Gracelight Counseling Center

2216 Shadowlake Drive
Oklahoma City, OK 73159

Phone: 405-626-1951
www.gracelightcounseling.com

Adult Client Information Form

Date: _____

A. Identification

Your name: _____ Date of birth: _____ Age: _____

Home street address: _____Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ Cell Phone: _____

Calls will be discreet, but please indicate any restrictions: _____

B. Referral: Who gave you my name to call?

Name: _____ Phone: _____

Address: _____

May I have your permission to thank this person for the referral? Yes No Initial _____

How did this person explain how I might be of help to you?

_____

C. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

Current medications: _____

D. Your current employer

Employer: _____ Address: _____

Work phone: _____

E. Your education and training

Dates From	To	Schools	Adjustment to school	Did you graduate?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

F. Employment and military experiences

From	To	Name of military/employers	Job title or duties	Reason for leaving

G. Family-of-origin history

FAMILY MEMBER	LIVING (Y/N)	AGE	HEALTH GOOD	FAIR	POOR	If deceased, cause of death
Father						
Mother						
Brothers						
Sisters						

Check condition and indicate relationship of any blood relative that has or has had any of the conditions listed below:

Alcoholism/Substance Abuse_____

Allergies_____

Birth Defects_____

Cancer_____

Depression_____

Heart Attack_____

High Blood Pressure_____

Migraine_____

Mental Illness_____

Learning/Attention Problems_____

Suicide/Suicide Attempt_____

Other (Specify) _____

H. Significant relationships

Name of person	Person's age started	ended	Your age started	ended	Reasons for ending

Date of current marriage: _____ Spouse's name: _____ Spouse's age: _____

I. Children (Indicate which are from a previous relationship with the letter P in the last column)

Name	Current age	Sex	School	Grade	Adjustment problems?	P?

J. Spiritual Life

Would you like to incorporate spiritual or religious beliefs in your treatment? Yes/ No Initial____

Agreement to Pay for Professional Services

I, the client, request that the therapist named below provide professional services to me and I agree to pay this therapist's fee of $ 150.00 per 45/50 minute session. This same fee will be applied per each hour of consultation, assessment, or other therapeutic activity unless otherwise negotiated in writing.

I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform her, in person or by certified mail that I wish to end it.
I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me up until the time I end the relationship.

I understand that if I do not pay for services that the services provided may be terminated by the therapist. Continued non-payment of fees may result in further consequences such as my case being referred to a collection agency. I agree that I am responsible for the charges for services provided by this therapist to me, although other persons or insurance companies may make payments on my account. If my any part of my fees is being paid by an insurance company or other third-party payer, I understand that this may result in limitations to my confidentiality.

_____ _____
Signature of client Date

_____
Printed name

I, the therapist, have discussed the issues above with the client. My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Signature of therapist Date

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CONSENT FOR TREATMENT FOR ADULTS

Client's Initials

Therapy sessions and file information are confidential.
Except in cases of: (a) court orders/subpoenas, (b) to defend legal action against Gracelight Counseling Center, (c) need to prevent harm to self or others, and (d) suspected child abuse/neglect. Third party billing and lawsuits I bring related to mental health issues may also limit the confidentiality of my file. _____

There are some limitations to my access to my file.
While I have the right to access my file, I understand that doing so may jeopardize the therapeutic process. I agree to consult with my therapist about any questions I have concerning the content of my file or sessions. _____

I must sign release forms before information can be exchanged with others.
The privacy of any electronic communication cannot be assured. Do not use email for urgent matters. I may request restrictions on the use/disclosure of information in my file for treatment, payment and health care operations, but the therapist is not bound to agree with my request. _____

Some information from my file may be used in research.
I understand that any identifying information will not be used in research. _____

Gracelight Counseling Center does not provide after-hours or emergency services (use 911 for after-hours crises). _____

The practice of psychology and related disciplines is not an exact science.
No guarantees have been made to me regarding the results of services. I am responsible for working with my therapist to help ensure better treatment outcomes. _____

The therapist is not a medical doctor and they cannot prescribe medications. _____

I consent to undergo all recommended testing and treatment procedures.
I can refuse or discontinue testing or treatment at any time. _____

I agree to pay my clinic bill. Payment is due at the beginning of sessions and I must cancel at least 24 hours before my session or I am responsible for the cost of the session.
Consequences of non-payment may include termination of services or being referred to a collection agency. _____

I acknowledge that my therapist has reviewed the General Consent for Treatment with me.

_____	_____	_____
Signature of Therapist	Signature of Client	Printed name of Client
Date: _____	Date: _____	

CONFIDENTIAL

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Notice of Privacy Practices

This notice talks about **privacy information**. We've always taken great care to safeguard your privacy. What is new is a government regulation requiring us to explain your rights. This notice describes how mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by applicable federal and state law to maintain the privacy of your health information. We are required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. In the event that the notice is changed, a new notice will be sent to you by mail or at the time of your next appointment. You may request a copy of our Notice at any time. This takes effect January 2011 and will remain in effect until we replace it.

Uses and Disclosures of Protected Health Information

You will be asked to sign a consent form. Once you have consented to the use and disclosure of your protected health information for treatment by signing the consent form, this agency will use or disclose your protected health information as described below.

- **Treatment:** We may use and disclose, as needed, your protected health information to provide, coordinate, or manage your health care and any related services.
- **Health Operations:** We may use and disclose, as needed, your health information in connection with our operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of mental healthcare professionals, evaluating practitioner and provider performance, employee review activities, conducting training programs, accreditation, certification, licensing or credentialing activities, and conducting or arranging for other business activities.
- **Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization:** Will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the notice.
- **Emergencies:** We may use or disclose your protected health information in an emergency treatment situation. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Other permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

- **Required by Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.
- **Health Oversight:** We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.
- **Abuse or Neglect:** We may disclose your protected health information to the Department of Human Services which is authorized by law to receive reports of child abuse or neglect. In addition,

we may disclose your protected health information if we believe that you have been a victim of abuse or neglect to the Department of Human Services.

- **Legal Proceedings:** We may disclose your protected health information in the course of any judicial proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.
- **Law Enforcement:** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- **National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities.
- **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages or letters).

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et.seq.

Client Rights Access: You have the right to inspect and copy your protected health information. We will use the format you request unless we cannot practicably do so. You must submit your request in writing to obtain access to your health information. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request copies, we will charge you $1.00 for the first page, and $.25 each page thereafter to locate and copy your health information plus postage if you want the copies mailed to you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

Restriction: You have the right to request restriction of your protected health information. You may also request that any part of your protected health information not be disclosed by family members or friends who may be involved in your care or notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. If we agree to the additional restrictions we will be able to abide by our agreement (except in an emergency).We are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your protected health information, your protected information will not be restricted.

Amendment Request: You have the right to request that we amend your protected health information. Your request must be in writing and explain why the information should be amended. In certain cases, we may deny your request for an amendment. If we deny your request for you amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Disclosure Accounting: You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment or healthcare operations as described in this Notice of Privacy Practices.

Questions and Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We support your right to the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

I have read and understand Gracelight Counseling Center's Notice of Privacy Policy.

Client's signature_____Date_____

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ADULT CHECKLIST OF CONCERNS

Name: _____ Date: _____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues."

___ Abuse—physical, sexual, emotional, neglect (of children or elderly), cruelty to animals
___ Aggression, violence
___ Alcohol use
___ Anger, hostility, arguing, irritability
___ Anxiety, nervousness
___ Attention, concentration, distractibility
___ Career concerns, goals, and choices
___ Childhood issues (your own childhood)
___ Children, child management, child care, parenting
___ Codependence
___ Confusion
___ Compulsions
___ Custody of children
___ Decision making, indecision, mixed feelings, putting off decisions
___ Delusions (false ideas)
___ Dependence
___ Depression, low mood, sadness, crying
___ Divorce, separation
___ Drug use—prescription medications, over-the-counter medications, street drugs
___ Eating problems—overeating, undereating, vomiting (see "Weight and diet issues")
___ Emptiness
___ Failure
___ Fatigue, tiredness, low energy
___ Fears, phobias
___ Financial or money troubles, debt, impulsive spending, low income
___ Friendships
___ Gambling
___ Grieving, mourning, deaths, losses, divorce
___ Guilt
___ Headaches, other kinds of pains
___ Health, illness, medical concerns, physical problems
___ Inferiority feelings
___ Interpersonal conflicts
___ Impulsiveness, loss of control, outbursts
___ Irresponsibility
___ Judgment problems, risk taking

___ Legal matters, charges, suits
___ Loneliness
___ Marital conflict, distance/coldness, infidelity/affairs, remarriage
___ Memory problems
___ Menstrual problems, PMS, menopause
___ Mood swings
___ Motivation, laziness
___ Nervousness, tension
___ Obsessions, compulsions (thoughts or actions that repeat themselves)
___ Oversensitivity to rejection
___ Panic or anxiety attacks
___ Perfectionism
___ Pessimism
___ Procrastination, work inhibitions, laziness
___ Relationship problems
___ School problems (see also "Career concerns . . .")
___ Self-centeredness
___ Self-esteem
___ Self-neglect, poor self-care
___ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
___ Shyness, oversensitivity to criticism
___ Sleep problems—too much, too little, insomnia, nightmares
___ Smoking and tobacco use
___ Spiritual or religious concerns
___ Stress, relaxation, stress management, stress disorders, tension
___ Suspiciousness
___ Suicidal thoughts
___ Temper problems, self-control, low frustration tolerance
___ Thought disorganization and confusion
___ Threats, violence
___ Weight and diet issues
___ Withdrawal, isolating
___ Work problems, employment, workaholism/overworking, can't keep a job

Any other concerns or issues: _____

_____

Please look back over the concerns you have checked off and choose the one that you most want help with. It is: _____

Licensed Behavioral Practitioners **Licensure Marital and Family Therapists** **Licensed Professional Counselors**	**State Board of Behavioral Health** **3815 N. Santa Fe, Ste. 110** **Oklahoma City, OK 73118** **Telephone: (405) 522-3696** **Fax: (405) 522-3691** **www.ok.gov/behavioralhealth**

STATEMENT OF PROFESSIONAL DISCLOSURE

Please check the appropriate license: ✓ **LPC** ☐ **LBP**

I am required by law to furnish this document to you. It requires that I inform you about my professional training, orientation /techniques, experience, fees and credentials. I am licensed to practice my profession by the State Board of Behavioral Health Licensure.

My license number is **LPC_____4112_____**

The licensing website is **www.ok.gov/behavioralhealth** where you can access the law and regulations which govern my license. I will furnish you with printed materials about the requirements of my licensure if you so desire. You may contact (without giving your name), the State Board of Behavioral Health Licensure at:

State Board of Behavioral Health Licensure
3815 N. Santa Fe, Ste. 110
Oklahoma City, OK 73118
Telephone: (405) 522-3696
www.ok.gov/behavioralhealth

Licensee's Printed Name: Shelley L Madden_____

Licensee's Signature: _____Date: _____

The above-designated licensee has satisfactorily supplied me with information regarding his/her practice, licensure and professional development.

Client's Signature: _____