

Marital History:

Additional Comments on Children or Marital History:

Church affiliation (if any) City Pastor

Are you currently under medical treatment? Yes No If yes, name of doctor:

Any medication currently taking? Yes No If yes, please list:

Please describe any current or chronic diagnosed medical conditions:

Are you currently involved in any legal matters, including custody disputes or insurance settlements? If so, describe:

Previous counseling experiences:

Counselor/Location	Dates/Length of counseling	Issues addressed
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Reason for currently seeking counseling: (describe presenting problem, including length & precipitation event, if applicable)

Goals for counseling:

Please circle any appropriate answers:

- Current or previous alcohol or drug abuse Eating Disorder Family/spouse current or previous alcohol/drug abuse
- Anger difficulty History of sexual abuse History of physical abuse Changes in sleep Changes in level of energy
- Financial stress Marital distress Parenting difficulties Recent loss of a loved one
- Job difficulties Anxiety difficulties

Have you ever had suicidal thoughts? If yes, please explain:

Give a brief history of relationships with:

Father

Mother

Siblings

Children

Friends

Are there any additional comments you would like to tell me about yourself?

Fees, Insurance and Confidentiality

THE STANDARD FEE for a psychotherapy session is \$120.00 per fifty-minute session. For those who do not have the resources to pay this fee, a sliding scale will be provided. Group therapy sessions have rates that vary with the type of group. Phone Sessions will be billed at your normal psychotherapy rate. Mediation and court appearances will be billed at the rate of \$200.00 per hour, regardless of your established fee for psychotherapy. Letters will be billed at your psychotherapy fee for hour(s) spent in preparation. Court reports, psychological evaluation reports, and legal reports will be billed at the rate of \$120.00 per hour spent in preparation, regardless of your established fee for psychotherapy, with a minimum charge of at least \$250.00.

EMERGENCY OR URGENT NEEDS – Selah Counseling Services does provide phone counseling for emergency or urgent needs that may occur during your time of being a client here. Please note Emergency or Urgent Calls will be billed at your regular hourly rate. Depending on your insurance plan, these fees may not be paid by your insurance provider and will therefore be billed in total to the responsible party.

FEE PAYMENTS are presented ahead of the session, unless prior arrangements are made with the therapist. Also, there are additional charges for psychological testing and for copying of records.

REGARDING INSURANCE: For those individuals with HMO's, the CO-payment will be made before the start of each session. For all other insurance plans, payment will be made in full before each appointment and a Superbill (submittal form) will be given to you so you may bill your insurance company for reimbursement, unless other arrangements are made.

YOUR APPOINTMENT TIME reserves a psychotherapist's time for you. Missed sessions will be billed at your full fee unless the appointment has been canceled 24 hours in advance of the scheduled time. A missed session will not be rescheduled automatically. You must call to reinstate appointments, or mention during canceling that you wish another appointment.

SOCIAL MEDIA POLICY for our therapists and clients – As professional therapists, we do not accept friend or contact requests from current or former clients on any social networking site. We believe adding clients could compromise your confidentiality and our respective privacy. Please do not contact your therapists through a Social Networking site (Twitter, Facebook, LinkedIn, etc.) These sites are not secure and we may not read them in a timely manner for your needs. The best way to reach us is by phone unless otherwise directed by your therapist.

EMAIL POLICY for our therapists and clients – We prefer using email only to arrange or modify appointments. Please do not email regarding content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate content, please be aware all emails are retained in the logs of your and our service providers. These logs are, in theory, available to be read by the system administrator of the internet service provider. Also, these emails received and responded to will become part of your legal record.

OUR PURPOSE is to provide excellence of service to each of our clients. Still, the success of therapy does not just depend on the skill of the therapist. Many other factors, such as the client's openness to working with difficult material, help to determine the outcome of therapy. If you have any questions regarding your progress in therapy at any point during therapy, please communicate this with your therapist.

CONFIDENTIALITY is a basic policy. Information and records regarding clients are kept confidential unless a signed, written consent form is obtained to release records. The court and legislature have determined that confidentiality cannot override the obligation of a therapist to report child abuse, elder abuse, or threats to harm oneself or others.

I UNDERSTAND AND AGREE TO THE ABOVE. MY FEE IS _____. IT IS MY RESPONSIBILITY TO NOTIFY SELAH COUNSELING SERVICES AT LEAST 24 HOURS PRIOR TO MISSING A SCHEDULED APPOINTMENT. I AGREE TO PAY THE FULL FEE FOR EACH MISSED SESSION I CANCEL WITHOUT GIVING PROPER NOTICE.

SIGNED

DATE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that we have provided. Selah Counseling Services' Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Selah Counseling Services' Notice of Privacy Practices is subject to change. If we change the notice, you may obtain a copy of the revised notice from our office by contacting the Executive Director at (530)268-1355 x1.

If you have any questions about our Notice of Privacy Practices, please contact our Executive Director at: 10091 Streeter Road, Suite 1, Auburn, CA 95602 (530) 268-1355 x1.

I acknowledge receipt of the Notice of Privacy Practices of Selah Counseling Services.

Signature: _____ Date: _____
(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We made good faith attempts to obtain the patient(s) acknowledgement of his or her receipt of the Notice of Privacy Practices, including _____. However, because of _____, we were unable to obtain the patient's acknowledgement.

Signature of Provider: _____ Date: _____