The Compass 4 Life

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Adult Questionnaire

Reason for Today's Visit

_____
_____
_____
_____
_____
_____

Client lives with _____

Significant Medical History: YES NO
If YES, explain:

_____
_____
_____
_____

Significant Psychiatric History/Current Treatment: YES NO
If YES, explain:

_____
_____
_____
_____
_____

Significant Chemical Dependency History/Current Treatment: YES NO
If YES, Explain:

_____
_____
_____

Symptoms Checklist:

Check off if you (the client) are CURRENTLY experiencing any of the following:

- ○ Thoughts of Harming Self
- ○ Thoughts of Harming Others
- ○ Psychiatric Problems
- ○ Irrational Fears
- ○ Constant Worry
- ○ Sleep Problems
- ○ Social Difficulties
- ○ Work/School Difficulties
- ○ Eating Disorders
- ○ Physical Pain
- ○ Marital Problems
- ○ Anxiety
- ○ Poor Appetite
- ○ Other_____
- ○ Other_____

The 3 things that concern me the most are:

1)_____
_____

2)_____
_____

3)_____
_____

The 3 Goals that I have for this process are:

1)_____
_____

2)_____
_____

3)_____
_____

I will know when things are better when:

_____
_____
_____
_____

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CLIENT INFORMATION FORM

Client's Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ Sex: M F

Home Phone: _____ Work: _____Cell: _____ Email: _____

Are there any restrictions or specific instructions for contacting you at these numbers? _____

Social Security #: _____-_____-_____ Date of Birth: _____/_____/_____ Age: _____ Marital Status: _____

Name of Employer (*or school if minor*): _____

How did you find out about our services? (Circle) **Online?** **Referral?** Who referred you? _____
School? **Other?** _____

INSURANCE INFORMATION (for BCBS PPO)

Primary Insurance Holder:

Name: _____

ID#:_____

Group#_____

Address: (if different from above) _____

Employer: _____

DOB:_____

SS#_____

Relationship to Client: _____

CREDIT CARD INFORMATION
(to be used at the clients discretion to pay for services or in the case of missed appointments

Card number: _____

Name on credit card: _____

Expiration date: _____

Billing zip code: _____

3 digit code on back: _____

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CONSENT TO TREATMENT

I realize that starting counseling is a major decision and that you may have many questions. This document is intended to inform you of what to expect regarding the policies and procedures. If you have other questions or concerns, please ask and I will do my best to give you the information you need.

CONFIDENTIALITY: Confidentiality is taken seriously. As a client, you have a right to privacy. However, under certain situations, there are limits to confidentiality. In the event that a client gives information regarding the suspected abuse of a child, as a mandated reported, I may be obligated to report such information to authorities. When a client is in danger of harming him- or herself or others, confidentiality may need to be broken to promote safety.

SESSIONS/CANCELLATION POLICY: Sessions are typically 55 to 60 minutes long, although the precise length may vary. The number and frequency of sessions is determined collaboratively. For successful therapy, regular and consistent sessions are recommended**.** If you need to cancel or reschedule an appointment, please do so 24 hours before your appointment by calling and leaving a voicemail message. Otherwise, you will be charged $150.00 for the missed session. Fees for missed sessions are expected, except in the case of an emergency. Missed appointment fees cannot be filed with insurance.

FEES: The fee for the initial assessment is $180 and $150 for each following 55 minute session. Telephone conversations, site visits, report writing and reading, consultation with other professionals, longer sessions, etc. will be charged at the same hourly rate, unless indicated and agreed otherwise.

PAYMENTS AND INSURANCE: Currently I am an in network provider for BCBS PPO. If you have this insurance I will submit the claims on your behalf. You will be responsible for any copayments, deductibles and/ or percentages of fees that your insurance doesn't cover. These fees will be due at the time of service, so it is important for you to know your insurance benefits. If you do not carry BCBS PPO, you will be expected to pay in full for each session at the time it is held, unless we agree otherwise. I currently accept credit card, cash and checks as payment for services rendered. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan. Should you have health insurance (other than BCBS PPO), I can provide you with the necessary paperwork to submit to your insurance for you to get reimbursed. Each insurance plan is different and you are responsible for finding out your coverage. It should be noted, however, that you (not your insurance company) are responsible for full payment of fees, so it is important to confirm exactly what mental health services your insurance policy covers. I will make sure you have the necessary information to do that if needed. Failure to keep payments current may result in discontinuation of counseling services.

TELEPHONE AND EMERGENCY PROCEDURES: Normally we will discuss significant matters during session. If you need to contact me between sessions, please leave a voice mail message (630.420.2596 x2) and I will return your call as soon as possible. I plan to return calls promptly but at times may be unable to return calls as soon as you may require. In the event that I am unavailable in an emergency, go to the nearest local

emergency room, or contact one of the following crisis intervention services: DuPage County: 630.627.1700; Kane County: 630.966.9393; you may also call 911, or call your primary care physician or psychiatrist.

THE PROCESS OF THERAPY/EVALUATION: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits; however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. I will ask for your feedback and views on your therapy, its progress and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc... or experiencing anxiety, depression, insomnia, etc... Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results.

THERAPIST INFORMATION The Compass 4 Life has independent sub contractors that provide counseling services. _____ is the independent contractor that I have agreed to work with. I understand that The Compass 4 Life is in no way liable or responsible for the services rendered between me and the independent contractor listed above. I also understand that Providence Counseling Associates is a group of independent contractors who provide mental health services and my therapist is not a part of that practice. Therefore, I agree to hold Providence Counseling Associates and The Compass 4 Life free of any and all liability associated with the therapist listed above. If I have any questions related to this information I will have them answered BEFORE starting the counseling process with my therapist.

I/We have read the above information and agree to these terms for the receipt of counseling services.

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

CONSENT TO TREATMENT FOR CHILDREN & YOUTH

When I work with children, especially those under the age of about 12, parents' questions about the therapy process will generally be answered. As children grow more able to understand and choose, they assume more rights. For those between the ages of 12 and 18, details discussed in therapy will be treated as confidential. However, adolescents will be encouraged by the therapist to share important information with their parents.

Consent for treatment of children or adolescents: I/We agree that _____ may be treated as a client of _____

Signature(s) _____ Date _____