

ADULT, CHILD & FAMILY COUNSELING

Sliding Scale Fee Schedule (circle the appropriate fee for you)

Combined Gross Family Income

Therapy Fee Per Session*

10,000 – 20,000

\$40

20,001 – 30,000

\$50

30,001 – 40,000

\$60

40,001 – 50,000

\$70

50,001 – 60,000

\$80

60,001 – 70,000

\$90

70,001 – 80,000

\$100

80,001 & Up

\$110

* Payment is by check or cash

ADULT, CHILD & FAMILY COUNSELING

Statement of Understanding and Consent for Treatment

BENEFITS AND RISKS OF THERAPY:

Research has shown that therapy can help a wide variety of problems for children, adolescents, and adults. However, because therapy is a cooperative effort between client and therapist, participation in therapy does not guarantee problem resolution or that the client necessarily will feel better. As with any treatment, whether psychological or medical, therapy should be entered into with appropriate consideration of the potential benefits and risks. If you have any questions about what to expect from therapy, please ask your therapist.

CONFIDENTIALITY:

Records and information collected about clients will be held and released in accordance with state and federal laws governing confidentiality of client records and information. Disclosure of information regarding services provided to the client is generally released to another party only with the client's written permission. Exceptions to this rule include the following cases: 1) when there is imminent danger to the client or another person, 2) when child abuse or neglect is suspected, 3) when disclosure must be made to medical personnel in a medical emergency, and 4) when the therapist is compelled by law to disclose client records or information.

CLIENTS WITH DISABILITIES:

It is the policy of **AC&F Counseling** to accommodate clients with disabilities, pursuant to federal and state law. Any client with a disability who needs accommodations should inform the therapist prior to receiving services.

NONDISCRIMINATION POLICY:

In accordance with Title VI of the Civil Rights Act of 1964 **AC&F Counseling** does not discriminate against participants or clients on the basis of race, color, or national origin. Services are offered to all eligible persons.

CONSENT FOR TREATMENT/RESPONSIBILITIES OF CLIENTS:

I do hereby authorize and give my consent to **AC&F Counseling** to provide treatment in accordance with the customary standards of practice specified by the state and federal laws, regulatory agencies, and professional discipline governing **AC&F Counseling**. **AC&F Counseling** does not overbook appointments. Each appointment is a reservation of resources specifically for you. Applicable charges are made for appointments not canceled within 24 hours prior to the appointment.

I have read, understand and agree to the conditions of treatment described in this document.

Client Signature / Parent or Guardian

Date

Adult

Child

Family

Counseling

ADULT, CHILD & FAMILY COUNSELING

Client Information

Date: _____

Name: _____ Parent/Guardian _____

Address: _____ **City:** _____ **St:** ____ **Zip:** _____

Home Phone: _____ **Okay to call:** Yes ___ No ___

Cell Phone: _____ **Okay to call:** Yes ___ No ___

Work Phone: _____ **Okay to call:** Yes ___ No ___

Date of Birth: _____ **Age:** _____ **Highest Grade Level:** _____

Marital Status: Single ___ Married ___ (years married ___) Widowed ___ Separated ___
Cohabiting ___ Divorced ___ (number of years divorced ___)

Spouses' Name: _____ **DOB:** _____ **Age:** _____

Cell Phone: _____ **Okay to call** Yes ___ No ___

Work Phone: _____ **Okay to call** Yes ___ No ___

Other Household Members: _____ **Relationship** _____ **Age** _____

How did you hear about this counseling service? _____

Emergency Contact: Name _____ Relationship _____

Phone number: Daytime _____ Evening _____

ADULT, CHILD & FAMILY COUNSELING

Client Information

Name: _____

PROBLEM INFORMATION:

For whom are you requesting counseling? _____ If other than you what is your relationship to them? _____

Briefly describe the nature of the problem: _____

Have you (or the person who will be receiving counseling) ever received outpatient counseling? Yes ___ No ___

If yes, from whom? _____ When? _____

Have you (or the person who will be receiving counseling) ever received inpatient treatment? If yes from whom? _____ When? _____

Are you currently being treated by a mental health professional? Yes ___ No ___ If yes from whom? _____ When _____

Medication prescribed for mental health issues:

ADULT, CHILD & FAMILY COUNSELING Medical Information

Name: _____

Date: _____

MEDICAL INFORMATION:

Which of the following illnesses or complaints have you (the client) experienced?

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Irregular menses |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Difficulty Sleeping |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Seizures | <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> Loss of Appetite |
| <input type="checkbox"/> Liver problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> PMS | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Sexually Transmitted disease(s) |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Respiratory problems | <input type="checkbox"/> Frequent constipation | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Stroke | <input type="checkbox"/> Loss of consciousness | |

What prescription medications are you currently taking and why?

- | Medication | Reason for taking it |
|------------|----------------------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |

Please identify any allergies that you have:

1. _____ 2. _____ 3. _____

What over the counter medications do you regularly take? _____

Name and Phone number of your **Primary care Physician:** _____

When was the last time you saw your doctor? _____ Why? _____

The last time you had a physical? _____