CLIENT INFORMATION—ADULT

(Revised January 2024)

Today's Date: _________________

Client Name: _______________________________ Form Completed by: ___________________________

Address: ____

City: _______________________________ State: ________________ Zip Code: __________________

Home Phone: ________________________ Alternate Phone (cell) (work): __________________________

E-Mail: _______________________________

Date of Birth: __________________________ Gender: Male ______ Female ______

Employment: Full-time ______ Part-time ______ Not employed ______ Student ______

Occupation______________________ Employer/School________________________ How Long? _____

Emergency Contact: ____

Relationship: _________________________ Phone Number: __________________________________

General Information

Have you ever sought help in counseling or psychotherapy before? Y N

Provider's name: ____

Date of service: ____

Are you currently working with another counselor? Y N

Provider's name: ____

Have you ever been treated by a psychiatrist? Y N

Provider's name: ____

Date of service: ____

Have you ever been hospitalized for a mental health reason? Y N

Date of hospitalization: ____

How did you find out about NLC/ABCS? (please circle)

Yellow Pages Pastor/church Physician Friend Internet

Family of Origin Information

By whom were you raised? (Please circle)

Both parents   mother   father   grandparent   other

Were your parents married to each other?   Y N

Did they remain married?   Y N

Your age at their divorce, separation or death: _____________

How many siblings do you have? ________________

Where are you in the birth order? ________________

Which best describes the atmosphere of the home in which you grew up (please circle all that apply):

Nurturing   Calm   Neutral   Conflicted   Angry   Abusive   Loving   Emotionally volatile

Relational Information

Current relational status:

Single, never married: ____ in relationship _____ not in relationship

Married: Name of spouse or significant other: ____________________________

Anniversary date: ____

Separated: Date of initial separation: _____________________________________

Divorced: Date of final divorce decree: ___________________________________

Cohabiting: When began: ____

Indicate number of marriages/cohabitations (including current one): _________

Which best describes your current relationship (please circle all that apply):

Abusive   bland   calm   conflicted   loving   satisfying   unfulfilling

Please list those with whom you currently live:

Name	Age	Relationship

Medical Information

Doctor: ____ Telephone Number: _________________________

Are you currently under a doctor's care? Y N

If yes, please explain: ____

____

May we contact your physician? Y N

List medications:

____

Please list any significant medical conditions (HBP, Gastric Reflux, Fibromyalgia, etc.):

____

Are you having trouble sleeping? Y N

Do you have trouble getting to sleep? Y N

Do you have trouble staying asleep? Y N

Do you have recurrent dreams or nightmares? Y N

Do you have trouble concentrating or getting organized? Y N

Have you noticed a recent change in your weight in the last 3-6 months? Y N

Gain or loss? How many pounds? _________

Have you noticed a recent change in appetite? Y N

Increase or Decrease?

Have you noticed a recent change in your sexual desire? Y N

Increase or Decrease?

Do you have any unexplained crying spells? Y N

Do you often feel any tightness in your chest or throat or heart palpitations? Y N

Do you often feel "nervous" or "anxious"? Y N

Do you often complain of headaches or stomach aches? Y N

Substance Use Information

What is your current substance usage, including alcohol and caffeine: ___________________________________

____

Do you recognize any addictions in your life (alcohol, drugs, gambling, sex, internet, work)? Y N

Please describe: ____

Emotional Information

Do you ever feel like running away? Y N

Do you ever feel like hurting yourself? Y N

Have you ever attempted suicide? Y N

Have you recently suffered a significant loss (job loss, death, divorce, etc.) Y N

Who? __________________ When? ____________________

Do you believe you have ever been a victim of abuse (emotional, physical, sexual, verbal)? Y N

Where? _________________ When? _____________________

Please describe: ____

Are you happy with your job or classes? Y N

Do you have a "best friend?" Y N

Who? ________________________________

What do you do for fun? ____

Spiritual Information

What is your spiritual/religious background? ____

Do you practice any type of religion or spirituality? (Please circle) Y N

Buddhism Christianity Mormonism Islam Judaism Other

Are you a member of a local church, mosque or synagogue? Y N

Congregation: ____

How often do you attend? ____

How do you maintain or nurture your spiritual life? _____________________________________

____

Presenting Concerns

Please describe the reason(s) for which you are seeking counseling at this time:

TREATMENT GOALS AND PHILOSOPHY

New Life Counseling is a Christ-centered, biblically based counseling ministry of Arizona Baptist Children's Services. We serve individuals, children, couples and families who are looking for new answers to old problems. Our goal is to help clients move beyond their current struggles to a place of peace and healing by providing effective solutions and coping strategies. These strategies are based on Christian principles integrated with recognized counseling techniques to help guide people to a meaningful relationship with God and others.

AVAILABLE SERVICES

New Life Counseling is an outpatient provider that employs counseling modalities which assist individuals, couples, and families in resolving their difficulties. **Counseling sessions are 50 minutes in length**.

CANCELLATION NOTICE or "NO SHOW" APPOINTMENTS

A 24-hour notice is required when canceling or rescheduling an appointment *except* in cases of an emergency. Your counselor reserves the right to determine what constitutes an emergency. A $50 fee will be assessed for any "no show" or a rescheduled appointment with less than 24 hours' notice. Arriving 15 minutes or more late to a scheduled appointment will be considered a "no show" appointment. If payment for services is handled through a third-party and the third-party does not cover the late cancellation fee or "no show" fee, then the fee will be assessed to the client. Failure to cancel in advance two times or if the client has two "no show" appointments may result in termination of services.

FEE FOR SERVICES

Payment is expected at the time of service, which may include auto charging of a credit card, cash or check. Any outstanding sessions will need to be paid prior to continuing counseling services.

LEGAL SERVICES AND LETTERS

Because we are committed to God's healing and redemption in our client's lives, we do not voluntarily provide forensic or legal services, which are assessments, treatments or recommendations to the courts and legal community (this includes custody related issues). In the event that a judge's order is issued for our counselor's records and/or testimony, the records may be given, but at the discretion of the counselor, the therapeutic counseling relationship may be terminated and a referral to another professional will be made. Cases requiring court-ordered involvement with the legal and judicial system (i.e. communication with attorneys, forensic research, and judge-ordered court appearances) will also be prorated at a rate equal to double the counseling fee with a 15-minute minimum. Additionally, any letters (medical, legal, employment) written will only state information of the dates counseling services took place and where. We do not diagnose or give medical recommendations and require a signed medical release for treatment plans and/or additional progress notes.

CLIENT RIGHTS

The rights and well-being of our clients are primary concerns to the counselors of New Life Counseling. We strive to provide quality care to our clients in caring and ethical atmosphere. Each client accepted for services shall be afforded the basic right to:

- Treatment and services under conditions that support personal liberty and restrict such liberty only as necessary to comply with treatment needs
- A reasonable explanation of all aspects of one's own condition and treatment
- Be informed in advance of charges for services

- All available services without discrimination because of race, creed, color, sex, age, handicap, national origin, or marital status

- Refuse treatment at any point in the treatment process

- Confidentiality of records; within guidelines of state law

- Be informed, in appropriate language and terms, of rights including the right to legal counsel and other requirements of due process

- Referral, as appropriate, to other providers of behavioral health and other services

URGENT/EMERGENCY CARE

Arizona Baptist Children's Services/New Life Counseling does not provide crisis services. If you are in need of crisis services you are encouraged to contact the local crisis center, go to the nearest emergency room or call 911 for assistance.

PARENT RESPONSIBILITY

Parents/guardians are responsible for supervising their children at all times while at the New Life Counseling office. Parents/guardians are financially responsible for any damages their children may cause while in the office or public restrooms.

NO WEAPONS POLICY

No weapons are allowed on the premises of New Life Counseling or in your possession during sessions with representatives of New Life Counseling. Our staff will take the necessary reporting steps in the event that you are found to be in possession of any type of weapon. This strict policy is designed to ensure the safety of everyone.

NO ALCOHOL OR STREET DRUGS

Do not attend counseling sessions if you have taken alcohol or street drugs.

CUSTOMER SATISFACTION SURVEY

When you are discharged you may be asked to fill out a client satisfaction survey or the survey will be mailed to you. This allows you to comment on the quality of your services at New Life Counseling. We strongly encourage you to honestly fill out this survey to provide us with information to improve the quality of our services.

FINANCIAL AGREEMENT

NEW LIFE COUNSELING offers Christ-Centered, Biblically Based counseling at an affordable rate. Standard fees are $90 per 50-minute counseling session. (Some counselors will schedule 75 minute sessions for family or marital counseling – fees for these sessions are 1 ½ times the standard rate at $135.) Unfortunately, AZ law does not allow NLC to accept health insurance, AHCCCS, Medicare or Medicaid as payment for services.

All clients (new and active) will be required to securely keep their credit cards on file for New Life Counseling to hold their appointment, as well be charged for their counseling session on the day of their appointment. Clients will be responsible for counseling fees and any outstanding fees (i.e. no shows, late cancellations) as well as notify New Life Counseling if they need to change their credit card or have insufficient funds. Sponsored/third party payments will be billed according to New Life billing procedures (once a month). If an agreed upon third party does not pay, the client will be responsible to pay the fees. The client will be informed in advance of any changes in the agreed upon fees for service.

Accepted method of payments include cash, credit, debit, HSA card or personal check. Checks are to be made payable to ABCS/NEW LIFE COUNSELING. Donations to ABCS/NEW LIFE COUNSELING are tax deductible, but counseling fees are not.

If clients need to cancel a scheduled appointment, they must provide at least 24 hours-notice. Otherwise if clients do not provide adequate notice or attend the scheduled appointment, the client (or payee who has card on file) will be billed $50.00 for the missed appointment. Clients are also responsible to pay for missed sponsored sessions. If there is a scheduling emergency, call the NLC office or counselor as soon as possible and client will be billed at the discretion of the counselor.

I ____agree to pay (please check one):

____$90 per session
____ $_____ Sliding Scale Fee (w/ confirmation of W-2)
____ Sponsorship (Sponsorship agreement form required from sponsor)
____$300 includes Prepare & Enrich assessment plus three (3) sessions*
____$150 includes Prepare & Enrich assessment plus one (1) session*

I have read, understand, and agree to the above financial policies.

__________________________________ ________________________
Client Signature Date

*Good Faith Estimate: Due to not using insurance to pay for services, this estimate is given to show the costs of projected services to meet state and federal requirements. A quarterly estimate at the standard rate of $90 for 4-12 sessions would range from $360-$1080.. Ultimately, you and your counselor will determine duration and frequency of services and a possible unofficial diagnosis may be given for treatment.

**A minimum of ½ the cost of the Prepare-Enrich package is due for sessions scheduled (non-refundable), as some preliminary work is required of the counselor.

INFORMED CONSENT

The following information is for your benefit so you can enter a cooperative counseling partnership in an informed manner. Counseling is a helping relationship for which you are voluntarily entering for assistance with specific and stated problems. It is expected that you will benefit from your counselor relationship, but there are no guarantees that you will. Keep in mind that it is common to feel worse before feeling better. It is also expected that the counseling relationship should end through mutual agreement once desired goals have been reached; however, you have the right to terminate counseling at any time. Understand that you have the right to refuse any recommended services, and to be advised of the consequences of that refusal.

CONFIDENTIALITY

Legal Confidentiality

By law, the counselor considers all information and issues presented in the course of counseling as privileged and confidential. Confidential information may be released only with the written consent of the person being treated or that person's legal guardian. State law also requires the release of confidential information under the following conditions:

1. The client threatens suicide.
2. The client threatens harm to another person(s), including murder, assault, or other physical harm.
3. The client is a minor (under age 18) and reports suspected child abuse, including but not limited to, physical beatings, and sexual abuse.
4. The client reports abuse of the elderly.
5. The client reports sexual exploitation by a counselor.

In addition, in certain circumstances, a judge may require court-ordered counseling records, a deposition or testimony from a counselor. The contemplation, commission of a crime or harmful act is not considered confidential communication.

Consultation and Professional Training

In accordance with ethical standards, the counselor is required to participate in direct supervision. The counselor requires your consent to obtain professional supervision or collegial consultation outside our ministry when he/she feels it will facilitate the work with you/your family. Your name and any uniquely identifying information about you/your family will be deleted or changed to protect your identity. **Your signature on this form indicates your consent. Please let your counselor know if you are withholding consent.**

Professional Records

The laws and standards of counseling require the keeping of case records. Records are electronically secure and HIPPA compliant. You are entitled to receive a copy of your records or a summary of your care if you make a written request request forms for the summary of your care are available to you. Please note that these are professionally-held records and can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records it is recommended that you review them with your counselor so that the contents can be discussed. You have the right to amend your record, if you find something disagreeable or concerning. Your record will NOT be disclosed to others unless you ask the counselor to do so in writing, or unless the law compels the counselor to do so. Communications between the counselor and client will otherwise be deemed privileged and confidential as stated under the laws of this state. You will be charged an appropriate fee for any professional time spent in responding to your request for information. Meetings will be scheduled at mutually convenient times.

AUTHORIZATION TO TREAT

Authorization for Treatment
My signature below indicates that I have read and understand this policy statement and its limits and have had my questions answered to my satisfaction. I accept, understand and agree to abide by the contents and terms of this agreement and further, I am voluntarily consenting to my counseling for specific and stated problems.

____
Client Name

_____________________________ _________________________
Client Signature Date

_______________________________ _________________________
Counselor Signature Date

New Life Counseling
Video Counseling Consent

New Life Counseling will be offering the option of receiving counseling through video-based services Video counseling will also provide access to counseling services for those who lack accessibility due to transportation and location issues.

Clients will be invited via email to the virtual platform on the day of their appointment by the counselor

Participating in Video Counseling services requires that the client agree to the following:

- The client will provide their own technology (including a secure strong internet connection, video/webcam, microphone and audio). Earphones are recommended.
- The client agrees to participate in their appointment from a non-public location that allows privacy and minimizes the ability of the appointment being overheard.
- The client needs to uphold the expectation of providing a safe and confidential space, otherwise the appointment will be ended, and the client will be responsible for fees associated with appointment cancellation.

Consent for Video Counseling Services

1. I understand that my counselor has offered me Video Counseling Services, that I can ask questions about video services, and that the information transmitted during Video Counseling will not be recorded.
2. I understand that Video Counseling services have the potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
3. I understand that there are potential risks to Video Counseling including interruptions, unauthorized access, and technical difficulties. This includes confidentiality risks in electronic communication.
4. I understand that if there is a service disruption due to technology failure, that my counselor will call me by telephone to continue the appointment in this format.
5. I understand that the counselor or I can request to discontinue the Video Counseling services if it is agreed that the video-conferencing connections are not adequate for this situation or that the client would be better served by another form of intervention or other referrals will be made.
6. Any videoconferencing platform is not an emergency service. In the event of an emergency, I will call 9-1-1

☐ Please check if using Video counseling services or will for future appointments

I certify that:

1. I have read the video counseling consent form or had the form read and/or explained to me.
2. I fully understand its contents including the risks and benefits of receiving counseling through videoconferencing.
3. I have been given ample opportunity to ask questions and that they have been answered.
4. I agree to provide the environmental conditions outlined above to ensure a safe and confidential environment.

☐I will not be using video counseling services now or in the future

Client Name (printed)____

Client/Parent Signature ____Date_________

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

Presented to: ____
Client Printed Name

For: ____
Client Printed Name

Presented by: ____
New Life Staff Printed Name

I, ____, hereby acknowledge that I have received the Notice of Privacy Practices for Arizona Baptist Children's Services and that their staff was available to answer any questions I had and to offer further clarification of the contents of the Notice. * *You may refuse to sign this acknowledgment**

Signature: ____ **Date:** ___________________
Client Signature

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign

____ Communications barriers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining the acknowledgement

____ Other (Please Specify) ____

Arizona Baptist Children's Services Staff Signature: ____

Arizona Baptist Children's Services
1779 N. Alvernon Way
Tucson, AZ 85712

Phone **520.795.7541**
Fax **520.795.7581**
Web **www.abcs.org**