Hope Enrichment Center, PC

52 Timber Creek Dr. – Suite 101
Cordova, TN 38018
901-440-8580

WELCOME to the Hope Enrichment Center. Please complete the following 5 sections of 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:***

☐ Angie Thomason, LPC-MHSP ☐ Scherri Henderson, LPC-MHSP ☐ Samantha Richardson, LPC-MHSP

☐ Andrea Stackpole, MSW ☐ Mary Catherine King, LPC-MHSP ☐ Zach Schappley, (T)MFT

☐ 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
OTHER PHONE # TYPE: ☐ HOME ☐ MOBILE ☐ OTHER	**MAY WE LEAVE A MESSAGE**: ☐ YES ☐ NO
GENDER :	
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

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

_____

SECTION 3 – Financial and Billing Information

Primary Insurance Carrier Information

NAME OF INSURED	**DATE OF BIRTH**
INSURANCE IDENTIFICATION #	**POLICY # (if applicable)** **GROUP #**
INSURED EMPLOYER	**PHONE #**
NAME OF INSURANCE CO.	**PHONE #**
ADDRESS OF INSURANCE CO.	**CITY STATE ZIP**

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

Filing for Secondary Insurance is the client's responsibility.

CONSENT AGREEMENT – PAYMENT FOR SERVICES

Your insurance coverage is an agreement between you and your insurance company. The consumer 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 four (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 **$250.00** for the Initial Evaluation and **$200.00** for 45-60 minute follow up sessions. In the event a credit is developed on your account, you have the option to apply said credit to future co-payments/co-insurance costs or your deductible. Consumers may also 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 thirty (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.

_____ (printed name)

_____ _____

Signature of responsible party **Date**

SECTION 4 – What brings you in today?

Have you had -

☐ 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)

☐ 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)

☐ 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: _____

Your therapist will ask questions about your health, medical background, family history and mental wellbeing to better assess what areas to work on with you and start setting goals today.

SECTION 5 – Confidentiality and General Office Policies

PLEASE REVIEW AND INITIAL BOTH PARTS.

Confidentiality and Privacy Policy

All sessions are confidential according to Illinois 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 DCFS 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.

With your permission, we will communicate with your insurance company in order to assist you in receiving your maximum health benefits. In most cases, insurance companies require us to reveal your diagnosis code and service code (e.g., individual psychotherapy visit). However, some companies require regular review of treatment goals, symptom severity, symptom changes/improvements, and therapy techniques utilized in treatment. If you have questions regarding this matter, please feel free to consult with your insurance company AND 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 therapist at the Hope Enrichment Center, PC is responsible for making their own appointments. Please consult with your individual therapist to both obtain and reschedule any and all appointments.

- SOCIAL MEDIAL 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. *In signing this document, you are acknowledging your agreement with this policy.*

- AFTER-HOURS or EMERGENCY NEEDS – Hope Enrichment Center office hours are Monday – Friday 9am – 7pm (Saturdays by appointment only). We are happy to return calls during regular business hours. If there is an emergency outside of our office hours, we encourage you to call 800-273-TALK, a 24 hour hotline, or 9-1-1.

- FEES/PAYMENTS – Our fees are $250.00 for your initial evaluation/interview session. A 45-55 minute session is $200.00. A 20-30 minute session is $100.00. *Co-pays and deductible are due 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 conservative 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, and Consent to 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, Consent for Treatment and HEC general policies are provided to the client for their information.

Emergency Contact

Release for Disclosure of Confidential Information

I,_____,date of birth,_____ authorize the release of
(Print Client's Full Name)
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.

This information is being released for the purpose of keeping both the client and the general public safe from harm.

Expiration of Consent: This consent shall expire automatically upon the fulfillment of the purpose stated herein. Additionally, this consent will expire on _____, 20_____.

Right to Revoke: This release is voluntary on my part. I may take back this consent at any time, except to the extent that action based on this consent have already been taken.

Authorization: I hereby authorize the information described above to be released to the party identified on this form.

_____ _____ _____
Signature of patient Printed name of patient Date

_____ _____ _____
Signature of Witness Printed name of Witness Date

I

☐ Copy for patient ☐ Copy for *Hope Enrichment Center, P.C.* ☐ Copy for recipient