

Health & Harmony Counseling/Life Coaching

3595 S Town Center Dr

Las Vegas, NV 89135

702-339-1165

Name: _____ Date: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone : (_____) _____ Cell: (_____) _____

May I leave a message, if so on which number? _____

Birth Date: _____ Age: _____ Social Security #: _____

Patient Occupation: _____ Employer: _____

Email Address _____ May I e-mail you? _____

(Please note: E-mail correspondence is not considered to be a confidential medium of communication)

Complete this section ONLY if someone OTHER than the patient is financially responsible.

Responsible Party: _____ Relationship to Patient: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: :(_____) _____ Cell: (_____) _____

Birth Date: _____ Age: _____ SSN: _____

Occupation: _____ Employer: _____

Insurance Carrier _____

Policy ID # _____ Group# _____

Primary Policy Holder's Name: _____

City: _____ State: _____ Zip: _____

Name of person/company who referred you: _____

Should your account be sent to collections, you will be responsible for all collection and service charges.

Signature of client or responsible party: _____ **Date:** _____

Your Rights as a Family Therapy Consumer Are:

1. To receive information concerning the methods of therapy employed, the techniques used, the duration of therapy (if known), and the fee structure for services provided.
2. To seek a second opinion. If needed, I can provide you with names of other qualified professionals.
3. To terminate therapy at any time without any moral, legal, or financial obligations other than those already accrued.
4. To know that in a professional psychotherapeutic relationship sexual intimacy or friendship between therapist and client is never permissible.
5. If you request, any part of your records can be released to any person or agency if you sign an authorization.

6. My professional code of ethics as set forth by AAMFT prevents me from disclosing or releasing information gathered from therapy or regarding your use of service to anyone without your express written consent unless mandated by law. Situations mandated by law are as follows: **A)** Where there is clear and imminent danger to yourself or others; **B)** Reasonable suspicion of child or elder abuse or neglect; **C)** I am responding to a court order from a judge to release information; **D)** When a child under 18 years or less is in counseling and I see a clear need to share information with parents, guardian, or authorities. I cannot guarantee confidentiality when other participants are involved in your therapy process.

I understand and accept the terms and conditions of the therapy being offered and voluntarily agree to participate. As a parent or guardian of a minor child, I also give permission for the following child to participate in therapy: _____

Client Signature Date

Client Signature Date

CONFIDENTIAL
CLIENT INFORMATION & CONSULTING AGREEMENT

Date:

Last Name:

First Name:

Birth date: Age:

Marital Status:

If married, how many years?

If previously married, please specify how many times and the duration of each marriage?

Do you have children? YES NO

If YES please specify how many _____, age and sex:

Are all your children from your present marriage? YES NO Please summarize briefly.

Current occupation?

Company Name?

Emergency contact: Name:

Phone:

Relationship:

What specific problem or issue brings you to this appointment today? Please summarize briefly:

Are you presently under a doctor's supervision? Yes No

If yes please specify:

List any medication you are currently taking.

Have you received outpatient treatment any time during the last three years?

Following is a list of common obstacles which often lead people to seek professional assistance. Please check those you feel may apply to you or add any that may have been missed.

- | | | |
|---|--|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Communication | <input type="checkbox"/> Self Esteem |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Addictions | <input type="checkbox"/> Eating Problems |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Weight Control |
| <input type="checkbox"/> Stress/Tension | <input type="checkbox"/> Smoking | <input type="checkbox"/> Personal Image |
| <input type="checkbox"/> Gambling | <input type="checkbox"/> Grief | <input type="checkbox"/> Shyness |
| <input type="checkbox"/> Work Problems | <input type="checkbox"/> Drugs | <input type="checkbox"/> Emotional Pain |
| <input type="checkbox"/> Relationships | <input type="checkbox"/> Sexuality | <input type="checkbox"/> Physical Pain |
| <input type="checkbox"/> Guilt Feelings | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Phobias (Please specify) |
| <input type="checkbox"/> Lack Motivation | <input type="checkbox"/> Emotional Upset | <input type="checkbox"/> Abortion |
| <input type="checkbox"/> Suicide Attempts | <input type="checkbox"/> Suicidal Thoughts | |

Other: _____

Do you have a family history of:

- Alcoholism Depression or other emotional problems
- Substance abuse or drug addiction History of physical or sexual abuse
- Suicide or any attempts Psychotic Disorders

If you smoke, how much do you consume on a daily basis?

Please describe your eating habits (i.e. preferred foods, regularity of eating, disordered eating)

If you use alcohol, what form and how much do you consume in an average week?

If you use illicit drugs, please specify what type, and how much you consume in an average week?

Have you ever received counseling? If yes, how long did you continue with counseling?
Do you feel it helped you?

What are your religious or spiritual beliefs?

What do you expect to achieve through therapy?

Agreement to pay for professional services

I request that the therapist named below provide professional services to me or to

_____, who is my _____, and I agree to pay this

therapist's fee of \$ _____ per session for these services. Sessions are 50 minutes in

length. I agree that this financial relationship with this therapist will continue as long as

the therapist provides services or until I inform her, that I wish to end it. I agree to pay

for services provided to me (or this client) up until the time I end the relationship.

Payment in full is due at time of each session.

If you fail to cancel a scheduled appointment, we cannot use this time for another client.

A \$25.00 late cancellation fee is charged for missed appointments or cancellations with

less than a 24-hour notice unless it is due to illness or an emergency. In the event of a

second late cancellation, the full session fee will be charged. A bill will be mailed

directly to all clients who do not show up for, or cancel an appointment.

Please be aware that additional fees may apply for any written documentation that is

provided at the client request. I agree that I am responsible for the charges for services

provided by this therapist to me (or this client), although other persons may make

payments on my (or this client's) account.

Client Signature

Date

Client Signature

Date

I, the therapist, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Maryjane A Henning, MS, MFT, LADC

Date