New Client Information

Client Information and Fee Agreement

T.Aisha Edwards, LMHC, LPC

Identified Client Name: ______________________________

Address ______________________________

____

DOB ____________ **Age** ____________

Phone(s) ____________ **Work** ____________ **Cell** ____________

May I leave messages? **Home: Y/N** **Cell: Y/N** **Work: Y/N**

Email: ______________________________

Single _ Married _ Partnered _ Seperated _ Divorced _ Poly _ Other _

Describe your gender in a way that make sense to you:

____

____

____

Pronouns: ______________________________

Ethnicity ____________ **Children: Y / N**

If yes, names and ages

____

____

____

Who lives in your household?: ______________________________

Emergency Contact

Name ______________________ **Phone Number** ______________________

Relationship ______________________________

Health Questionnaire

Current Primary Doctor/NP/ND: ______________________________

Phone: ______________________________

Address: ______________________________

____

____

May I contact this person for coordination of care: Y / N

Health Concerns ______________________________

____

____

Medications: ______________________________

____

____

Hospitalizations in the last 5 years (Mental / Physical Health): ______________

Most Recent Counseling/Psychiatric History: ______________________

____

____

Family History

Is there any fmily history of (circle all that apply):

Depression   Alcoholism   Substance Abuse   Eating Disorders   Anxiety

Physical Abuse   Sexual Abuse   Emotional Abuse   Severe Mental Illness

Suicide/Gestures   Homicide   Abandonment   Foster Care Involvement

Major Medical Problems   Divorce   Compulsive Behavior   Adoption

Autism   ADHD   OCD   PTSD

Substance History

How many times per week do you drink alcohol?   1   2-3   Almost Daily   Daily

How many drinks do you have in a sitting?   1-2   3-4   4-5   5+

Do you use recreational drugs (prescription of illegal):   Yes/No

Which drugs: ______________________________

____

____

How many times per week: 1 2-3 Almost Daily Daily

How much per allowance? ______________________________

Behavioral History

Do you have any history of (circle all that apply):

Depression Alcoholism Substance Abuse Out of Control with Food

Physical / Sexual Abuse Anxiety Emotional Abuse Severe Mental Illness

Suicide / Gestures Homicide Abandonment Foster Care Involvement

Adoption Death of Parent Self Harm Excessive Screen Time

Gambling Shoplifting / Theft Sexual Acting Out Houselessness

Incarceration Birth Trauma Mania Hallucination / Delusion

Major Medical Problems Divorce Compulsive Behavior / Thoughts

Please Explain:

____

____

____

Have you been hospitalized for mental health crisis? Y / N

Do you currently have urges to kill yourself? Y / N

Do you currently have urges to kill anyone else? Y / N

If yes to any, please explain:

____

____

____

Do you or have you harm(ed) yourself without the intention to kill yourself in the last 6 months? Y / N

If yes to any, please explain:

____

____

____

Confidentiality

The client-therapist realtionship remains confidential, meaning that whatever happens in treatment remains in treatment unless:

1. I believe you are an imminent threat to yourself or someone else
2. You report abuse of a child, elderly or vulnerable adult person.
3. You request that I release information to a 3rd party via a Release of Information

Confidentiality - continued

The client-therapist realtionship remains confidential, meaning that whatever happens in treatment remains in treatment unless:

4. A judge subpoenas your files
5. I am consulting with a supervisor or consult group to improve your quality of treatment
6. For the purposes of billing or collections of outstanding debts

As your counselor, I am ethically bound to keep information related to our work confidential unless I have your express written permission to release information to a specific person or organization.

As a result, please know that if we ever see one another by chance in the community, I will not greet you in order to protect your privacy, unless you greet me first.

Also, if you refer a friend, colleague or family member to my services, I greatly appreciate it but will never confirm or deny your participation in treatment with me without your express consent to do so.

For convenience, I frequently use an electronic health record, email and digital fax services to expedite your care, schedule appointments, and provide crisis support. These digital mediums have limitations to confidentiality. If you object to using these, modes of communication, please submit a request in writing for US postal mail or phone communication only.

I/We have read and understand limitations to confidentiality: *Client*

Print ______________________ **Signature** ______________________ **Date** __________

Print ______________________ **Signature** ______________________ **Date** __________

Fee Agreement

Please consult the fee schedule if you have questions about your fee. If you have circumstances that will influence your ability to pay the regular fee, please let me know so we can arrange services.

My Copay/Coinsurance is $ ______________ per session. I am using ______________________________ ____________________________________ insurance company for the remainder of my session fee. I understand that I am the ultimate guarantor of payment if my insurance company refuses payment.

-OR-

My sliding scale hourly rate per session has been set at $ ____

I agree to pay this fee at the beginning of each session or to pay in advance for the month.

Cancellation Policy: Attending sessions consistently is how we ensure progress in treatment and guarantees your position on my caseload. I encourage you to pick a sustainable time that consistently works for our mutual availability. Clients that are consistently late, cancel frequently, schedule erratically or no show to appointments may be charged or have their cases closed due to lack of consistency with treatment.

I understand that cancellation or reschedule must happen 48 hours in advance or I may be subject to pay the full rate of the missed session.

By signing below, I/We consent to above annotated therapy services with T. Aisha Edwards and the fee agreement as stipulated above:

Print ___________________________ Signature __________________________ Date __________

Print ___________________________ Signature __________________________ Date __________