Tina Saunders, LMHC, CAP
600 S.W. 3rd Street, Suite 51000
Pompano Beach, FL 33060-6932
(954) 347-0651

POLICY AND PROCEDURES

Consent for Treatment, Authorization for Payment, Cancellation Policy

I hereby consent to psychological treatment therapy (individual/family/group) with Tina Saunders, LMHC (MH-8071).

As with any powerful treatment, there are some risks, as well as benefits, involved with therapy. I acknowledge that I have been thoroughly informed about these benefits and risks (like, recalling unpleasant memories, experiencing feelings of sadness, guilt, or anger, etc.). These and other risks are to be expected when people are making considerable changes in their lives and I understand that it is my responsibility to cooperate with the treatment to the best of my ability. I understand Florida State, Federal law and professional ethical standards provide for the confidentiality of psychotherapist, including records. {This therapist and office will not disclose or confirm your use of services at this office. Lawful and legally required exceptions to this privilege of confidentiality include: information of child abuse, elder abuse, the immediate physical danger to yourself or another, a lawful court order and your signed consent}.

Initial _____

I understand that payment in full is **due and payable at the time services** are rendered. Initial _____

A copy of the HIPAA Notice of Privacy Practices has been made available to me. Initial _____

Because time has been reserved for me and/or members of my family, I understand that, except in a true emergency, I am expected to provide at least 24 hours advanced notice if I am unable to keep a previously scheduled appointment. ***In the event that I do not provide notice at least 24 hours prior to canceling an appointment, I understand that I will be charged the normal fee.***

Initial _____

I have had all my questions answered fully about the therapy and its fees. I do hereby seek and consent to take an active role in this therapeutic intervention and acknowledge that there have been no promises made to me as to the results of the therapy or of any procedures provided.

I hereby understand and agree with the above statements.

Client Name: (print) _____ Date: _____

Signature: _____

I, Tina Saunders, LMHC, have thoroughly discussed the above issues with my client. My observation of this person's behavior and responses give me no reason to believe that he/she is not fully competent to give informed and willing consent.

Therapist: _____ Date: _____

Tina Saunders, LMHC

This is a strictly confidential medical record. Law expressly prohibits re-disclosure or transfer.

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CLIENT INFORMATION

Name: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

E-mail Address: _____

Emergency Contact: _____ Relationship: _____

Phone Number: _____

Referred by: _____

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Client: _____ Date of Birth: _____

BIO-PSYCHOSOCIAL ASSESSMENT

Gender: ❑M ❑F Age: _____ Marital Status: _____

Reason for counseling: _____
_____

The presenting problem has affected which of the following area's in your life:

❑ Relationships with self and/or family
❑ Work or school performances
❑ Legal problems
❑ Other: (specify) _____

Have you had any previous counseling? ❑Yes ❑No If yes, when and how long? _____
_____

Do you have any substance abuse history? ❑Yes ❑No If yes, please answer the following questions:
What was your drug(s) of choice? _____
When was the last time you used? _____

Medical Conditions & Complications

Do you have any major medical problems (past and/or present)? Have you ever been hospitalized for medical problems (what year and what for)? _____
_____

List any medications you are currently taking: _____
Have you ever been in a psychiatric hospital? ❑Yes ❑No If yes, when, what for and how long? _____
_____

Have you ever had any…
a) suicidal thoughts? (when and how long) _____
b) suicide attempts? (when and how) _____
c) a suicide plan? (explain) _____

How healthy are you physically? ❑Poor ❑Unsatisfactory ❑Satisfactory ❑Good ❑Very good
How well are you sleeping? ❑Poor ❑Unsatisfactory ❑Satisfactory ❑Good ❑Very good
Are you experiencing any abnormal eating patterns? ❑Yes ❑No If yes, please specify: _____

Abuse History / Issues

Have you ever been a VICTIM of the following abuse(s)? ❑Yes ❑No (check all that apply)

❑Physical
❑Emotional / Verbal
❑Sexual
❑Spiritual
❑Neglect
❑Exploitation (financial or other)

Have you ever been a PERPETRATOR of the following abuse(s)? ❑Yes ❑No (check all that apply)

❑Physical
❑Emotional / Verbal
❑Sexual
❑Spiritual
❑Neglect
❑Exploitation (financial or other)

Have you ever had counseling to process the abuse? ❑Yes ❑No If yes, did it help you? ❑Yes ❑No

Has there been any domestic violence in your family growing up? ❑Yes ❑No

Family History & Environment

Home Environment: (check all that apply)

❑Live alone ❑Live with children
❑Live with spouse / partner ❑Live with parents
❑Other: (please specify) _____

Who has been the most important adult in your childhood: _____
Are there any crucial family issues? _____
Birth Order: ❑Youngest child ❑Middle child ❑Oldest child
Number of siblings: Brother(s): age(s) _____
Sister(s): age(s) _____
Significant losses: (death, divorce, job, etc.) _____
_____
_____

	Father / Stepfather	Mother / Caretaker	Siblings	Spouse / Partner
Alcohol / Drug Abuse	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____
Major Medical Issue	_____	_____	_____	_____

Do you have any children? ❑Yes ❑No If yes, how many, what gender, and what ages? _____
_____

Relationships / Marital Status:

❑Married (# of times): _____ ❑Divorced
❑Committed relationship ❑Widowed
❑Separated ❑Single

Current Relationship: How long? _____
What is your perception of your current relationship? _____
_____
Describe how you and your partner generally resolve arguments: _____
_____

Educational & Vocational

What is your highest level of education?

Below high school Bachelor's Degree (major): _____
High school or GED (circle one) Master's Degree (major): _____
Some college: (how long) _____ Other: _____
Do you have any learning disabilities? ❑Yes ❑No If yes, specify: _____
Military Service: ❑Yes ❑No What type and how long? _____
Are you employed? ❑Yes ❑No If no, reason for unemployment: _____
If yes, list your job title, company, and length of employment: _____
Do you enjoy your work? Is there anything stressful about your current work? _____
_____

Sexual History

Sexual Orientation: ❑Heterosexual ❑Homosexual ❑Bisexual Transgender
Has your sexual desire this past month: ❑Increased ❑Decreased ❑No Change
Name three strengths you believe you have: _____

Name three weaknesses you believe you have: _____
What type of coping skills do you use if you are depressed, anxious, fearful, etc.? _____
_____

Religious and Cultural Interests

Do you have any religious/spiritual preference? ❑Yes ❑No If yes, please describe: _____
_____
Is a religious belief a source of hope and strength for you? ❑Always ❑Most of the time ❑Sometimes ❑Not at all
Do you attend religious services? ❑Weekly ❑Major holidays only ❑Whenever possible ❑Never
What culture do you identify with? _____
Do you feel your cultural practices have an impact on your life? ❑Yes ❑No If yes, please explain: _____
_____
How often do you pray? ❑Daily ❑Never ❑Occasionally
Do you feel life has meaning and purpose? ❑Always ❑Most of the time ❑Sometimes ❑Not anymore ❑Never
Do you feel God has treated you unfairly? ❑Never ❑Occasionally ❑Most of the time ❑Always
How often do you think about death? ❑Never ❑ Occasionally ❑Daily
Are you currently experiencing overwhelming sadness, grief or depression? ❑Y ❑N If yes, for approximately how long? _____
Are you currently experiencing anxiety, panic attacks or have any phobias? ❑ Y ❑N If yes, when did you begin experiencing these symptoms? _____
_____