Choices Clinical Counseling, LLC
2517 Bedford St.
Johnstown, PA 15904
Ph 814-241-7990
Fax 814-217-1327

Name _____ DOB _____

Address _____ City _____

State _____ Zip _____ Phone Number _____

Family Doctor (PCP) _____

Email Address _____

Current Medications _____

Past Medications_____

Medical Conditions _____

Top 3 Reasons for seeking counseling:

1.

2.

3.

Health Insurance Co. _____

Policy Holder's name _____ Date of Birth _____

Insurance ID Number_____

Policyholder's Employer _____

_____ _____

Signature Date

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Client Name: _____

DOB: _____

Payment Agreement

I agree to receive treatment by Choices Clinical Counseling, LLC. I hereby authorize you to bill and/or contact my insurance company regarding payment for services rendered at this office. I understand I am responsible for all payments and if after 3 months no payments have been made Choices will send me to a collection agency.

In situations where a 3rd party payer is involved, I authorize Choices Clinical Counseling, LLC to release all records or other information that may be necessary to determine benefits payable to them.

I have been advised of the available HIPPA Notice of Privacy Practices that is posted in the waiting room at Choices. A copy is available upon request. The Therapist-Patient Services Agreement is available upon request. This agreement outlines patient and Social Worker responsibilities.

Please choose one: I ☐ **authorize/** ☐ **do not authorize** Choices to leave a voice message on my phone when calling for an appointment reminder.

I understand that co-pays are due at the time of visit by cash, check or credit card.

Cancellation Policy $30 charge for appointments canceled within 24 hours of scheduled appointment

Discharge Policy

- Three appointments canceled within a three month period
- Two cancellations in a row can be grounds for discharge
- One no call/no show appointment → any subsequent appointments will be canceled out

_____ _____

Signature Date

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Consent to Treatment

I hereby consent to receive treatment voluntarily at Choices Clinical Counseling. I have been given the information concerning the services here and authorize Choices Clinical Counseling to administer such treatment as is deemed advisable or necessary by the clinician. However, such consent does not waive my civil rights and I reserve the right to decline any treatment that I believe is not in my best interest.

I acknowledge that my rights and responsibilities as a client at Choices Clinical Counseling have been fully explained to me and I further acknowledge that I have been given a copy of said rights and responsibilities, upon my request, to keep in my possession for future reference. I also understand that I have the continuing right to an explanation of the treatment to be administered. I further have the right to voice any dissatisfaction with my treatment through channels established by the Choices Clinical Counseling. I acknowledge that complaints and appeal will go through Clinical Director, Adam Kleinman, who can be reached at (814) 244-2239. Please allow 7-10 business days for resolution of complaints and appeals.

I understand that my records are confidential and will not be released to other individuals or agencies without my expressed written consent, in accordance with HIPAA. However, I realize that certain information may be released without my authorization under the following circumstances.

Upon receipt of a legitimate subpoena or court order.

In the event of a valid medical emergency.

If there is evidence to suggest that child abuse has occurred.

When a hazard to the public, (such as homicide) requires disclosure.

To third party payors to verify provision of services.

When a hazard to myself (such as suicide).

This consent must be signed by the client, or by the nearest relative or guardian if the client is a minor, (under 14 years of age), or is physically / mentally incompetent. The party signing as sole parent or guardian represents that no one else has the authority to sign on behalf of the patient. Said party shall likewise indemnify and hold harmless Choices Clinical Counseling for the treatment that it renders to patient in reliance on this Consent as so signed and executed.
I have read and understand the Consent to Treatment:

_____ _____

Signature **Date**

Printed Name: _____ **DOB:**_____

In the instance when the client is under the age of 14 please record their answers below.

1. What is your motivation level to improve?	High ☐ Moderate ☐ Low ☐ Not Sure ☐
2. Have you been in counseling before?	No ☐ Yes ☐ Where?_____
3. Are you coming because you want to or for someone else?	I want to ☐ Someone else ☐
4. Do you have a history of depression and anxiety?	Yes ☐ No ☐
5. Any history of traumatic events, recent or in the past?	Yes ☐ No ☐
6. Have you ever tried to hurt yourself or anyone else?	Yes ☐ No ☐
7. Are you feeling suicidal or homicidal?	Yes ☐ No ☐
8. Do you abuse alcohol or drugs?	Yes ☐ No ☐
9. Any family history of mental health challenges?	Yes ☐ No ☐
10. Are you in any danger from spouse or significant other?	Yes ☐ No ☐
11. Are you familiar with different types of therapy?	Not at all ☐ Somewhat ☐ Very ☐
12. Are you having any legal problems or child custody issues?	Yes ☐ No ☐
14. Do you have an addictive personality?	Yes ☐ No ☐ Not sure ☐

This is so we can better help you. Thanks for your time!