**Hope Enrichment Center, PC**

7467 Swinnea Rd

Southaven, MS 38671

**WELCOME** to the Hope Enrichment Center! Please complete the following information prior to your first appointment. This will help us to better serve you! As you answer the questions, if you have any questions or concerns, please feel free to ask your therapist.

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Today I am here to see:***

□Carrie Ann Carr, MA, LPC-S, LPC-MHSP □Molly Okeon, MS, NCC □Jaimie Walker, MS, NCC

□Angela Thomason, LPC-MHSP □ Scherri Henderson, MS, LPC

□Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SECTION 1 **–** Contact information

|  |  |
| --- | --- |
| **CLIENT NAME** | **DATE OF BIRTH**  **Age** |
| **ADDRESS** | **CITY ZIP** |
| **PREFERRED PHONE #**  TYPE: □ HOME □ MOBILE □ OTHER | **MAY WE LEAVE A MESSAGE**: □ YES □ NO |
| **SECONDARY PHONE #**  TYPE: □ HOME □ MOBILE □ OTHER | **MAY WE LEAVE A MESSAGE**: □ YES □ NO |
| **GENDER**: □ MALE □ FEMALE | **TRANSGENDER:** □ YES □ NO |
| **MARITAL STATUS** □ SINGLE □MARRIED  □ DIVORCED □ SEPARATED □ WIDOW | **EMPLOYER/SCHOOL NAME** |
| **EMAIL ADDRESS** | **OCCUPATION/JOB POSITION** |
| **EMERGENCY CONTACT & PHONE:** | **EMERGENCY CONTACT RELATIONSHIP TO CLIENT:** |
| **RELEASE OF INFORMATION SIGNED FOR EMERGENCY CONTACT: YES NO** | **MAY WE SEND MAIL TO YOUR HOME:** □ YES □ NO  (*All mail comes from “HEC” discreetly)* |

*If the client is a minor, please complete the following information.*

|  |  |
| --- | --- |
| **WHO DOES MINOR RESIDE WITH?** | **NAME OF RESPONSIBLE PARTY** |
| **RELATIONSHP TO CLIENT** | **NAME OF SCHOOL/CURRENT GRADE** |
| **ADDRESS** | **CITY ZIP** |
| **PREFERRED PHONE #**  TYPE: □ HOME □ MOBILE □ OTHER | **MAY WE LEAVE A MESSAGE**: □ YES □ NO |

*For office use only:*

**DSM Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

SECTION 2 - Referral Information

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| **We appreciate our referral sources! May we inquire as to who referred you to our office?**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

SECTION 3 – Fees for Services & Consent Agreement

**Primary Insurance Carrier Information**

□ **Self – Pay client** (no insurance will be used).

In order to provide our clients with the highest level of care, we refrain from engaging in contracts with private insurance carriers that can dictate treatment and compromise private health information. Payment for services are due *at the time of* services in the form of cash, personal check, or charge. Our fees as of 11/2017 are as follows:

**1-hour Individual/Couples Psychotherapy - $150.00**

**45 min of Individual/Couples Psychotherapy - $100.00**

**30 min of Individual/Couples Psychotherapy - $75.00**

**30 min Neurofeedback Session - $75.00**

|  |  |
| --- | --- |
| **NAME OF INSURED (Name on insurance card)** | **DATE OF BIRTH** |
| **INSURANCE IDENTIFICATION #** | **POLICY # (if applicable)**  **GROUP # (if applicable)** |
| **NAME OF INSURANCE CO.** | **PHONE #** |
| **ADDRESS OF INSURANCE CO.** | **CITY STATE ZIP** |

**Has your deductible been met?** □ **Yes** □ **No** □ **Does not apply**

If you are unsure if you have met your deductible or if it applies, please refer to the customer service number on the back of your insurance card and call your insurance company.

*🙜 Filing for Secondary Insurance is the client’s responsibility.*

Hope Enrichment Center will assist our clients wishing to obtaining reimbursement from their private insurance carriers by:

-Creating receipts for services with the information required by most insurance carriers for reimbursement.

-Creating a super bill on a monthly or quarterly basis.

-Answering questions regarding insurance forms and procedures.

**CONSENT AGREEMENT – PAYMENT FOR SERVICES**

Your insurance coverage is an agreement between you and your insurance company. The consumer (or the Responsible Party listed in the Minor’s section) is ultimately responsible for any and all expenses incurred for treatment at the Hope Enrichment Center PC. We will file all claims for the services rendered at the Hope Enrichment Center, PC with your primary insurance carrier. If your insurance carrier does not pay its portion within 4 weeks of the filing date, and we have done everything in our power to effectively obtain payment for services, the consumer is ultimately responsible for your service fees. We will be diligent in communicating any insurance reimbursement difficulties with the consumer as this information becomes apparent to our billing department.

I hereby authorize Hope Enrichment Center, PC. to release any information required in the processing of claims.

I acknowledge and agree that the Hope Enrichment Center, PC has permission to send my case to a third- party collection agency in the event that I neglect to pay for services in a timely fashion.

I understand that the cost per clinical hour is $150.00 for the Initial Evaluation, and $150.00 for any follow-up sessions. In the event a credit is developed on your account (Less than $50.00), we will automatically apply said credit to future co-payments/co-insurance costs or your deductible. Consumers may request to receive their account credit back in the form of a check from the Hope Enrichment Center PC. This request for a credit must be done in writing and submitted to the Hope Enrichment Center PC billing department. The Hope Enrichment Center PC has up to 30 business days after the request is submitted for said credit to be returned to the consumer.

I understand that there will be a **$50.00 charge for failed appointments** (i.e. not canceling your appointment with 24-hour notice or failing your scheduled appointment time). There will be a $30.00 charge for returned checks. Payment is due upon receipt of services. I also attest that I have received and read the General Policy Statement.

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**Signature of responsible party Date**

SECTION 4 – What brings you in today?

**Have you had -**

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| --- |
| □ Frequent mood changes □ Depression □ Anxiety □ Worry  □ Change in sleep patterns □ Change in appetite □ Panic attacks □ Difficulty focusing  □ Feel overwhelmed □ Crying spells □ Low motivation □ Racing thoughts  □ Nightmares □ Irritability □ Self injury □ Acting out/impulsivity  □ Increased substance use □ Thoughts to harm self □ Thoughts to harm others  □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Recent stressors – (last 12 months)**

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| --- |
| □ Marital issues □ Divorce/Separation □ Relationship conflict □ Remarriage  □ Pregnancy/Miscarriage □ Sexual identity issues □ Infertility □ Parenting  □ Major life transition □ Health/Medical issues □ Financial stress □ Traumatic event  □ Loss of a loved one □ Issues at work/school □ Identity issues □ Aging parents  □ Spiritual issues □ Legal issue □ Hospitalized for mental health or substance use  □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Health review – (last 4 weeks)**

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| □ Feel tired □ Feel like you are running on a motor □ Nausea □ Aches/pain  □ Oversleeping □ Sleep disturbance □ Hot or cold spells □ Excessive sweating  □ Increase in weight □ Decrease in weight □ Headaches □ Shortness of breath  □ Rapid pulse □ Chest pain □ Cardiac issue □Diarrhea/Constipation  □ Vomiting □ Broken bone/sprain/strain □ Hair loss □ Decreased sex drive  □ Sexual performance concern □ Difficulty recovering after pregnancy  □ Missed menstrual period □ Cancer □ Surgery  □ Hospitalization  □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Primary Healthcare Physician (PHP): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Last visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician’s address & phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Release of Information for Primary Care Physician signed: YES NO Date Signed:** *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

□ **No Primary Health Physician**

SECTION 5 – Confidentiality and General Policy Statement

*PLEASE REVIEW AND INITIAL BOTH PARTS*.

**Confidentiality and Privacy Policy**

|  |
| --- |
| All sessions are confidential according to Mississippi and federal law. However, we have a duty to prevent harm to you and others. Therefore, we are required by law to respond responsibly. Laws require us to report suspicion of child or elder abuse to either the Department of Children and Family Services or the Department of Aging.  We are also required to secure adequate care of those struggling with suicidal or homicidal thoughts and behaviors. If you have specific questions, please discuss them with your counselor.  In some circumstances, mental health records and information may be subpoenaed for legal purposes. Please inform your counselor of any legal issues IMMEDIATELY and consult with your attorney for counsel on receiving mental health services. *A full explanation of our privacy policy is available to you upon request and you are encouraged to review it if you have any questions or concerns regarding your confidentiality rights.*  **INITIALS \_\_\_\_\_\_\_\_\_\_** |

**General Office Policies**

|  |
| --- |
| 🙜 APPOINTMENTS – Each clinician at the Hope Enrichment Center, PC is responsible for making their own appointments. Please consult with your individual therapist to both obtain and reschedule all appointments.  🙜 SOCIAL MEDIA POLICY – The Hope Enrichment Center, PC asks that you agree to review and sign our *Social Medial Policy* to ensure the highest level of ethical communication possible regarding your private health information.  🙜 CANCELATION POLICY – The Hope Enrichment Center, PC asks that you respect our 24 hour cancelation policy. If you are in need of rescheduling or canceling an appointment, please provide your counselor with a 24 hour notice. This allows your therapist to place another client into that time slot and adjust his/her daily schedule accordingly. There is a **$50.00 charge** for same day cancellations (less than 24 hour notice) and failed scheduled appointments. This fee is due at your next scheduled session or within thirty (30) days of the failed appoitnment  ***In signing this document, you are acknowledging your agreement with this policy.***  🙜 AFTER-HOURS or EMERGENCY NEEDS – Hope Enrichment Center staff is NOT on 24 hour call for clinical assistance or emergencies. Hope Enrichment Center office hours are Monday – Thursday 8am – 7pm; 8am – 5pm on Fridays. Saturdays are by appointment only. We are happy to return calls during regular business hours. Hope Enrichment Center staff agrees to do its best to address psychiatric emergencies during its regular business hours however, it cannot guarantee immediate response. Therefore, if you experience a psychiatric emergency you are encouraged to call 800-273-8255, a 24 hour hotline, or 9-1-1.  🙜 FEES/PAYMENTS – Each psychotherapy clinical hour is $150.00. A 45-minute session is $100.00. A 30-minute session is $75.00. Neurofeedback sessions are $75.00 per 30-minute session. Any contact with your clinician that lasts 20 minutes or longer via phone, or in person, will constitute a minimum charge of $75.00. *Payment for services is due in full at the time of service*. We accept cash, personal check, or Visa, MasterCard, or Discover for payment. *There is a $30.00 charge for any returned checks.*  🙜 MEDICATIONS – The staff at the Hope Enrichment Center does not prescribe medications of any type. However, if you are in need of such services, we will be happy to refer you to a competent physician who can provide you with medication management.  **INITIALS \_\_\_\_\_\_\_\_** |

**CONSENT FOR TREATMENT**

The type of psychological treatment that you will be receiving is based on the research findings regarding the optimal methods of helping people effectively cope with and/or overcome a wide range of mental health conditions. The mental health conditions are described in detail in the Diagnostic and Statistical Manual of Mental Health Disorders – Fifth Edition (DSM-V). The specifics of your diagnosis will be discussed with you prior to you beginning treatment. Before beginning psychological treatment, a mental health history will be taken during an interview or interviews with your Hope Enrichment Center clinician. In addition, prior diagnostic evaluations that are related to mental health will be reviewed. These evaluations may include, but are not limited to, medical reports regarding health conditions, neurological functioning, neuro-psychological and psychological skills, Speech-Language, Occupational Therapy, and prior mental health diagnoses and treatment. Your Hope Enrichment Center clinician will discuss your initial diagnosis and treatment plan with you to ensure your understanding of the plan and proposed treatment.

Hope Enrichment Center provides a variety of mental health treatments, including:

• Individual psychological counseling that is structured to meet the needs of the specific person. The counseling approach for each individual is specifically tailored to that person’s mental health needs. Depending on an individual’s needs, several approaches to counseling may be incorporated into treatment, including: Cognitive and Behavioral Therapies (CBT & DBT), psychodynamic approaches, relational therapy, cognitive restructuring techniques, EMDR (Eye Movement Desensitization and Reprocessing), mindfulness, art therapy, movement therapy, performance enhancement, biofeedback, and neurofeedback.

• Family counseling.

• Marital counseling.

* Group counseling.

• Consultation with other mental health providers, schools, and medical service providers *(with approved signature of release).*

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to the above Confidentiality, Privacy, and General

(please print your name)

Policies, as well as Consent for Treatment of the Hope Enrichment Center, P.C.

Client Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I agree to communicate any and all changes in the above statements or policies of the Hope Enrichment Center, PC as they are established.

Therapist signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*🙜 A copy of the Confidentiality, Privacy, General Policies, and Consent for Treatment can be provided to the client for their information upon request.*

**Emergency Contact**

*Release for Disclosure of Confidential Information*

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Born on,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize the release of

(Print Client’s Full Name) (Date of Birth)

information regarding my *current* mental and physical health status to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Printed name of emergency contact)

at (Emergency Contact’s phone number) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in the event of an emergency.

An *emergency* is defined here as an event or situation in which the client named above is unable to adequately care for him/herself due to lack of consciousness, severe physical illness, or client self-report of suicidal/homicidal ideation. I understand that outside of these circumstances, the individual I have provided as my emergency contact will have NO access to my mental health records or treatment information at the Hope Enrichment Center, PC. (NOTE: *This agreement does* ***NOT*** *preclude Hope Enrichment Staff from also contacting the necessary authorities as deemed appropriate by state mandate or overall safety for the client, the Hope Enrichment Center staff, and those on the premises at the time of the event*.)

This consent shall expire automatically upon the fulfillment of the purpose stated herein. Additionally, this agreement will expire on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_\_. I understand I have the option to renew this agreement after it has expired.

I hereby authorize the information described above to be released to the party identified on this form. I understand that this release is voluntary and I agree that I was free of pressure or influence from any person or entity upon signing this agreement.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient Printed name of patient Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness Printed name of Witness Date

Copy for patient ٱ Copy for Hope Enrichment Center, P.C. ٱ Copy for recipient