Client Information and Consent Form

 Kanawha Pastoral Counseling Center
16 Leon Sullivan Way, Suite 300
Charleston, WV 25301 Phone: 304-346-9689

Name _____
Street_____ Apt. _____
City _____ State _____ Zip _____
Day Phone _____ _____ Night Phone _____ _____ Cell Phone____ _____
Email address (useful for scheduling - please print clearly) _____

Birth date _____/_____/_____ SS # _____/_____/_____ Age ___ Sex (M/F) _____

Emergency contact person: _____ Phone: _____

Parent, Guardian or Family Member: _____ Phone: _____

Insurance Information: (Please give your insurance card to the receptionist so we can make a copy of it for our records.)

Name of Insurance Co: _____ Telephone:_____

Name of Policy Holder: _____ Policy Holder's SS#:_____/_____/_____

Policy Holder's Employer: _____ Policy Holder's Date of Birth: _____

Group / Policy #:_____ Insurance ID# (if different than SS#) _____

Authorization and Consent for Treatment and HIPAA Notification

I hereby give my consent to KPCC to provide evaluation, treatment and/or other services that we may mutually determine to be appropriate. I understand that KPCC is a pastoral counseling training center, and that my clinician may be a non-licensed intern or resident under supervision.

I authorize KPCC to directly bill and receive payment from my insurance company and/or other persons liable to pay my bill. I assign my right to receive payment directly from any available source to KPCC. I will get authorization from my insurance company for any of KPCC's services if it is required by my policy. I will personally pay all charges not paid by my insurance company or anyone else.

I am aware of the KPCC "Notice of Privacy Practices" and understand a hard copy can be provided at my request. I understand that KPCC may make verbal summaries or send summaries or records of my evaluation and/or treatment to my insurance/managed care company for clinical review as part of its responsibility to manage my care. I further understand that these services are confidential and that information about me will not be disclosed or released to anyone other than authorized KPCC staff without my written consent, with the following exceptions: 1. Information necessary to authorize services or pay claims will be communicated to the insurer/claims payor when required. 2. If I disclose information in the course of evaluation or treatment which indicates I present a clear and present danger to myself or others. 3. As mandated by state or federal law.

Signature of Client: _____ Date: _____

If signed by guardian, guardian's authority is based on

_____

Client / Therapist Agreement

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304-346-9689 www.kpcc.com

Name _____

Date _____/_____/_____

I agree to abide by the following policies in my relationship with my therapist and Kanawha Pastoral Counseling Center, Inc.:

1. I agree to keep any appointment made between me and my therapist. I understand that any change or cancellation must be made 24 hours in advance of the appointment time or the Missed Session Fee will be charged. Messages can be left on KPCC voice mail when the office is closed. If my Insurance does not pay for a late cancellation, I will be responsible for the full fee. Sessions are considered cancelled due to inclement weather if there is a county school closing. Missed group sessions will be charged full group fee, even with advance notice. KPCC may use a medical billing agency if I have an overdue or outstanding balance.

2. I may be asked to have a psychiatric examination, a medical checkup, and/or psychological testing. I will be responsible for these fees. Appointments with the KPCC Medical Director require advance payment of the full fee and payment is expected before an appointment is scheduled.

3. My confidentiality will be carefully protected by the KPCC staff. I am aware of specific situations in which WV law sets limits on my privilege of confidentiality: These are if I disclose to my therapist or a staff member any of the following: a) my intent to harm myself; b) my intent to harm other persons; c) my involvement in abuse or neglect of children or of elders. I will be honest and candid with my therapist about any of the above impulses or actions. I understand that KPCC will take action to protect me or others; such as notifying the Department of Human Services and/or other appropriate persons or agencies.

4. KPCC may offer me a fee subsidy based on my financial circumstances. This subsidy will not apply for missed sessions, for psychiatric services, or for case management services, such as letters or conferences related to my therapy or for offering legal testimony, etc.

5. Telephone contacts for purposes other than setting appointment times will be billed on a prorated basis. Long distance conferences will be initiated by the client.

6. KPCC office hours are Monday through Friday, 9 am through 5 pm. My therapist will be available to meet with me by appointment only. Emergency services are not available at KPCC. If I am in crisis I agree to seek help through the Emergency Room services of the hospital closest to me, or by calling 911. If I anticipate a crisis I will make arrangements with my therapist for appropriate support.

7. If I receive a benefit for therapy costs through a health insurance plan, I may elect to pay my share at the time of the session and to sign over insurance payments to the Center. Statements not honored by the insurance company remain my responsibility. I will reimburse KPCC for any insurance benefit incorrectly paid to me.

8. Fees: $ 175 per 60 minute session; $85 per group session; $175 case management hour

   My payment: $_____; insurance payment: $ _____; Other 3rd Party $ _____;
   Fee Subsidy: $ _____; deferral: $ _____
   Missed Session / Late Cancellation Fee: $100
   I understand that payment is expected and due at the time of each session.

9. I understand and agree to follow the KPCC policies stated above:

_____ _____
Witness Client Signature

_____/_____/_____ _____/_____/_____Date
Date

Medical History Form

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Client Name _____

Date _____/_____/_____

Family History:

Where were you born? _____ Where did you grow up? _____

Number of siblings _____ Your birth order _____ (youngest, oldest, etc.)

Do you have any family members who have been in counseling or hospitalized for psychiatric reasons?

Do you have any family members who have struggled with addictions?

Do you have any family members who have struggled with hurting themselves or others?

Medical/Surgical History:

Do you have a regular Doctor? _____ Name _____ Phone _____

Date of Last checkup _____

KPCC encourages its clients to have a regular medical exam at least once a year. Medical issues can sometimes cause mental, emotional or relational distress, and so it is important to rule these out as not being a factor in what has brought you to counseling.

If you do not have a regular doctor, we urge you to get one. If you do not have insurance or a medical card, you may qualify for free medical service at HealthRight. We have information on HealthRight in the main office, or from your therapist.

Please check any illness you currently have or had in the past.

_____ Diabetes	_____ High Blood Pressure	_____ Lung Disease	_____ Venereal Disease
_____ Rheumatic Fever	_____ Low Blood Pressure	_____ Cancer	_____ (Syphilis/ gonorrhea)
_____ Arthritis	_____ Heart Disease	_____ Jaundice	_____ Kidney Disorder
_____ Thyroid Disease	_____ Pneumonia	_____ Hepatitis	_____ Head Injuries
_____ Anemia	_____ TB	_____ Cirrhosis	_____ Injuries
_____ Ulcer	_____ Colitis	_____ Bone Disorder	_____ Muscular Disorder
_____ Nerve Disorder	_____ Seizures		

_____ Other: _____ _____

(over please)

Please list any medications you are currently taking

Medication	Dosage	Reason	Start Date	Doctor

Any drug sensitivities or allergies: _____

Daily consumption of coffee, tea, or soft drinks containing caffeine: _____

Estimated consumption of tobacco: _____ per day per week. Type: _____

Estimated consumption of alcohol: _____ per day per week. Type: _____

Estimated use of "recreational drugs": _____ per day per week Type: _____

Do you have easy access to a firearm? _____ Is it loaded? _____ Is it locked? _____

KPCC recommends that client who have access to firearms take precautions that the firearm be locked and stored unloaded. If there is anyone in your household, including yourself, who may be depressed or angry, we urge you to remove the firearm completely form the house.

Traumatic Life Experiences _____

_____

Have you had counseling before? When? _____

With Whom? Was it helpful? _____

Have you ever thought about hurting yourself? _____ How recently? _____

Have you ever tried to hurt yourself? _____ How recently? _____

Have you ever thought about hurting someone else? _____ How recently? _____

Have you ever tried to hurt someone else? _____ How recently? _____

Symptom Checklist

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Name _____

Date _____/_____/_____

Listed below are a number of categories in which persons commonly find some difficulties. Please indicate how you are affected by each by circling the appropriate number. Circle a number for every item. Please use the number scale outlined below.

Not a Problem	A Slight Problem	Moderate Problem	Serious Problem	Severe Problem
1	2	3	4	5

	Your Physical Functions	
1	Sleep Pattern	1 2 3 4 5
2	Eating Pattern	1 2 3 4 5
3	Bladder Control	1 2 3 4 5
4	Bowel Control	1 2 3 4 5
5	Seizures or Convulsions	1 2 3 4 5
6	Speech (stuttering or stammering)	1 2 3 4 5
7	Weight Problem	1 2 3 4 5
8	Sexual Functioning	1 2 3 4 5
9	Other	1 2 3 4 5
	Your Experience at Work	
10	General Performance	1 2 3 4 5
11	General Satisfaction	1 2 3 4 5
12	Lateness	1 2 3 4 5
13	Absenteeism	1 2 3 4 5
14	Negative Feelings about Work	1 2 3 4 5
15	Relating to Supervisors	1 2 3 4 5
16	Relating to Co-Workers	1 2 3 4 5
17	Relating to Supervisees	1 2 3 4 5
18	Other	1 2 3 4 5
	Your Behavior	
19	Difficulty with Daily Routine	1 2 3 4 5
20	Letting Others Take Advantage of You	1 2 3 4 5
21	Hyperactivity (Can't sit still)	1 2 3 4 5
22	Repeating Certain Acts, Again and Again	1 2 3 4 5
23	Physically Abusing Others	1 2 3 4 5
24	Using Alcohol to Cope with Problems	1 2 3 4 5
25	Using Drugs to Cope with Problems	1 2 3 4 5
26	Lying	1 2 3 4 5
27	Stealing	1 2 3 4 5
28	Withdrawal from Others Socially	1 2 3 4 5
29	Dependency (Relying on others too much)	1 2 3 4 5
30	Suspiciousness (questioning other's motives)	1 2 3 4 5
31	Hostility (feeling angry towards others)	1 2 3 4 5
32	Other	1 2 3 4 5
	Your Feelings & Moods	1 2 3 4 5
33	Depression (sadness)	1 2 3 4 5
34	Euphoria (feeling "high")	1 2 3 4 5
35	Sudden Changes in Mood for No Apparent Reason)	1 2 3 4 5
36	Anxiety (nervousness)	1 2 3 4 5
37	Lack of Energy	1 2 3 4 5
38	Feeling Angry	1 2 3 4 5
39	Not Liking Self	1 2 3 4 5
40	Not Liking Others	1 2 3 4 5
41	Other	1 2 3 4 5
	Your Inner Thoughts & Ideas	
42	Thoughts about Hurting Yourself	1 2 3 4 5
43	Thoughts about Hurting Others	1 2 3 4 5
44	Having Unwanted Thoughts, Again & Again	1 2 3 4 5
45	Worrying about Your Health	1 2 3 4 5
46	Believing You Are Inferior to Others	1 2 3 4 5
47	Believing You Are Better Than Others	1 2 3 4 5
48	Seeing Things Without Apparent Cause	1 2 3 4 5
49	Hearing Things Without Apparent Cause	1 2 3 4 5
50	Experiencing Confusion	1 2 3 4 5
51	Memory	1 2 3 4 5
52	Other	1 2 3 4 5

Please list any particular worries you have about the symptoms you have listed:

What do you think is causing your symptoms?

Have any of the symptoms affected your daily life and activities? How?

What are your goals for therapy here at KPCC?

Would you like prayer to be a part of your sessions? yes / no / maybe / sometimes

_____

Client Signature *Date*