living with someone Separated Divorced Widow(er) Married

How long in current status? _____

Spouse/partner name_____ Age_____ Occupation _____

How long married or living with this partner? _____ Are you happy in this relationship? _____

Number of prior marriages for you _____ For your partner _____

Household Members Names	Relationship to You	Age

If you have minor children from a previous relationship not living with you, give first names, ages, location: _____

_____

Does anyone else in your household have any major medical or emotional problems? _____ If yes explain: _____

_____

Describe your general health: Excellent ____ Good ____ Average ____ Poor ____

List all doctors that you see: _____

_____

List any ongoing medical conditions (high blood pressure, diabetes, etc.): _____

_____

List any medications you are currently taking (include dosage and purpose): _____

_____

_____

Have you ever been hospitalized in a mental health or substance abuse treatment facility? _____ If so, give reason, dates, and name of facility: _____

_____

If you have been to counseling before, list reason, dates, and name of counselor: _____

_____

If you are currently involved in any type of counseling or support groups, please specify: _____

_____

Circle your current use of alcoholic beverages: Never Occasionally Once per week Several times per week Daily

Describe any other current drug use _____

Circle any losses you have experienced within the last 18 months:

Death of: Spouse Child Parent Sibling Grandparent Friend Pet

Divorce Separation Broken engagement Change of school Suicide of loved one Miscarriage Abortion

Infertility Bankruptcy Homelessness Career or job loss Other _____

Circle any of the following that you have experienced:

Child abuse: physical, sexual, emotional. Spouse abuse: physical, sexual, emotional. Abandonement Rape Robbery

Assault Suicide attempt Major accident Major surgery Other _____

Circle any of the following that concern you now:

Relationship with: Spouse Boyfriend/Girlfriend Children Parents In-laws Co-workers Friends Teachers

Alcohol Drugs Eating habits Shopping Overwork Weight Procrastination Sleep Sex Anger Depression

Grief Anxiety Loneliness Low self-esteem Stress Fear Mood swings Spirituality Suicidal thoughts

Other _____

_____ _____

Client signature Date

Consent for Services

I hereby authorize Steps Counseling Inc. to administer mental health and/or substance abuse treatment to the below named client.

I understand that this consent can be revoked orally or in writing prior to or during the treatment period at which point treatment would cease and an appropriate referral would be provided to me. I acknowledge that no guarantees or assurances as to the results of treatment are made or implied.

I understand that I am personally responsible for the costs of all therapy services rendered and the costs of treatment will be discussed with me. I also understand that payment for services is expected at the time services are rendered.

I have read and fully understand the above consent:

Client Name_____Date_____

Parent or guardian for minors_____

Please answer the following questions:

How did you learn about our Center or who referred you:_____

_____

Explain why you are pursuing counseling:_____

_____

What would you like to gain:_____

_____

Steps Counseling, Inc.

Important Information for Clients

As a client, you have the right to be treated with respect and dignity, to be treated by qualified professionals and to be treated in privacy. You have the right to have answers to your questions and to know about the treatment process. You have the right to have your written records and all information about you known by your therapist held in strictest confidence. However, your therapist may reveal confidential information about you under any of the following conditions:

a. If you sign a Release of Information Form, information can be shared with the person or agency that is designated on the form.
b. Even without a release, a court may order your therapist to reveal information about you.
c. By law, all suspected cases of the abuse and neglect of a child, elderly person or handicapped person must be reported to the Department of Children and Families.
d. If you threaten to harm yourself or another person, your therapist may reveal information as necessary to protect you or the other person.
e. Your therapist will gladly discuss their background and qualification with you. Furthermore, all therapists licensed in Florida are under the supervision of the Department of Health. To verify their licensure or register a complaint which you cannot resolve with your therapist, you may contact:

Florida Department of Health
Board of Clinical Social Work, Marriage and Family Therapy,
and Mental Health Counseling
4052 Bald Cypress Way, Bin #C08
Tallahassee, Florida 32399-3258 Phone: (850) 245-4474

As a Client, you will be expected to:

a. Arrive on time for your scheduled appointments. If you arrive late, your session may still need to end at the appointed time so others can begin their time. In that case, you would still be responsible for the cost of your entire session. Therapy sessions are usually 50 to 60 minutes.
b. To provide at least 24 notice if you need to cancel or reschedule. There will be a $25.00 no show fee if you miss your appointment unless indicated by your therapist.
c. Call and stay home if you are ill or have a cold or fever or are in quarantine.
d. To pay for services at the end of each session. If we are billing your insurance company, you still are expected to pay co-pays. You are responsible for any fees the insurance company doesn't pay.
e. All paperwork is to be filled out as required by the therapist. If you refuse to do so, the therapist has the right to not accept you as a client.
f. Pay your co-pay over the phone by credit card if you have a Virtual Appointment scheduled.

I understand and have read the above:

Client Signature Date: Parent/Guardian

Steps Counseling Inc. 11029 Spring Hill Drive, Spring Hill, FL 34608

Insurance Consent

I understand that I am personally responsible for the costs of services not covered by my insurance but not limited to unmet deductibles, co-payments, and any fees or portions of fees not paid by my insurance carrier. I understand that these fees are due at the time of service.

I hereby choose to have my insurance company billed for these services. Benefits due to me under the below policy are hereby assigned to Steps Counseling Inc. **I understand that specific diagnostic and treatment information will be required by my insurance company. I consent to the release of all requested confidential information to billing services and insurance companies for the purpose of processing my claims.** I understand that Steps Counseling, Inc. cannot be responsible for confidential information once it is released to others.

Client Name_____

Client Signature:_____Date_____

Parent or guardian_____

Insurance Co._____(phone)_____

Policy #_____

Please allow us to make a copy of your insurance card

Many managed care insurance companies request that you primary care physician (PCP) about your treatment here. We will not release this confidential information without your consent. Please let us know by checking the box of your choice and signing:

1._____I choose to have the confidential information release to my PCP. His/her name and

address is _____

2._____I choose not to have confidential information released to my PCP because:

_____I don't have a regular physician

_____I don't want them informed about my treatment

_____I would rather have information sent to

_____

_____

Client Signature _____Date_____

Signature of Parent/Guardian_____

Important Information For Clients

As a client, you have a right:

1. To be treated with respect and dignity.
2. To be treated by qualified professionals.
3. To be treated in privacy.
4. To receive answers to your questions about the treatment process.
5. To have your written case record and all information about you known by your therapist held in strict professional confidence. **However, your therapist may reveal confidential information about you under any of the following conditions:**
   a) If you sign a release of information form, information may be shared with the person or agency that you designate on the form.
   b) Even without a signed release, the Court may order your therapist to reveal confidential information about you.
   c) By law, all suspected cases of the abuse or neglect of a child, elderly person, or handicapped person must be reported to the Department of Children and Families (formerly HRS).
   d) If you threaten harm to yourself or another person, your therapist may reveal information as necessary to protect you or the other person.
6. To have access to information about the qualifications of your therapist. Your therapist will gladly discuss their background with you. Furthermore, all therapists licensed in Florida are under the supervision of the Department of Health. To verify the licensure of a therapist or to register a complaint which you have been unable to resolve with your therapist, you may contact:

   Florida Department of Health
   Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling
   4052 Bald Cypress Way, Bin #C08
   Tallahassee, Florida 32399-3258 Telephone: (850)245-4474

As a client, you will be expected:

1. To arrive on time for your scheduled appointments. If you arrive late, your session may still need to end at the appointed time so that other sessions can begin on time. In that case, you would still be responsible for the cost of your entire session. For planning purposes, therapy sessions generally last approximately 50 minutes.
2. To provide at least 24 hours notice if you wish to cancel or reschedule an appointment. When you schedule an appointment, that time is set aside just for you. **Therefore, if you miss an appointment or fail to provide 24 hour notice when changing appointments, you will be charged a fee.**
3. To pay for services at the end of each session unless other arrangements were previously made with your therapist. If we are billing your insurance company for services, you are still expected to make any required copayments for each session. Also, remember that if your insurance company does not pay for any reason, then you are responsible for the payment of all fees.

I hereby acknowledge reading and/or understanding the above.

_____	_____	_____
Client Signature	Date	Parent/Guardian (for minors)