Adult

The Hope Center

206 South 28th Avenue
Hattiesburg, MS 39402

Client Information Form

Please provide the information below as it applies to the *client*.

Name _____
Last **First** **Middle** **Maiden**

Address _____
Street or P.O. Box **City** **State** **Zip**

Home Phone _____ **Important: May we leave a "return call" message at this number? ____Yes ____No**

Work Phone _____ **Important: May we leave a "return call" message at this number? ____Yes ____No**

Cell Phone _____ **Important: May we leave a "return call" message at this number? ____Yes ____No**

E-mail Address _____ **Important: May we communicate with you via e-mail? ___Yes ___ No**

Would you like to be on Dr. Smallwood's e-mail newsletter list? ___Yes ___No

Place of Employment _____

Social Security # _____**Date of Birth** _____**Years of Education** _____

Marital Status _____ **Spouse/"Significant Other" Name**_____

Emergency Notification

_____
Name **Address** **Phone** **Relationship**

_____
Name **Address** **Phone** **Relationship**

Referred by _____
Newspaper, Phone Book, Physician, Friend, etc. (Give person's name if applicable.)

Family Physician _____
Name **Address** **Phone**

What other professionals (doctors, lawyers, etc.) might we need to talk to about your case? (We would get written permission first)

_____

_____

Is there a possibility that your case will involve court proceedings? ___Yes ___No

I have read and I understand the statement of "Client Rights and Responsibilities" in this packet. All the information given in this form is true and complete to the best of my knowledge.

Signature_____ **Date** _____

Witness _____ **Date** _____

Briefly indicate your reasons for seeking services at this time:

_____

_____

_____

_____

_____

What led you to choose to call our clinic?

_____

_____

_____

_____

How long do you think therapy should last?_____

Check all the words that describe how you are feeling about beginning the therapy experience:

___ Nervous	**___ Pressured by someone**
___ Hopeful	**___Open**
___ Skeptical	**___ Angry**
___ Very committed	**___ Excited**

What questions do you have about any aspects of the therapy experience?

_____

_____

_____

_____

How do you hope things will be different for you after counseling? (Be as specific as possible.)

_____

_____

_____

Description of your household:

Name (List Yourself)	Age	Sex	Relationship	Employment
			Self	

Have you been in therapy before, or have you received any prior professional assistance? If so, please give the following information about the professional(s) who have helped you.

- **Name & Professional Title _____**

  Organization & Address _____

  Approximate dates of treatment _____
  Problems for which you sought treatment, and results _____
  _____
  _____
  _____

- **Name & Professional Title _____**

  Organization & Address _____

  Approximate dates of treatment _____
  Problems for which you sought treatment, and results _____
  _____
  _____
  _____

FEES AGREEMENT

THE HOPE CENTER

206 South 28th Avenue
Hattiesburg, MS 39402
601-264-0890

1. **I, _____, understand that fees for services are as follows:**

Dr. Smallwood:		**Thomas Pough, MS, LPC:**	
$175.00	**1 diagnostic hour**	**$155.00**	**1 diagnostic hour**
$165.00	**1 hour**	**$145.00**	**1 hour**
$149.00	**¾ hour**	**$131.00**	**¾ hour**
$ 99.00	**½ hour**	**$ 87.00**	**½ hour**
$ 50.00	**¼ hour**	**$ 44.00**	**¼ hour**

2. **I understand that a therapeutic hour is <u>50 minutes</u>. This allows your therapist time to complete documentation and schedule your next appointment. This is standard practice in the mental health profession.**
3. **These fees apply to therapy sessions, telephone consultations, records review, consultations with lawyers and other professionals, and letter/report preparation.**
4. **I also understand that payment for outpatient services is DUE AT THE TIME SERVICES ARE RENDERED. I further understand that insurance is a method of reimbursement to me for my payment to the clinic and is not considered a substitute for payment. Should I wish to file insurance, I understand that I will be given the proper forms so that I may collect for covered services.**
5. **I hereby give my consent to release pertinent information (i.e., diagnosis codes, procedure codes, summary of treatment, etc.) to my insurance company or managed care company, should they request it.**
6. **I further understand that I will be charged full fee for any missed appointment should I fail to cancel my appointment at least one business day in advance (i.e., I must cancel Monday appointments by 5 p.m. the preceding Friday; and Tuesday through Friday appointments must be canceled 24 hours in advance). I also understand that I will be charged for any portion of time spent in therapy over my scheduled session length. In addition, any phone calls in excess of 15 minutes will be charged accordingly, at quarter-hour increments.**
7. **I am aware that some psychological testing may be necessary for treatment, and that fees for such testing are available upon request and will be discussed with me by my therapist.**
8. **I further understand that if my account should become delinquent, legal action for collection may be undertaken. I hereby give my consent to release necessary information, that is, name, address, account number, phone numbers, amount due, action taken to date, place of employment, for taking such action.**

Signature of client or legal guardian _____
Signature of witness _____
Date _____

Checklist of Current Problems

The following section is designed to help you describe your current problems in greater detail and to identify problems that might otherwise go unnoticed. This will help us design your treatment experience and to tailor it to your specific needs. Please check the behaviors/symptoms/feelings that you have experienced in the past three months. Please write in any details which may be helpful.

Name _____ Date _____

___ Depression

___ Appetite disturbance (Up or down?)

___ Weight gain or loss (Circle one, then, write in number of pounds)

___ Sleep disturbance (Too much or too little? Describe hours/times of sleep)

___ Low energy level/fatigue

___ Feelings of inadequacy/low self-esteem

___ Decreased effectiveness/productivity

___ Difficulty concentrating

___ Withdrawal from people

___ Loss of interest and pleasure in things you usually enjoy

___ Irritability/anger (Toward whom?)

___ Difficulty responding positively to praise or reward

___ Less active than usual

___ Less talkative than usual

___ Pessimistic attitude about the future

___ Brooding about the past

___ Feeling sorry for yourself

___ Crying/tearfulness

___ Excessive guilt

___ Recurrent thoughts of death or suicide

___ Plan for suicide

___ Recurrent thoughts of hurting someone else

___ Plan for hurting someone else

___ Fears/phobias (describe)

___ Panic attacks or anxiety

___ Problems with breathing

___ Heart racing or unusual heartbeat

___ Chest pain or discomfort

___ Dizziness or unsteady feelings

___ Feeling as if things around you aren't real

___ Tingling in hands

___ Tingling in feet

___ Hot flashes

___ Cold flashes

___ Fear of dying

___ Fear of going crazy

___ Fear of doing something uncontrollable

___ Excessive worrying

___ Thoughts that go over and over in your mind

___ Behaviors you do over and over, like a "ritual"

The following questions relate to past trauma. Please respond accordingly if you have experienced a past trauma in your life.

Past trauma (describe and give approximate dates):

_____

_____

_____

When past trauma has been experienced, respond to the following:

___ Recurrent distressing memories of the event

___ Recurrent distressing dreams of the event or about some aspect or feeling of the experience

___ Acting or feeling as if the event were actually recurring

___ Intense distress when something "brings back the event"—either a situation that you encounter or your own thoughts

___ Physical stress reactions (e.g., perspiration, increased heart rate, change in breathing) when you are exposed to something that reminds you of the traumatic event

___ Efforts to avoid thinking about, feeling, or talking about the trauma

___ Efforts to avoid places, activities, or people that bring back memories of the trauma

___ Inability to remember an important part of the trauma

___ Decreased interest or participation in significant activities

___ Feeling detached, different from, far removed from others

___ Restricted feelings (e.g., unable to have loving feelings)

___ Difficulty seeing a good future ahead (e.g., not expecting to have a career, marriage, children, normal life span)

___ Difficulty falling/staying asleep

___ Irritability/outbursts of anger

___ Concentration problems

___ Heightened caution; "looking over your shoulder"

___ Easily startled

___ Seeing things others don't see

___ Hearing things others don't hear

___ Strong feelings of being controlled by others

___ Difficulty standing up for yourself

___ Difficulty saying no

___ Difficulty expressing negative feelings

___ Concerns over body/weight

___ Overeating/binging

___ Vomiting

___ Regular use or overuse of laxatives

___ Drinking too much (Please describe your drinking patterns, how much, how often, in what situations?): _____

_____

_____

___Use of non-prescription mood-altering drugs (Please describe what drugs, how often, in what situations?)_____

_____

_____

___ Working too hard

___ Procrastination

___ Loss of control (Describe.)

___ Difficulty keeping a job

___ Aggressive behavior

Adult

CLIENT'S RIGHTS AND RESPONSIBILITIES

IMPORTANT-PLEASE READ!

The Hope Center
206 South 28th Avenue
Hattiesburg, MS 39402
Phone (601) 264-0890

To be an effective consumer of psychological services, it is important that you know about your rights and responsibilities and about our obligations to you. Please read this statement carefully before signing the "Client Information Form," and discuss any questions with your therapist.

OUR COMMITMENT TO YOU:

We are dedicated to providing quality counseling, testing, and consulting services. We work hard to assure that each client receives competent, considerate, prompt, and respectful services regardless of race, ethnic background, religion, sex, age, sexual or affectional preference, or disability. When necessary, and with your written permission, we consult with other specialists, and we may refer you to additional sources of help.

We welcome you, your questions, and your concerns. Our administrative policies are set up to allow us to work smoothly and efficiently. We welcome your feedback as to how they work for you.

RIGHTS

When you become our client, you have the rights to:

1. ***Confidentiality*: It is our policy to respect your privacy and to protect the confidentiality of your relationship with us. It is also our policy to inform you of the limits we have in protecting this right to confidential care. Some limitations are imposed by state statute and others come from the ethical standards for therapists. They are:**
   - **A. Ethical standards encourage therapists to confer with other professionals when helpful and appropriate, provided you have signed a written release of information.**
   - **B. We are obligated by law to inform relevant parties when there is a clear and imminent danger to an individual or to society. We also must report to appropriate authorities when there is evidence of child abuse or abuse of vulnerable adult.**
   - **C. By law we must comply when ordered by court to supply records.**
   - **D. Parents (including non-custodial parents) have the legal right to information concerning a minor child. However, from a therapeutic standpoint, it is important for the child or adolescent to develop a trusting relationship with the therapist. Therefore, we request that parents grant the child's confidentiality subject to the above limitations. We will, of course, consult with the parents regarding their involvement in the treatment process.**
   - **E. Except in the circumstances outlined in A, B, and C above, we will not release to others any information regarding you and/or our services to you unless you request and authorize its release with your signature. We encourage you to discuss any questions you may have about confidentiality or release of information with your therapist.**

2. ***Cost of Services Information*: You have the right to be informed of the cost of professional services before receiving the services. This is described in the Fees Agreement.**
3. ***Informed Consent:* As our client, you have the right to know the nature of our services you are receiving. In the first session, you and your therapist will discuss goals and design a plan to meet your needs. We encourage you to be active in those discussions.**

YOUR RESPONSIBILITIES

1. **You are responsible for supplying accurate and complete information about yourself: your problems and their history, your past illnesses, previous counseling, medication, and family and work history when appropriate.**
2. **You are responsible for honoring your financial agreement with us. Fees for groups, workshops, and organizational consultation are negotiated on a situation-by-situation basis.**
   Our clinic operates on a *cash check, or credit card basis.* You must make payment each time you receive services.
   Psychological services are covered under many health insurance plans. We advise that you check your insurance policy or the benefits department at your place of employment to confirm that you do, indeed, have such coverage. Your service ticket, given to you upon each visit, will provide all of the information you will need so that you can process your claims. Insurance is considered a method of reimbursing the fees paid to the therapist, not as a substitute for payment.
3. **You are responsible for keeping appointments. *Missed appointments, except in emergencies, will be billed at the normal rate.* To avoid billing, you must cancel one business day prior to your appointment; that is, you must cancel Monday appointments before 5 p.m. the preceding Friday, and Tuesday through Friday appointments must be canceled at least 24 hours in advance. You may cancel by calling (601) 264-0890. We are also available at this number to answer your questions.**

If any of these rights and responsibilities seem unclear to you, please feel free to ask your therapist for clarification. We look forward to working with you!

_____	_____
Date	**Signature of Client**
_____	_____
Date	**Signature of Witness**