GORDON COUNSELING SERVICES

CHRIS GORDON, M.S., LPC

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Please fill in the information as complete as possible. Information provided on this form is protected as confidential.

PERSONAL INFORMATION

Name:____ Date:_________________

Parent/Legal Guardian (if under 18)____

Address____

City____State_____________Zip____________________

Phone/Cell____May we leave a message/send reminders? YES or NO

Work/Other____ May we leave a message? YES or NO

E-Mail____May we leave a message/send reminders? YES or NO

*Please note: email correspondence is not considered a confidential form of communication.

DOB:_________________________ AGE:_________ Gender:___________________

Marital Status:

[ ]Never Married [ ]Domestic Partnership [ ]Married

[ ]Separated [ ]Divorced [ ]Widowed

Referred by (if any) or how you heard about us: ____

Emergency Contact:___________________________________ Relationship to you:_______________________________

Address:____ Phone:________________

Employment Information:

Occupation: ____ Education: ________________________________

Employer: ____ Work Phone: ______________________________

Address: ____

Length of Employment at above: _______________________________________

Were/are you a member of the armed or community services?_________If so, when? _____What branch? __________

INSURANCE AND PAYMENT INFORMATION

Primary Insurance: ____ Group No: ____________________________

Policy Holder: ____ I.D. Number: __________________________

Relationship to Patient: _______________________ Birthdate: _______________ Effective Date:______________

Employer: ____City & State: _________________________

Do you qualify for an Employee Benefit Program (EAP)? If yes, what employer: ___________________________

(If applicable)-
Secondary Insurance:_____________________________________ Group No: ______________________________

Policy Holder: ____ I.D. Number: ___________________________

Relationship to Patient: __________________________Brithdate: ____________ Effective Date: ______________

AGREEMENT TO PAY FOR CANCELLED AND MISSED APPOINTMENTS

If the cost of my treatment exceeds my benefits from my insurance company, to the full extent contractually allowed, I understand and agree that I am responsible for full and timely payment.

I agree to cancel appointments no less than twenty-four hours prior to the appointment time. If I do not give twenty-four hours notice and another client does not fill my appointment time, I understand that I will be charged a cancellation fee of $50.

Illness and other situations beyond control, will be given due consideration on a case-by-case basis.

Missed appointments or cancellations with less than twenty-four hours notice are not covered by most insurance plans. If this is the case, I understand I will be personally responsible for payment of the appropriate fees.

(Note:Most major credit cards can be kept on file for payment of all co-pays, deductibles and fees if you choose.)

AUTHORIZATION FOR FILING INSURANCE

I authorize the release of any medical or other information to process insurance claims. I authorize the payment of medical benefits to Gordon Counseling Services, LLC as outlined above.

Signature: ____ Date: ___________________
(Client's parent/Guardian if under 18)

HEALTH HISTORY

1.Have you previously received any type of mental health services (counseling, psychiatric, inpatient, etc?)
[ ]No [ ]Yes, previous therapist/practicioner:____

2. Are you currently taking any prescription medications?
[ ]No [ ]Yes, please list:____
____

3. Have you ever had any major medical issues or injuries(hospitalization, accidents, head injuries, surgeries, etc)?
[ ]No [ ]Yes, please list:____

4. How would you rate your current physical health? (Please Circle One):

Poor Unsatisfactory Satisfactory Good Very Good

5. Please list any specific health problems you are currently experiencing: ___________________________________
____

6. How would you describe your current sleeping habits? (Please Circle One):

Poor Unsatisfactory Satisfactory Good Very Good

7. Please list any specific sleep problems you are currently experiencing: ____________________________________
____

8. How many times per week do you generally exercise?_______
What types of exercise do you participate in?____

9. Please list any difficulties you experience with your appetite or eating problems: _____________________________

10. Are you currently experiencing overwhelming sadness, grief or depression? [ ]No [ ]Yes
If yes, for approximately how long?____

11. Are you currently experiencing any anxiety, panic attacks or have any phobias? [ ]No [ ]Yes
If yes, for approximately how long?____

12. Are you currently experiencing any chronic pain? [ ]No [ ]Yes
If yes, please describe____

13. Do you drink alcohol more than once a week? [ ]No [ ]Yes, about how often?______________________________

14. Do you smoke? [ ]No [ ]Yes, about how often?____

14. How often do you engage in recreational drug use? (Please circle one):

Daily Weekly Monthly Infrequently Never

FAMILY HEALTH HISTORY

In this section, please identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you (e.g. father, grandmother, uncle, etc).

Alcohol/Substance Use [ ]No [ ]Yes Family Member____
Anxiety [ ]No [ ]Yes Family Member____
Depression [ ]No [ ]Yes Family Member____

Domestic Violence [ ]No [ ]Yes Family Member____
Eating Disorders [ ]No [ ]Yes Family Member____
Obesity [ ]No [ ]Yes Family Member____
Obsessive Compulsive Behav. [ ]No [ ]Yes Family Member____
Schizophrenia [ ]No [ ]Yes Family Member____
Suicide Attempts [ ]No [ ]Yes Family Member____

CURRENT STRESSORS
Marriage/Relationships:____
Children/Parents:____
Work/School:____
Financial:____
Social:____
Spiritual:____
Sexual:____
Other:____

ADDITIONAL INFORMATION
1.If employed, do you enjoy your current employment situation? Is there anything stressful about current work?
____
____

2. If in a romantic relationship, on a scale of 1-10 (1 being poor and 10 exceptional) how would you rate your relationship?____

3. List any current life changes or stressful events not already mentioned:___________________________________
____

4. List any current or past legal history or current legal problems: ____
____

5. Do you consider yourself to be spiritual or religious?____

6. Please explain any childhood history of abuse (physical, sexual, emotional or spiritual)? ___________________
____

7. What do you consider some of your strengths? ____
____

8. What do you consider some of your weaknesses? ____
____

9. Briefly describe the main problem that prompted you to seek therapy? __________________________________
____

10. How can therapy be most helpful to you? ____
____

11. What would you like to change about your situation? ____
____

12. What have you done so far to find solutions to the problem? Has anything been helpful? _________________
____

CONSENT FOR TREATMENT
And Limits of Liability

I understand that Chris Gordon, LPC provides confidential, client-centered, psychotherapeutic counseling to individuals, couples and families. Chris believes in the value and worth of each individual life. He believes there is hope in the most challenging life circumstances. Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. *Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.*

I understand that developing a treatment plan with Chris and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or any of the procedures provided by this therapist.

I understand that the diagnostic/intake fee is $200 with subsequent session fees at $150/per clinical hour (50 min).
If insurance is billed, I am responsible for co-pay amounts at the time of services.
If I am paying "out of pocket" a cash discount will be applied ($120 per clinical hour).
These fees also apply to the preparation of assessment reports, court appearances, consultation, or meetings you have authorized as part of your therapeutic process. If payments for the services I receive are not made or arranged, treatment may have to be terminated.

I understand that once sessions begin, the duration and termination of therapy is something that should be a joint decision. Thoughts and feelings around wanting to stop therapy are important and you are encouraged to raise these concerns in counseling sessions. I am aware that I may stop my treatment with Chris at any time. I will be responsible for paying for all services I have already received.

I understand that I must call to cancel an appointment at least 24 hours before the scheduled appointment. If I do not cancel and do not show up (no show), I will be charged a $50 fee for that appointment.

Limits of Confidentiality

Records maintained by Gordon Counseling Services are considered medical records and protected health information (HIPAA, see below). We place a high value on confidentiality and will make every effort to ensure your privacy. What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to warn and Protect
If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults
If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities. This includes prenatal exposure to controlled substances that could be harmful to the mother or child.

Minors/guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers
Insurance companies and other third-party payers are given information that they request regarding services to the clients.
The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of empanelment, progress of therapy, case notes, summaries, etc.

PRIVACY POLICY, PATIENT RIGHTS AND HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The HIPAA Notice of Privacy Practices and Authorizations to Disclose Limited Mental Health Information provides a detailed description of the potential uses and discloses of my protected health information, as well as my rights in these matters. I acknowledge receipt of this document and my signature below indicates that I understand and consent to treatment under these conditions.

I acknowledge and authorize Chris Gordon, LPC to use and disclose my individual identifiable health information for the purpose of providing treatment to me, receiving payment from responsible parties for behavioral health care services rendered and/or engaging in behavioral health care operations. My signature below allows Chris Gordon, LPC to receive all benefits which are or shall become payable from any third party payer. I authorize and direct all third party payers to pay all benefits directly to Gordon Counseling Services, LLC, which provided a description of the uses and disclosures of protected health information.

With my signature I acknowledge I have read and understand the nature of counseling services, my rights, responsibilities, HIPAA Notice of Privacy Practices and hereby consent to treatment with Chris Gordon, LPC.

By signing below, I agree to the above assumption of risk, limits of confidentiality and understand their meanings and ramifications.

____ ___________________________

Client Signature (printed name if under 18) Date

____ ___________________________

Printed Name (parent guardian signature if under 18) Relationship to client

____ ___________________________

Chris Gordon, M.S., LPC Date

Please submit payment at time of service.