**Today's Date:** ____________________

**Hope Center**
**10274-A Hwy 104**
Fairhope, Al. 36532

**Name:** ______________________________________________
First MI Last

**Address:** ____________________City____________State & Zip____________Email:____________

Home# (___)____________Cell# (___)____________**Pharmacy Name-Location and #**____________

________________________________________________________________________________

**Date of Birth:** ______________ **Sex:** ❑ Male ❑ Female **Social Security Number:** ______________

**Race/Ethnicity:** ❑African American ❑White ❑Native American ❑Asian ❑Latino/Latina ❑Other (specify):________

**Marital Status:** ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other (specify):____________

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**Employment Status:** ❑ Employed ❑ Unemployed **Number of hours worked each week:**_____

**Employer's Name:**________________________ **Employer Phone #** ______________

**Health Insurance:** ❑ None ❑ Medicaid ❑ Medicare ❑ Other ______________

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**Please Provide 2 Emergency Contacts**

**Next of Kin/Emergency Contact:**________________**Phone:**(___)________**Relationship:** ________

**Emergency Contact:**________________**Phone:**(___)________**Relationship:** ________

**Church Affiliation:**____________________________________________

**Referred by:** ❑Physician ❑Dentist ❑Friend/Family ❑Hospital ❑Media ❑Yellow Pages ❑Church______________ ❑Other (specify):______________

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**Primary Care Physician:** ____________________ **Physician Phone:** (___)____________

**Have you been to the Emergency Room in the last 12 months?** ❑Yes ❑No
If yes, which hospital ____________________ Month/Year ________/________

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**COMPLETE IF PATIENT IS A CHILD UNDER 18:**

**Name of Responsible Party:** ________________________________

**Social Security Number:** ______________ **Date of Birth:** ____________

❑**Same as Above** or **Street Address:** ____________________**City:** ____________ **Zip:** ________

**Home Phone:** ______________ **Work Phone:** ____________ **Other Phone:** __________

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**The above information is true to the best of my knowledge. I understand that I am financially responsible for the balance of any office visits. By signing below I am stating I have no insurance of any kind. I also authorize Hope Center, Inc. to release or obtain any information required to establish my status as a client/patient.**

**Signature:**________________________________ **Date:**______________

**Signature of Parent/Guardian:** ____________________ **Date:**______________

**Hope Center Witness:**__________________________ **Date:**______________

List the members of your family and all others in your home

Name Age Relationship

Has there been any psychiatric/psychological counseling for self and/or anyone else in your family? Circle one: Yes No

If you answered yes:

Who When Where

Please list any dates and places of psychiatric hospitalizations ______________________

Have any major changes of any kind occurred in your family in the last five years? (e.g., moves, changes in family composition, marital status, income, disability)

List any significant health problems for which you are currently receiving treatment

List any medications that you are taking, dosage and frequency, and prescriber

Medication Dosage/Frequency Prescriber

Please circle any of the following problems that pertain to you:

| | | | |
|---|---|---|---|
| Nervousness | Depression | Fear | Shyness |
| Health problems | Sexual problems | Work | Finances |
| Legal Matters | Divorce | Anger | Friends |
| Self Control | Relaxation | Stress | Ambition |
| Making decisions | Insomnia | Energy | Temper |
| Inferiority feelings | Children | Sleep | Drug Use |
| Alcohol Use | Infertility | Headaches | Appetite |
| Marriage | Suicidal thoughts | Fatigue | Concentration |
| Education | Career choices | Memory | Nightmares |
| Stomach trouble | Separation | Loneliness | Unhappiness |

How would you like our center to help you?

______________________________________________

______________________________________________

______________________________________________

______________________________________________

# CONSENT FOR SERVICES AND FEE AGREEMENT

## OFFICE HOURS

Our office staff provides receptionist services from 8:30a.m. until 5:00p.m. Monday through Wednesday. Thursday and Friday vary, however; voice mail is available.

## EMERGENCIES

The Hope Counseling Center is staffed by Christian Counselors who volunteer their time. Due to this fact, we have limited operating hours and DO NOT provide after hours services. In the event of an emergency, call 911 or proceed to the nearest hospital emergency room. After business hours, our phones are answered by a voice mail system and messages are not retrieved until the following business day. If your therapist will be unavailable for an extended time (vacation or illness) he/she will provide you with the name of a colleague to contact if necessary. However, **all** after hours emergencies should be handled as described above.

## SCHEDULING APPOINTMENTS

Scheduling appointments is your responsibility and is generally done jointly with your therapist. Should you need to cancel or reschedule an appointment, please call our office within 24 hours of the scheduled appointment. *Please refer to our "Missed Appointment" policy for more information.

## COUNSELING SESSIONS

Therapy sessions usually last 50 minutes. Their frequency will be determined between you and your therapist according to your needs. Parents who bring their children to the HCC are responsible for their supervision at all times in the lobby and/or the building at large.

## THE HOPE CENTER LIMIT OF SERVICE

The HCC does not seek to represent itself as a full-service, mental health facility. We are staffed by Christian Counselors who volunteer their time, therefore, counseling services are provided by appointment only. We DO NOT provide an after hours emergency phone number for life-threatening emergencies. If a client feels that they are in danger of harming them self or others, we instruct them to call 911 or to proceed to the nearest hospital emergency room.

## NOTICE OF CONFIDENTIALITY

Federal and state laws and regulations protect the confidentiality of mental health records maintained by our office. Violation of such is a crime. No information is released to any source outside the agency without your written permission or a court order or a medical emergency. Crimes committed against the HCC staff, property, or threats of crimes are not protected by confidentiality laws. Suspected child/elder abuse and neglect is not protected and must be reported

to proper authorities. If you would like a Notice of Privacy Practices that covers how your health information is used and disclosed please ask the Office Manager for a copy.

## CANCELLATION/NO SHOW POLICY

For the consideration of your therapist and other clients, you are expected to keep scheduled appointments or cancel at least 24 hours in advance. Please refer to our "Missed Appointment" policy for more information.

## DISCHARGE FROM SERVICES CAN OCCUR IF YOU:

1. Agree that your treatment goals are met and/or discharge planning has occurred;
2. Refuse to follow your treatment goals;
3. Require services that are not offered here;
4. Miss 2 (two) scheduled appointments without 24 hours notice or do not keep your account current.

## PAYMENT

**Payment is expected at the time of service unless there is a prior agreement in your file.**

## CONSENT FOR SERVICES

I authorize the HOPE Counseling Center to provide outpatient counseling and referrals to other agencies as my therapist deems necessary. I will actively participate in counseling and work towards the goals that my counselor and I develop. I will keep my account with the HOPE Counseling Center current. (You may request a copy of this form for your records)
***I understand and agree that as part of the Hope Center's commitment as a training facility, a counselor-in-training in the master's or doctoral program at ______________________, under the supervision of ______________________, an assigned faculty member, may participate in counseling sessions, may be primary counselor, and may discuss my case with the Hope Center Counseling Coordinator.

*****I have read and understand this Consent for Services and Fee Agreement. I understand that a copy of the Notice of Privacy Practices is posted in the Hope Center waiting room. I understand that I may request a copy of this form and/or the Notice of Privacy Practices.**

______________________________________________________________

Signature of Client, Parent or Guardian Date

Hope Counseling Center
10274-A State Highway 104
Fairhope, AL 36532

# Limits of Confidentiality

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another part without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

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**Duty to Warn and Protect**
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

**Abuse of Children and Vulnerable Adults**
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social serve and/or legal authorities.

**Prenatal Exposure to Controlled Substances**
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

**Minors/Guardianship**
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

**Court Order**

*I agree to the above limits of confidentiality and understand their meanings and ramifications.*

______________________________________________
Client Signature (Client's Parent/Guardian if under 18)

______________
Today's Date

**CONSENT FOR TREATMENT**

I give consent for ________________________________________to be seen at Hope Center; whether it be for medical, dental or counseling for evaluation and treatment. (If you are the patient, please sign for yourself).

Signature______________________________________________Date_____________
Relationship to Patient____________________________________

I_______________________________________________________do hereby give Hope Center and parties designated by Hope Center, the right to use my image or photo in publications or promotional materials and displays.

Signature______________________________________________Date_____________

**RECORD OF HIPAA NOTIFICATION**

I have read the Notice of Privacy Policy and Practices of the Hope Center.

Signature______________________________________________Date______________
*If you would like a copy of the Privacy Policy and Practices please notify the receptionist.

**EMERGENCIES**

I understand the Hope Center Medical and Dental Clinic is staffed by professional doctors and dentists who volunteer their time. Due to this fact, the Hope Center has limited operating hours and does not provide after hours services. In the event of an emergency, call 911 or proceed to the nearest hospital emergency room. After business hours, Hope Center phones are answered by a voice-mail system and messages are not retrieved until the next business day.

Signature______________________________________________Date__________________

Hope Counseling Center
10274-A State Highway 104
Fairhope, AL 36532

# Missed Appointment Policy

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Missed appointments make scheduling prompt and convenient appointment times for our new and existing clients extremely difficult. Therefore, the Hope Counseling Center has a policy that requires 24 hours advance notice to cancel or reschedule an appointment. If you do not cancel an appointment at least 24 hours ahead of time, this will be considered a missed appointment and you may be charged a "missed appointment fee." **Please note, after 2 (two) missed appointments, you will be required to pay in advance in order to re-schedule any future appointments. Continued missed appointments may result in termination of services. Referrals to other community resources will be made available upon request.

Thank you for your cooperation in this matter.

*I have read and understand the statement noted above.*

______________________________________________

Please Print Your Name

______________________________________________

Client Signature (Client's Parent/Guardian if under 18)

____________

Today's Date