The Hope Center
2013 Hardy Street
Hattiesburg, MS 39401

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

Name ____
Last **First** **Middle**
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 email? ___Yes ___ No**
Would you like to be on Dr. Smallwood's email 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

____
Name **Address** **Phone** **Relationship**

Family Physician:

____
Name **Address** **Phone** **Relationship**

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. I have submitted to The Hope Center any and all relevant court documents, including court orders.

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
2013 Hardy Street
Hattiesburg, MS 39401
601-264-0890

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

Dr. Smallwood:		Amanda Heitmuller, MS, LCSW Michelle Howard, MS, LCSW	
$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 50 minutes. 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

IMPORTANT-PLEASE READ!

The Hope Center
2013 Hardy Street
Hattiesburg, MS 39401
Phone (601) 264-0890

CLIENT'S RIGHTS AND RESPONSIBILITIES

To be an effective consumer of psychological services, it is important that you know about your rights and responsibilities as a client, and to know our obligations to you as mental health services providers. Please read this statement carefully before signing the "Client Information Form." Feel free to discuss any questions you may have 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, gender, age, sexual/affection 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.

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

YOUR RIGHTS

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

1. ***Confidentiality*****:** It is our policy to respect your privacy and to protect the confidentiality of the therapist/client relationship. It is our policy to inform you of our limits in protecting this right to confidential care, which are imposed by state statute and/or ethical standards for therapists. They are:
    a. We are bound by ethical standards which encourage all therapists to confer with other professionals when helpful and appropriate, provided that the client has signed a written release allowing us to 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 are obligated to 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, it is important from a therapeutic standpoint for the child or adolescent to
    develop a trusting relationship with the therapist. Therefore, we request that parents grant the child *their right* to 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 or exchange any information to others regarding you and/or your services 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*****:** We strive to provide fee information during your initial contact with our office. These are described in detail in the Fees Agreement. You have the right to be informed of the cost of professional services before receiving the services.
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 your goals, and your therapist, with your input, will design a plan to meet your needs, which may be redesigned with your changing needs. We encourage you to be active in those discussions.

YOUR RESPONSIBILITIES

1. **You are responsible for supplying accurate and complete information about yourself**. Please describe your problems in detail, including your personal trauma history, details about your family, your past illnesses, previous counseling, medications, work history, and other information when appropriate.
2. **You are responsible for honoring your financial agreement with us.** We want you to know that our clinic accepts *cash, check, or credit card.* **You must make a full payment each time you receive services.** Psychological services are covered under many health insurance plans, and we encourage you to check with your insurance agency or employee benefits department to know your provider's benefits and limits. ***We do not accept insurance payments or process claims.*** However, you will be given a service ticket at each appointment which will provide all of the information you will need to submit claims on your own. Fees for groups, workshops, and organizational consultation are negotiated on a situation-by-situation basis.
3. **You are responsible for keeping appointments.** ***Missed appointments, except in emergencies, will be billed at the normal rate.*** To avoid receiving a bill for a missed appointment, you must contact us to cancel the appointments **one full business day prior** to your appointment. Monday appointments must be cancelled before 5 p.m. the preceding Friday. 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.

____

Signature of Client **Date**

____

Signature of Witness **Date**