LIFE in BALANCE
COUNSELING & WELLNESS CENTER
Enriching Mind, Body & Spirit

New Client Packet Checklist:

Welcome to Life in Balance Center. Full completion of this packet will enable us to provide you with the best possible service. This packet takes about 45 to 60 minutes to complete.

To enable us to provide you with the best care possible,
please be sure to fill out all pages front and back.

Please bring the following to your first appointment. They are required for insurance and medical records compliance:

- Insurance card
- Driver's license or Photo ID
- Any additional medical records or notes you may have from previous practitioners
- Copay or other payment required by your insurance company

Please note the following:

- Client registration (next page) must be filled out completely. The date of birth and social security number of the insurance policy holder is required to submit insurance claims. If you do not have this information, we cannot bill your insurance. You would then be held responsible for charges that your insurance would otherwise cover.

- Please fill this packet out as completely as you can. This will help your practitioner understand more about your visit.

- The Authorization to Release Protected Information is the last page of the packet. Please fill in your name and date of birth, the name of the practitioner that you will be working with at Life in Balance on the line next to clinician's name, and the name and demographic information of the person or entity that you wish to share your information with. Please wait to sign and date this sheet until you check in with our receptionist so that they can witness your signature.

- **Please review that each page has been signed and initialed.**

Thank you for your cooperation and patience in filling out these forms to help us better understand your needs and bill your insurance correctly.

We appreciate the opportunity to serve you.

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CLIENT REGISTRATION

Today's Date: _____ Date of Birth _____

Client's Full Name:_____ Social Security:_____

Home Address:_____

City: _____State: _____ Zip_____

Mailing Address (if different) _____

Do we have authorization to send mail to the address listed above? □ yes □ no

Phone home: _____ Cell phone: _____

Work: _____

Client Employer:_____ Occupation:_____

Sex: □ M □ F / □ Single □ Married □ Partnership □ Separated □ Divorced

□ Employed □ Retired □ Unemployed □ Disabled Are you a Student? □ Yes □ No

Family Physician: _____ Phone: _____

Referred by: _____

Emergency Contact Name: _____ Phone:_____

INSURANCE: All items in this section must be completed to bill your insurance

Policy Holder's Full Name: _____DOB: _____

Policy Holder's SS #: _____Relationship to Client: _____

Home Address: _____Phone: _____

Employer and Address: _____Phone: _____

□ Single □ Married □ Employed □ Unemployed □ Retired □ Disabled

Primary Insurance: _____ ID# _____

Group#: _____ Mental Health Phone #: _____

Secondary Insurance: _____ ID#:_____

Group#: _____ Mental Health Phone #: _____

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Thank you for choosing Life in Balance Counseling & Wellness Center. Today's initial appointment will take approximately 50 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of what to expect, our policies, State and Federal Laws, and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need. All of the clinicians in our practice have earned a graduate degree (Masters or Doctorate) from an accredited University. All Life in Balance Clinicians are licensed to practice in the state of Virginia or are resident clinicians who have completed a graduate degree and are pursuing licensure under direct supervision of a licensed clinician. The clinical supervisor's name and credentials may be obtained upon request. Our clinicians only practice within their scope of training and experience. In the course of our training and previous employment, we have had experience in treating a wide variety of individuals including children, adolescents, adults, individuals, couples, families, and groups. Your counselor will have his/her own primary specialty areas of expertise. Treatment practices, philosophy, and plan limitations and risks will be discussed with you today.

OUR PRACTICE CONSISTS OF THE FOLLOWING CLINICIANS:

☼ Angela McGoldrick, LPC ☼ Dr. Alan Forrest, LPC, LMFT ☼ Cynthia Blevins, LPC ☼ Andrew Burns, LPC ☼ Jenna Reece, LPC ☼ Megan Propps, LPC ☼ Tracy Wills, LPC ☼ Annie Chalmers, LCSW ☼ Danna Broach, LPC

RESIDENTS IN COUNSELING:

☼ Season Childress, MS ☼ Angela Cardenas MS ☼
Both under the supervision of Cynthia Blevins, LPC.
If you have questions or concerns, please contact Cindy at 540.381.6215 ext 307

OFFICE HOURS

Our office hours are Monday – Thursday 9am-6pm and Fridays 9:30-4:30pm. You may reach our office by phone at (540) 381-6215 to schedule an appointment. If we are unavailable you may leave a message on our confidential voice mail box and someone will return your call as soon as possible during normal business hours. Most practitioners have confidential voice mail boxes. Do not leave messages if you have a psychiatric emergency; please call ACCESS at (540) 961-8300, dial 911, or go to the Emergency Room.

COMMUNICATION

It is our normal practice to communicate with you at your home address and daytime phone number that you gave us when you scheduled your appointment about health matters, such as appointment reminders, etc. You have the right to request that our office communicate with you in a different way.

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Please DO NOT provide phone numbers if you do not wish for us to leave messages. If a phone number is provided as a form of contact, the front office will leave a message at that number.

Please check all that apply. You may contact me and leave messages at:

□ At home at_____

□ At work at _____ □ On my cell at_____

□ Please contact me *only at the following number* _____

□ Please do not leave a message

□ Please DO NOT remind me of appointments

FINANCIAL/INSURANCE

As a courtesy, we will bill your insurance company. All payments and/or co-payments are due at the time of each appointment. If you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If the balance is not paid after 45 days, it will be charged 1.5% interest/month (18% APR). If the account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for collection fees charged to our office to collect the debt owed. Our office accepts personal checks, cash, Discover, Visa, and MasterCard (not American Express). A returned check fee of $35.00 will be charged. If we receive more than one returned check from an individual we may refuse future payment by check.

FEES FOR SERVICE

Initial Assessment & Diagnosis (45-55 minutes)	$125.00
Individual Therapy Session (55 minutes)	$115.00
Individual Therapy Session (45 minutes)	$ 90.00
Family Therapy	$115.00
Phone Consults (30 minutes) may not be covered by insurance	$ 47.50
Phone Consults (55 minutes) "	$ 95.00
Group Therapy Session (50 minutes)	$ 40.00
Deposition or Appearance in Court	$500 + $100/hour
Records and Document Review ($30 minimum)	$ 95.00/hour
Written Correspondence (depending on type)	$ 50.00/page
No Show/Late Cancellation Fee	$ 50.00

NO SHOW AND LATE CANCELLATION POLICY

Please contact our office within 24 hours if you are not able to make your appointment. If you do not show for a scheduled appointment or cancel with less than 24 business hours notice, a NO SHOW/LATE CANCELLATION FEE of $50.00 will be charged for the cost of the missed appointment if permitted by your insurance company. This cost is not covered by insurance and is your responsibility and must be paid in full before your next appointment. If a second appointment is missed without canceling with a 24 hour notice, your counselor will speak with you about future appointments. If a third

appointment is missed your counselor may not be willing to reschedule with you depending on your situation.

AUTHORIZATION

I authorize treatment deemed necessary by Life in Balance Counseling & Wellness Center Practitioners. I authorize Life in Balance Counseling & Wellness to release to my health plan any and all information which she deems necessary regarding my care and treatment to insure prompt payment of all charges for services provided. I hereby assign the payment for all insurance benefits to Life in Balance Counseling & Wellness for any and all charges incurred in connection with services provided to me. I also consent to a copy of this authorization and assignment being used in place of the original.

I understand fully that I remain responsible to pay Life in Balance Counseling & Wellness Center for all charges not paid by either my insurance companies and/or employer, subject to the rules of any federal or state health insurance program such as Medicaid, or to other contractual provisions that may limit a patient's responsibility to pay for medical costs and services. Payment shall be due at the time of the appointment or within thirty days of receipt of a statement.

UNDERSTANDING PSYCHOTHERAPY AND INFORMED CONSENT

It is important for you to understand what counseling is about and what you may expect during therapy. Please read this material carefully and ask the therapist to explain anything that is unclear to you.

What are Counseling and Psychotherapy?

"Counseling" and "Psychotherapy", or simply "therapy", are words for the same process which is: using proven methods to assist people in changing how they think, feel and behave. Legitimate therapy is practiced by professionals Licensed (or license eligible under supervision) by the state in the areas of Clinical Social Work, Professional Counseling, Psychology, or Psychiatry.

The Risks of Counseling:

Research has shown that competent therapy provided by trained and licensed professionals is helpful to most people. At the same time, therapy is not guaranteed to result in a successful outcome every time for everyone. It is important that you understand this before you invest time and money in counseling. The greatest risk of counseling is that it may not, by itself, resolve your problem or concern. Unexpected emotional strain, stress, and life changes may happen during therapy. Other people in your life may not respond how you might like them to to changes you make during therapy.

How does therapy work?

Therapy at Life in Balance will involve several steps. Therapy sessions are usually 45 to50 minutes in length, and are typically held one time per week to start.

First, your counselor will listen to the concerns that you brought to counseling. He/she will get to know you and how you view your life and yourself. You will probably understand your situation better as you and your counselor talk. After you and your counselor explore your concerns, you will choose specific goals and objectives for therapy. Next, you and your counselor will work together to develop a plan for meeting those goals.

You and your counselor will define and work toward accomplishing your goals using research-proven methods. These methods include, for example, accessing your inner strengths and resources, changing thoughts that affect how you feel and what you do, or homework assignments in which you try on new behaviors to see how they fit. You and your counselor may decide to involve other family members in your session. Please know that any work in the sessions will occur only with your permission. It is very important to your counselor to see that your limits are respected. Your specific needs and concerns will determine what is done.

Your counselor will frequently take time to examine your progress toward your goals to make sure you both are on the right track. You and your counselor will decide together when your therapeutic goals are met and when to move toward completing therapy. Your therapy may be terminated if you fail to maintain regular attendance or if your therapist feels you are not making progress. You will be notified in advance of any possible termination of services.

In the unlikely event that your clinician is unable to provide ongoing services, another clinician within the group practice can provide those services. Our office will maintain your records for a period of 7 years. Please contact the Executive Director, Angela McGoldrick, LPC, for any questions pertaining to this.

CONFIDENTIALITY AND EMERGENCY SITUATIONS

Your verbal communication and clinical records are strictly confidential except for situations covered in the Notice of Privacy Practices. Please note that confidentiality cannot be guaranteed if you use electronic communications with practitioners or office staff. This includes e-mail, instant messaging, social media and text. In addition, we will protect your privacy in public. We will not communicate with you in public unless you initiate contact nor disclose that you are a client. If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact ACCESS services at (540) 961-8400, CONNECT at 1-800-284-8898, emergency services (911), or proceed to the nearest Emergency Room for assistance. Life in Balance Clinicians are not on-call outside of their office hours. Our Clinicians will follow up those emergency services with standard counseling and support to the client or the client's family.

You have the right:

- To be treated in a humane and dignified way.
- To be informed of your treatment options, risks, and benefits.
- To take an active role in treatment planning.
- To have questions answered fully.
- To have confidentiality and privacy within legal/ethical guidelines.
- To facilitated review of your clinical information.

You have the responsibility:

- To be honest in providing information.
- To keep your appointments, to be on time, and to give a 24 hour notice if you should need to cancel your appointment.
- To be free of alcohol/drugs during your therapy session.
- To respect the therapist and facility.

- To respect the privacy and rights of others.
- To know your insurance requirements, deductibles, and co-pays.
- To pay your co-pay, deductible, or full charge at the beginning of each appointment.

COORDINATION OF TREAMENT

It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. If you prefer to decline consent no information will be shared, however we do need your physicians name and demographic information for insurance billing.

____You may inform my physician(s) ____I decline to inform my physician

Physician's Name:_____
Clinic_____
Address:_____
Phone:_____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS

I/We have reviewed and received a copy of the Notice of Privacy Practices, if requested. The Notice of Privacy Practices is available on our website at www.lifeinbalancecenter.com or through the Front Office. Signing this acknowledgement does not mean you have agreed to any uses or disclosures of your protected health information outside the purposes outlined in the Notice of Privacy Practices.

CHILD SUPERVISION

Children's Names & Ages

_____ _____

_____ _____

_____ _____

Life in Balance Counseling and Wellness Center strives to maintain a peaceful therapeutic environment to enhance well-being and healing. This includes keeping noise and activity levels to a minimum to avoid disrupting services. Many of our services such as meditation, massage, yoga, and hypnosis are best provided in a quiet environment.

We would prefer that children always be supervised by a responsible parent or other adult at all times while at Life in Balance. However, we do understand that sometimes it may be necessary to leave them in the waiting and/or play room. Please keep the following in mind:

1. Life in Balance will neither provide supervision nor assume liability for your children's safety while they are unsupervised.
2. Children under the age of 5 should never be left unsupervised.
3. You must let front desk staff know you are leaving your children in the waiting and/or play room. Staff will need to know children's names and ages as well as which practioner you are seeing.
4. Please inform your children left waiting that they must play or sit quietly.

5. Rough play or disruption to other Life in Balance services, guests, or practitioners will not be tolerated.
6. Three step process for unruly children:
   a. If your children become disruptive, they will be asked once to curb disruptive behaviors by Life in Balance staff.
   b. If your children continue to be disruptive, staff will request you speak to your children to curb their disruptive behaviors.
   c. If your children continue being disruptive, they will not be permitted to be left unsupervised at Life in Balance again. You will need to make other arrangements for your children while receiving services.

PRESENTING PROBLEM AND PAST TREATMENT

Please briefly describe why you are seeking counseling: _____

_____

How long have you had this problem? _____Did something happen before it started?_____

_____

If you have been diagnosed with a mental disorder, please list here: _____

Have you received mental health treatment before? ____ If so when? ___Where?_____

What was the reason for seeking treatment?_____

_____

What was most helpful about your mental health treatment? _____

_____

What was least helpful about your mental health treatment? _____

_____

Have you had psychological testing before? _____ If so when? _____

Where?_____

Are you receiving other mental health services such as: Psychiatrist _____ Substance Abuse Treatment ___ Mental Health Supports ___ Case Management___ Crisis Services ___

If yes, Provider's name:_____Phone:_____Agency: _____

Are you receiving services with Dept of Rehabilitative Services or other Agencies? _____

Have you ever been hospitalized for psychiatric reasons? _____If so when? _____

Where? _____ Briefly describe the reason: _____

_____

Have you ever had Suicidal thoughts? Yes/No Have you ever attempted Suicide? Yes/No

If so when?_____ What was going on that lead to these feelings/thoughts?

_____

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SYMPTOMS: Please check any problems that either you have had in the past or are currently having.

Now	Past	
☐	☐	Change in appetite (more or less)
☐	☐	Feeling sad
☐	☐	Crying spells
☐	☐	Too little sleep (falling or staying asleep)
☐	☐	Sleep more than usual
☐	☐	Fatigue
☐	☐	Loss of interest &/or pleasure
☐	☐	Avoiding friends or family
☐	☐	Expect failure
☐	☐	Decreased concentration
☐	☐	Thoughts of death
☐	☐	Cutting or burning oneself
☐	☐	Suicide plan or attempt
☐	☐	Depression
☐	☐	Often sick
☐	☐	Loneliness
☐	☐	Slow moving
☐	☐	Hopelessness
☐	☐	Confusion
☐	☐	Worthlessness
☐	☐	Friendly
☐	☐	Lack of confidence/Low self-esteem
☐	☐	Guilt
☐	☐	Reckless or dangerous behavior
☐	☐	Racing thoughts
☐	☐	Pressured speech
☐	☐	Inflated self-esteem
☐	☐	Obsessive thoughts
☐	☐	Compulsive or repetitive behavior
☐	☐	Marital/family problems
☐	☐	Sexual problems
☐	☐	Relationship problems
☐	☐	Long term memory problems
☐	☐	Short term memory problems
☐	☐	Wound up or tense more days than not
☐	☐	Panic attacks
☐	☐	Irritable
☐	☐	Anxiety
☐	☐	Easy going
☐	☐	Muscle tension
☐	☐	Irrational fear of something or someone
☐	☐	Talking/acting w/out thinking
☐	☐	Fidgety, restless, overactive
☐	☐	Difficulty paying attention
☐	☐	Frequent day dreams
☐	☐	Bored easily
☐	☐	Learning difficulties
☐	☐	Often lose things
☐	☐	Excessive dieting/exercise
☐	☐	Obsessed with losing weight
☐	☐	Use of laxatives
☐	☐	Engage in self-induced vomiting
☐	☐	Eating things that are not food
☐	☐	Vandalism
☐	☐	Fire-setting
☐	☐	Lack of remorse for wrong-doing
☐	☐	Selfish
☐	☐	Bullies/gets in fights
☐	☐	Lying
☐	☐	Truancy
☐	☐	Theft
☐	☐	Argumentative/sudden anger
☐	☐	Defiant of authority
☐	☐	Temper tantrums
☐	☐	Stubborn
☐	☐	Avoid adults
☐	☐	Afraid to leave a loved one
☐	☐	Easily embarrassed
☐	☐	Upset by minor changes
☐	☐	Feeling detached from one's body
☐	☐	Feelings of unreality
☐	☐	See or hear things others don't
☐	☐	Believe things others tell you aren't true
☐	☐	Fear of strangers
☐	☐	Difficulty trusting
☐	☐	Believe others are out to get you
☐	☐	Intrusive thoughts
☐	☐	Avoid things related to traumatic event
☐	☐	Startle easily
☐	☐	Flashbacks
☐	☐	Nightmares

Other symptoms not mentioned above _____

_____

_____

How do your symptoms affect your life? _____

_____

_____

_____

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SUBSTANCE USE HISTORY

SUBSTANCE	History of Use? Yes	No	Date of first Use:	Date of Last Use:
Alcohol	☐	☐	_____	_____
Marijuana	☐	☐	_____	_____
Barbiturates	☐	☐	_____	_____
Klonopin, Ativan, Xanax, Valium	☐	☐	_____	_____
Cocaine/Crack	☐	☐	_____	_____
Heroin/Opiates	☐	☐	_____	_____
PCP, LSD, Mescaline	☐	☐	_____	_____
Inhalants	☐	☐	_____	_____
Amphetamines, Speed, Uppers, Crystal Meth	☐	☐	_____	_____
Designer Drugs, Ecstasy	☐	☐	_____	_____
Over the Counter drugs	☐	☐	_____	_____
Caffeine	☐	☐	_____	_____
Nicotine	☐	☐	_____	_____
Other	☐	☐	_____	_____

If you are currently using any substances, please describe when and where you typically use:

_____

_____

Please describe how your use affects family and friends, including how they perceive your use:

_____

How do you perceive your use?_____

_____

Have you ever received substance abuse treatment? ____ If yes, when/where? _____

Have you ever had the following due to substance use? ☐Blackouts ☐Hallucinations ☐Seizures ☐Tremors ☐Legal Charges ☐DUI

CASE ASSESSMENT

If you currently or ever have used alcohol and/or recreational drugs or overused prescription drugs, please answer below:

Have you ever felt you ought to cut down on your drinking or drug use? ☐Yes ☐No
Have people annoyed you by criticizing your drinking or drug use? ☐Yes ☐No
Have you ever felt bad or guilty about your drinking or drug use? ☐Yes ☐No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover? ☐Yes ☐No

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MEDICAL HISTORY

Physician's Name	Specialty	What are they treating you for?	Dates of treatment
	Primary Care Physician		

Date of last physical exam:_____ Date of last dental exam: _____

Please list all prescription, non-prescription medications, and supplements below:

Name of Medication	Prescribed by	Dosage/Frequency	Helpful?	Side effects/comments	Taken as Prescribed?
			☐ Y ☐ N		
			☐ Y ☐ N		
			☐ Y ☐ N		
			☐ Y ☐ N		
			☐ Y ☐ N		
			☐ Y ☐ N		
			☐ Y ☐ N		
			☐ Y ☐ N		
			☐ Y ☐ N		
			☐ Y ☐ N		
			☐ Y ☐ N		

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Please mark X if you now have or ever have had any of these conditions:

□Hypertension	□PMS/painful menstruation	□ Seizures
□Heart disease	□Easy bruising	□ Head injury
□Arteriosclerosis	□Skin rash	□ Headaches
□Arthritis	□Allergies_____	□ Back pain
□Kidney disease	□Asthma	□ Chronic pain
□Varicose veins	□Skin sensitivity	□ Fibromyalgia
□Phlebitis	□Environmental sensitivity	□ Chronic fatigue
□Blood disorder	□Numbness/Stabbing Pain	□ Digestive disorder
□Cancer/Malignancy	□Sensitive to touch/pressure	□ Operations _____
□Diabetes	□Abscess or open sore	□ Infectious Diseases
□Accident _____	□ Thyroid □ Hypo (low) □ Hyper (high) □ Other_____	

How do your medical conditions affect your life? _____

_____

Were you exposed to drugs or alcohol while your mother was pregnant? _____

Did you have any mental or physical problems growing up (birth defect, learning problems, etc.)? _____

_____

Do you have any barriers to getting healthcare? _____

What types of foods do you usually eat? _____
What is your activity level? __ Chores only **OR** ___ 30 min moderate exercise: 1-2x/wk 3-4x/wk 5-7x/wk
What is your highest adult weight? _____ Lowest adult weight? _____ Current weight?_____
How many hours do you sleep at night? _____Do you have trouble falling asleep? ___
staying asleep? ___

FAMILY HISTORY
Has any blood relative of your child (parent, sibling, grandparent, aunt, uncle, etc.) ever had issues or been diagnosed with any of the following:

□ Mental Illness □ Suicide □ Alcoholism □ Drug Problems □ Seizure Disorder □ Mental Retardation
□ Chronic Illness □ ADD □ ADHD □ Bipolar Disorder

Father's Name: _____ □Living □ Deceased
Cause and age of death: _____
Mother's Name: _____ □Living □ Deceased
Cause and age of death: _____

List yourself and siblings in birth order and include ages:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

List your children in birth order (living and deceased) and include ages:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

List all current members of your household (people who live with you):

_____ _____ _____
_____ _____ _____
_____ _____ _____

Do you have any pets? If so what type and their name:

_____ _____ _____
_____ _____ _____

If involved in an intimate relationship (spouse, partner, fiancé, boyfriend/girlfriend, etc.), please describe your relationship:

_____
_____

Have you ever been emotionally/mentally, sexually or physically abused?

_____

Have you ever: been in a war zone or civil unrest? _____ Experienced a natural disaster? _____

Been a victim of a crime? _____ Had other traumatic experiences? _____

WORK, SOCIAL AND LEISURE ACTIVITIES

Are you currently working or disabled? ____ If working, where? _____

Does your job involve hazardous duties, irregular shifts or other potential stressors?

_____

Do you have any attendance issues? _____ Job performance issues?___ Threat of job loss? _____

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Do you like your job? _____ If no, what would you rather do? _____

Did you serve in the military? _____Branch _____ How long? _____ Combat exposure? _____

How far did you go in school? Grade K-8 __ Grade 9-12 __ Graduated H.S. __ Some college ___ Bachelor's degree __ Graduate School __ Master's or doctorate degree_____
Did (or do) you struggle in school? _____ Get along with teachers and classmates? _____

In your daily life, can you adequately read? _____ Write? _____ Do math? _____

Who do you turn to for support?_____

How is your relationship with your family? _____

What do you do for fun? _____
_____

What do you do for relaxation? _____
_____

SPIRITUAL

Would you say you are spiritual or religious in any way? Please explain activities:

_____

Have you had any loss or death in your life that is currently causing you distress? If so, please describe:

_____

How do you cope with loss and/or death? _____

CULTURAL

What language(s) are spoken in your household? _____

How would you describe yourself ethnically or culturally? _____

Do you have any physical disabilities? _____ Do you have limitations on vision, hearing, or speech? _____

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FINANCIAL HISTORY

What are your sources of income? _____

Do you receive any kind of assistance with food, housing, or other necessities? _____

_____

Do you struggle with your bills? _____ Do you have your own transportation? _____

HOUSING

Have you been or are you facing being homeless? _____ Do you have issues where you live now (unsafe housing or neighborhood, poor relationship with neighbors or landlord)?_____

LEGAL HISTORY

□ No legal history

□ Involved in lawsuit currently: _____ in past _____

□ History of involvement in legal system (describe)

_____

□ Served jail or prison sentence ____ For what crime(s)? _____

□ Current legal charges (describe) _____

□ Involvement with Child or Adult Protective Services (describe) _____

Is there anything else not written above that would be helpful for me to know? _____

_____

Thank you for the time and effort you invested in completing this paperwork. This will help me to understand you more fully and be better able to assist you on our journey together.

Reviewed all the above content with client:

_____ _____

Therapist Signature Date

_____ _____

Supervisor Signature (if applicable) Date

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Authorization to Release Protected Health Information (PHI)

I (Client's Name) _____ (Date of Birth)_____ give permission to Life In Balance Counseling and Wellness Center and

_____ (Clinician's Name) to send and/or discuss confidential case records and/or test results, to send treatment summaries and diagnosis information to and to receive confidential information from my PRIMARY CARE PHYSICIAN, PSYCHIATRIST, OR OTHER PERSON/ENTITY:

Name:_____

Address:_____

_____

Phone:_____ Fax_____

I understand my service record is protected under Federal and State regulations and that information to be released by my signature may contain information pertaining to medical, psychiatric, substance abuse treatment and/or confidential HIV/AIDS related information.

This consent shall be in effect from_____ until_____
(Not longer than one year)

_____ _____
(Signature of Patient) (Date)

_____ _____
(Signature of Witness) (Date)