Choices Creative Therapy, LLC

Janice Bobo Watson, MA, LPC
Licensed Professional Counseling Offering Christ Centered Options.
Phone: 662-336-4411

For I know the plans I have for you, says the Lord. They are plans for good and not for evil, to give you a future and a hope. Jeremiah 29:11 Living Bible (TLB)

Please print neatly. Certain questions are repeated several times in this paperwork; this is for legal and insurance purposes. Please complete every item on every page. Thank you.

Appointment Date: _____ Client's DOB: _____

Client's Name: _____ Client's Age: _____

Client's Address: _____

City, State, Zip Code: _____

Client's Phone Cell: _____ Home: _____ Work: _____

Client's Email Address:_____ _____

In case of an emergency, who do you give permission for us to contact? Name: _____
Relationship: _____ Phone Cell: _____Home: _____ Work: _____
Does this person know that they are documented as your emergency contact? ( ) Yes ( ) No

Current Primary Care Physician: _____

Current Medications (please list dosage):_____

_____

Referral Source – How did you learn of our services? Name: _____

Occasionally, it will be necessary for our office to contact you. We will always be discrete in any message or correspondence, but we cannot guarantee confidentiality once a message or mail is sent. Please initial preferred methods if you give consent for us to contact you or leave you a message.

_____ Text _____ Cell Phone _____ Home Phone _____ Work Phone _____ Email _____

USPS Mailing Address _____Other: _____

For parents/guardians, by signing below, I certify that I have full legal authority to give consent for my child to receive counseling services.

Client's Signature: _____

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Financial Agreement

(PLEASE PRINT NEATLY)

Please select the financial agreement of your choice: _____ I choose to Bill My Insurance _____ I choose to Self-Pay

Insurance Information of Primary Insured (Primary Insured may be yourself, your spouse, or a parent or guardian of a minor):

Primary Insured: _____ Date of Birth: _____Relationship to Client: _____

Mailing Address:_____ Employer: _____

City, State, Zip Code:_____ Work Phone: _____

Insured Information (Please present your insurance card to be copied):

Insured Client's Name: _____ Client's DOB: _____

Insurance Carrier: _____ Phone # for providers: _____

Member ID: _____Pre-Authorization/Pre-Certification: _____

Copy of Insurance card on file? ( ) Yes ( ) No

Has your deductible been met? ( ) Yes ( ) No Co pay per session: _____

Billing Policy/Release of Information:

1. Payment for services rendered is expected at each session. Acceptable forms of payment include cash, personal checks, or money orders. We also accept debit or credit cards. Billing arrangements can be set up with your counselor on your initial visit and will occur in monthly cycles. Accounts 60 days past due are subject to referral to an outside collection agency. In the event that your account is forwarded to an external collection agency, all collection fees will be added to your account. Information such as name, social security number, employer, address and date of birth of the client and/or billing party are released for collection purposes only. My initials indicate my acceptance of this policy: _____ (Initial)

2. I understand that my insurance company may require information regarding my treatment, and I authorize the release of such information, if applicable. I understand that I am responsible for any charges not reimbursed by my insurance company. I also request CCS to obtain/release/exchange information as requested by my insurance company for the purpose of service coordination and continuity of care. _____ (Initial)

3. I understand that my counselor will not willingly testify in any court proceeding as this role, more often than not, may jeopardize the therapeutic relationship. However, if required by law to appear and/or testify. I understand that I will be charged $100.00 per hour for time spent in activities preparing for a courtroom appearance, including travel time. I also understand that I will be charged $100.00 per hour regardless of the time spent in the courtroom and regardless of whether my counselor is able to testify that day or not. Payment for courtroom appearance will be required prior to my counselor's appearance in court. _____ (Initial)

Invoicing an Individual OR Agency

If you would like us to invoice an individual or agency (example: a parent or employer), please sign below given consent for us to invoice this individual or agency; as well as, their contact information for billing.

Please select one of the follow: _____ I GIVE my consent to bill a third party _____ I DO NOT GIVE my consent

Name of individual or agency: _____Relationship to client: _____

Address: _____

_____

Phone Number: _____ Email: _____

Cancellation Policy: Our cancellation policy requires that you cancel your appointment 24 hours in advance to avoid being charged a $30 fee. You may call or text me at **662-336-4411** anytime to cancel an appointment. When cancelling, please indicate if you would like to reschedule your next session. In the event that I have to cancel a session, I will notify you as soon as possible. _____ (Initial)

By signing below, I agree to all of the terms of CCS's financial agreement:

Client/Guardian Print: _____ Signature: _____ Date: _____

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Office Policies and Agreements

Please read and review the following information. Your signature indicates your understanding, acknowledgement, and agreement to these policies. Please feel free to ask for assistance should you have any questions while completing paperwork.

NOTICE: As your counseling provider, we keep a dated record of the services we provide to you. You may ask to see and review your record at any time; however, a scheduled appointment must be made to review the records in the presence of the Therapist. You may also ask for clarification about the record or to correct the record. WE WILL NOT disclose your records or acknowledge your client status to others UNLESS you direct us to do so or UNLESS the law authorizes or compels us to do so. Applicable fees and past due balances must be paid in advance before your record will be reviewed with you, released to you, or copied for legal disclosure. Policy requires written request and notice at least 15 business days before records may be released under any circumstance.

Authorization to Release Information and Assignment of Insurance Benefits

I, (printed name of responsible party) _____, hereby authorize Practitioner to:

1. Furnish my insurance company with any/all information requested concerning my present claim(s).
2. Bill and accept payment from my insurance company on my behalf for all services related to my care. I acknowledge that I AM RESPONSIBLE for all co-payments and charges not covered by my insurance.
3. Mail any balance due invoices to the address I listed on the intake sheet. If I choose not to have such material mailed to the address listed, I shall notify this office in writing.

Financial Policy

Thank you for choosing Choices Creative Therapy, LLC as your mental health care provider. We are committed to your treatment being successful. Please understand that payment of your bill as a responsible financial practice is considered part of your treatment. The following is a statement of our Financial Policy which is required for you to read and sign prior to any treatment. Please ask any questions you may have before signing the agreement. Full payment (or a pre-determined co-payment) is expected at the time of service. We accept cash, check or payment through PayPal. All returned checks are subject to a fee of $50.00.
*Any changes in my financial situation I, _____, will discuss with my therapist or the Office Administrator. If I find it necessary to change my mental health provider I will pay my account/balance in full.

Regarding Insurance: We are able to provide you with a receipt appropriate for submission to your insurance carrier for each visit/service. The balance is your responsibility whether your insurance company pays or not. You may also be responsible for a filing fee for any third party billing. For clients seeing a Licensed Professional Counselor or even a Preferred Provider please be aware that some, and perhaps all of the services provided may be noncovered services or may not be considered to be reasonable and/or necessary under your medical insurance program. It is your responsibility to contact your insurance carrier to determine whether your policy covers our services and what fees are allowed for reimbursement. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We do not guarantee payment from your insurance company. If your insurance company has not paid your account IN FULL within 90 days, the balance will be automatically due and payable by you.

Fee Agreement

I agree that I am responsible for payment to Choices Creative Therapy, LLC for each counseling/service session not cancelled with notice as stated above. I agree that invoices for rendered services may be mailed to my address listed on the intake sheet. If I do not agree to such mailings, I must notify this office in writing of how to inform me of any balance due. I also agree to the fee schedule for all rendered services, whether reimbursed by my insurance carrier or not, as acknowledged by my signature below and assigned and indicated in the Financial Agreement.
I HAVE READ AND UNDERSTAND THESE OFFICE AND FINANCIAL POLICIES, AND AGREE TO SAID TERM

Client/Guardian Signature_____ Date_____

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OUR PHILOSOPHY, MISSION AND APPROACH TO THERAPY

Life is a ***Journey*** filled with ***Choices***. ***Choices*** can be as simple as, "which crayon will I use to color this picture?", or "what will I wear today?" ***Choices*** concerning "how to spend our time", "who to spend time with", and "what we might like to be when we grow up" can be more challenging. Still more difficult are the ***Choices*** to make when we experience:

- Mistreatment or harm by others
- Loss of a dear loved one
- Gripping FEAR of the "what if's"
- News that our physical or mental health is in jeopardy
- Concerns that our precious child needs special help
- Strife in our marriage and family relationships
- Lack of purpose
- Sadness or emptiness that feels like a dead weight upon our entire being
- And the list goes on……..

The mission of ***Choices*** Creative Therapy LLC, is to aid and equip clients who face life's inevitable challenges with tools to make ***Choices*** that can produce the most favorable outcomes in the situations that they are facing.

Though we can and do work very successfully with clients with a secular world- view, our core belief and experience is that God's Word is the most effective instruction book to direct our ***Choices***. Therefore, our approach to therapy is a mixture of Christian, Biblically-based, cognitive-behavioral, and rational-emotive therapies which help us to explore the client's presenting issues in order to help them to develop appropriate solution-based goals. One of our greatest hopes is through your counseling experience with us, that you will also experience the love of Christ and find that you are never alone in your journey of ***Choices***.

Definitions of CBT and REBT

Cognitive behavioral therapy (**CBT**) is a short-term, goal-oriented psychotherapy treatment that takes a hands-on, practical approach to problem-solving. Its goal is to change patterns of thinking or **behavior** that are behind people's difficulties, and so change the way they feel.

Rational Emotive Behavior Therapy (REBT) is a short-term form of psychotherapy that helps you identify self-defeating thoughts and feelings, challenge the rationality of those feelings, and replace them with healthier, more productive beliefs.

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Client Intake Questionnaire

Please fill in the information below and bring it with you to your first session. Please note: information provided on this form is protected as confidential information.

Personal Information

Name:_____ Date: _____

Parent/Legal Guardian (if under 18): _____

Address: _____

Home Phone: ___ _____ May we leave a message? □ Yes □ No

Cell/Work/Other Phone: _____ May we leave a message? □ Yes □ No

Email: _____ May we leave a message? □ Yes □ No *Please note: Email correspondence is not considered to be a confidential medium of communication.

DOB: _____ Age: _____ Gender: _____

Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Referred By (if any): _____

History Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No □ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication? □ Yes □ No If yes, please list:

_____
_____

Have you ever been prescribed psychiatric medication? □ Yes □ No If yes, please list and provide dates:

_____
_____

General and Mental Health Information

1. How would you rate your current physical health? (Please circle one) Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing: _____

_____

2. How would you rate your current sleeping habits? (Please circle one) Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____
_____

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

4. Please list any difficulties you experience with your appetite or eating problems: _____

_____

5. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes If yes, for approximately how long?_____

6. Are you currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? □ No □ Yes If yes, please describe:

_____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes If yes, for how long?

_____

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship?

_____

11. What significant life changes or stressful events have you experienced recently? _____

_____ _____

Family Mental Health History In the section below, identify if there is a family history of any of the following.

If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes / no	_____
Anxiety	yes / no	_____
Depression	yes / no	_____
Domestic Violence	yes / no	_____
Eating Disorders	yes / no	_____
Obesity	yes / no	_____
Obsessive Compulsive Behavior	yes / no	_____
Schizophrenia	yes / no	_____
Suicide Attempts	yes / no	_____

Additional Information

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation? _____

_____

Do you enjoy your work? Is there anything stressful about your current work? _____

_____

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief: _____

_____

3. What do you consider to be some of your strengths? _____

_____

_____

_____

4. What do you consider to be some of your weaknesses? _____

_____

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

_____

_____

_____