FAMILY COUNSELING SERVICE **CLIENT INFORMATION**

Client's Last Name__________________________First____________________________SS#____________________________

DOB____________________Age______________Race___________Gender__________Religion__________________________

Phone: Home________________________Work______________________________Cell________________________________

Name of Legal Guardian(s) (if under age 19): ____

Would you like to have access to our online patient portal? ☐ Yes ☐ No Email____

Address______________________________________City, State, Zip_________________________County________________

Spouse's Last Name____________________________First________________________Date of Marriage ____________________

DOB____________________Age ___________Race___________Gender__________Religion_____________________________

E-mail______________________________Phone: (Spouse) Home_________________________Cell _______________________

Education: Self___________________________________ Spouse Education ____________________________________

Employer: Self____________________________________ Spouse Employer _____________________________________

Physician: Self__________________________Spouse________________________Children ______________________________

Children: Name________________________________Age______; Name_______________________________Age_______

Name________________________________Age______; Name_______________________________Age _______

How did you hear about us? ☐ Website/Internet ☐ Brochure ☐ Friend ☐ Insurance Company ☐ Doctor ☐ Pastor ☐ Attorney ☐ Another Counselor ☐ EAP ☐ School ☐ Court

Session cost will be covered by? ☐ **EAP** ☐ **Insurance** ☐ **Self-Pay** ☐ **Positive Directions** ☐ **Other**

If cost is covered by an EAP, please list employer:_______________________If other, please identify: ____________________

INSURANCE INFORMATION

Person Responsible for Bill:_____________________________________Date of Birth: _______________________________

Method of Payment: ☐ Insurance ☐ Credit Card ☐ Cash or Check ☐ Co – Pay $________________due today

Is this patient covered by insurance? ☐ Yes ☐ No Insured's Date of Birth: ____

Insurance Name:____Contract #: _____________________________________

Policy Holder:____Group #:_______________________________________

Secondary Insurance:____Contract #:_____________________________________

Policy Holder:____Group #:_______________________________________

Client's relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____

Policy Holder Address:____Phone Number: ______________________________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Family Counseling Service or insurance company to release any information required to process my claims.

____

Client Signature **Date**

Office Use Only: **Fee Per Session**: __________________

Case #:_________________________Counselor:______________________________Date: _________________

Family Counseling Service
Client Questionnaire

Client Name:______________________________________Date: ________________

Over the past 6 months, have you been bothered by any of the following problems?	Mark only that apply to you	How often does the problem occur?
Depressed mood (feeling sad, empty)		
Feelings of hopelessness		
Diminished interest or pleasure in activities		
Weight loss of over 5% in the past month when not dieting		
Decrease or increase in appetite		
Problems getting enough sleep or sleeping too much		
Moving or speaking so slowly that other people have noticed		
Fidgety or restless/moving around more than usual		
Fatigue or loss of energy		
Diminished ability to think, concentrate or make decisions		
Recurrent thoughts of death		
Feelings of low self-worth		
Anxiety in social settings		
Feeling anxious overall		
Feelings of losing control		
Excessive worry		
Feeling restless, or on edge		
Irritability		
Tension		
Feelings of panic		
Socially withdrawn		
Making careless mistakes		
Do not complete tasks		
Difficulty staying organized or focused		
Forgetful		
Confused		
Disoriented		

Family Counseling Service
Client Questionnaire

Over the past 6 months, have you been bothered by any of the following problems?	Mark only that apply to you	How often does the problem occur?
Compulsive checking or counting		
Indecisiveness		
Feeling emotionally distant from others		
Racing thoughts		
Impulsiveness		
Recurrent or distressing dreams		
Sexual problems		
Gender concerns		
I don’t like my body		
Intense fear of weight gain		
I do risky or dangerous things		
Binge eating		
Laxative abuse		
People talk about me		
Some people want to hurt me		
I hear voices or sounds others do not hear		
I see things others do not see		
I smell things others do not smell		
My symptoms significantly impact my social, work, or family life.		
Sometimes I think I would be better off dead		
I think of hurting myself in some way		
I have engaged in self-mutilation		
I have tried to hurt myself		
Thoughts of hurting someone else		

Have you ever been exposed to a s gnificant traumatic event, such as a violent event, serious accident, life-endangering event or other life-changing incident? ☐ YES ☐ NO

In your own words, please describe what has led you to seek counseling?

____

____

____

Family Counseling Service
Client Questionnaire

Personal Medical History:

- ☐ Thyroid Disease
- ☐ Anemia
- ☐ Liver Disease
- ☐ Chronic Fatigue
- ☐ Kidney Disease
- ☐ Diabetes
- ☐ Asthma/respiratory problems
- ☐ Stomach or intestinal problems
- ☐ Cancer (type)
- ☐ Fibromyalgia
- ☐ Heart Disease
- ☐ Epilepsy or seizures
- ☐ Chronic pain
- ☐ High Cholesterol
- ☐ High blood pressure
- ☐ Head trauma
- ☐ Liver problems
- ☐ Other

Do you have any other current medical problems?

____

____

Do you have any past medical problems, hospitalization, or surgeries?

____

____

Current Weight:________________Height: ________________

Current Psychiatric Medications:

Please list any psychiatric medications you are taking even if prescribed by your family physician.

Medication Name	Total Daily Dosage	Estimated Start Date

List any other current prescription medications and how often you take them: (if none, write none)

Medication Name	Total Daily Dosage	Estimated Start Date

Family Counseling Service
Client Questionnaire

How many caffeinated beverages do you drink a day? Coffee__________Sodas__________ Tea _________

Do you smoke cigarettes or used tobacco products (chewing tobacco, pipes, cigars) Yes No

If yes, what type ___________________________________ and how often ____________________________________

Do you drink alcohol? Yes No If yes, how often? ____

Past Psychiatric History:

Outpatient treatment? **Yes** **No** If yes, please describe when, by whom, and nature of treatment.

Reason Dates Treated By whom

____

____

Psychiatric Hospitalization? **Yes** **No** If yes, describe for what reason, when and where.

Reason Date Hospitalized Where

____

____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar Disorder	☐ Yes	☐ No	Schizophrenia	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Post-traumatic stress	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No	Alcohol Abuse	☐ Yes	☐ No
Anger	☐ Yes	☐ No	Other substance abuse	☐ Yes	☐ No
Suicide	☐ Yes	☐ No	Violence	☐ Yes	☐ No

If yes, who had each problem?

____

____

Emergency Contact:

Name:_____________________________________ Relationship:____________________________ _____

Telephone #:_________________________________

FAMILY COUNSELING SERVICE
CONSENT FOR THE PURPOSES OF SERVICE, PAYMENT AND HEALTHCARE OPERATIONS

FAMILY COUNSELING SERVICE (FCS) IS DEDICATED TO MAINTAINING THE PRIVACY OF YOUR PERSONAL HEALTH INFORMATION. FCS IS ALSO REQUIRED BY LAW TO DO THIS.

SHARING OF SOME INFORMATION, HOWEVER, IS NECESSARY UNDER SOME LIMITED CIRCUMSTANCES DESCRIBED BELOW. THIS CONSENT FORM MUST BE COMPLETED BY CLIENTS BEFORE THEY ARE SEEN BY A FCS MENTAL HEALTH PROFESSIONAL.

IF YOU HAVE ADDITIONAL QUESTIONS OR CONCERNS ABOUT OUR AGENCY'S PRACTICES IN THIS REGARD, PLEASE FEEL FREE TO CONTACT OUR PRIVACY OFFICER, LARRY DEAVERS, AT (205) 752-2504.

I consent to the use or disclosure of my protected health information, including mental health information, by Family Counseling Service (FCS) and its staff for the purpose of (1) providing services to me, (2) obtaining payment for my health care bills or (3) as necessary to conduct health care operations of Family Counseling Service. I understand that services provided to me by FCS may be conditioned upon my consent as evidenced by my signature on this document.

I authorize Family Counseling Service to release any health, mental health, medical or other information necessary to process any claim filed with my health insurance provider for services rendered by Family Counseling Service. I authorize payment of health/ mental health/ medical benefits to Family Counseling Service for services provided.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out services, payment or healthcare operations of the practice. If Family Counseling Service agrees to the restriction that I request, the restriction is binding on Family Counseling Service and its staff. Any request for restrictions on the use or disclosure of my protected health information must be submitted in writing.

I have the right to revoke this consent, in writing, at any time, except to the extent that Family Counseling Service has taken action in reliance on this consent. I understand that such revocation may mean cessation of healthcare services by Family Counseling Service, except as may be required by law.

My "protected health information" means health information, including mental health information, collected from me and created or received by my mental health provider, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I hereby confirm that I have read and understand FAMILY COUNSELING SERVICE'S NOTICE OF PRIVACY PRACTICES and understand that I may have a copy, upon request, to take with me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my mental health care, payment of my bills, or in the performance of health care operations of Family Counseling Service. The Notice of Privacy Practices for Family Counseling Service is also posted in the office waiting area and on the Family Counseling Service web site at www.counselingservice.org /notice.htm. This Notice of Privacy Practices also describes my rights and Family Counseling Service's duties with respect to my protected health information.

FCS reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by accessing the Family counseling Service web site, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

____

Name of Client, Parent or Guardian (Print)

____

Signature of Client, Parent or Guardian

____

Date

Family Counseling Service
Client Consent to Participate in TeleTherapy (Online Services)

Name of Client:____

1. **PURPOSE.** The purpose of this form is to obtain your consent to receive Telehealth/Telemedicine services with a FCS service provider. Telehealth/Telemedicine is the provision of healthcare remotely by means of telecommunications technology.

2. **NATURE OF TELEHEALTH/TELEMEDICINE SESSIONS.** Telehealth/Telemedicine involves the use of audio, video or other electronic communications to provide assessment, counseling or educational services to you. During your Telehealth/Telemedicine sessions, details of your personal case will be discussed, just as though you were physically present to receive services. You are responsible for ensuring that all necessary steps are taken on your end to protect your privacy. It is *imperative* that you take steps to preserve the integrity of the Telehealth/Telemedicine session. These measures may include avoiding engaging in sessions in the presence of others not involved in the session, minimizing disruptions and eliminating interruptions.

3. **EQUIPMENT**. In order to receive Telehealth/Telemedicine services, the client will be responsible for acquiring and maintaining all equipment needed to receive services on their end, including a high-speed internet connection and up-to-date software for accessing online services. The device must have a camera. This could be a desktop computer, laptop, tablet or smartphone. The internet connection must be able to support a 60 to 70-minue session without interruption.

4. **RISKS, BENEFITS AND ALTERNATIVES.** The benefits of Telehealth/Telemedicine include having access to services without having to travel to the FCS office. It is possible that because of your specific situation, a face-to-face session still may be necessary after the Telehealth/Telemedicine appointment. Additionally, in rare circumstances, security protocols could fail causing a breach of patient privacy. The alternative to Telehealth/Telemedicine consultation is a face-to-face session. Additional risks are that the counselor is unable to assure the privacy of confidential sessions on the user end and the sessions may be interrupted due to a disrupted internet connection.

5. **COUNSELOR DISCRETION**. Your counselor reserves the option of denying Telehealth/Telemedicine services if the risks pose a threat to the integrity of service provision or if the details of your specific circumstances are not conducive to conducting a therapeutically sound session remotely.

6. **CONFIDENTIALITY.** All existing confidentiality protections under federal and Alabama State laws apply to information used or disclosed during your Telehealth/Telemedicine session.

7. **RIGHTS.** You may withhold or withdraw your consent to Telehealth/Telemedicine services at any time before and/or during a session without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

8. Location. The principle location of the client while receiving the services described above is

__(Insert name of City or County)____ in Alabama_

I understand and acknowledge the risks, benefits and details described above and hereby give my consent to receive Telehealth/Telemedicine services from Family Counseling Service.

____ ___________________

Signature of Client or Client's Legal Guardian Date

Authorization to provide services to a minor client

As the parent, legal guardian, and/or custodian of ____, (child's name) I give permission for my child to be treated by Family Counseling Service. I further acknowledge and attest that I have the legal standing and authority to provide this consent. Relationship to minor client: ____

Name of individual providing this consent: ____

Signature of legal guardian/custodial parent: ____ Date: _______________________