Carlisle Counseling & Consulting Services

Instructions for your first appointment (Couples Therapy)

Welcome to Carlisle Counseling & Consulting Services! Attached is your Registration packet (**Couples Registration Packet**) that must be completed **prior** to your first appointment with us. You can also access your packet on our website at https://www.carlisleforgrowth.com/forms.

Please complete your Registration Packet, add a legible copy of the **Driver's License** and **Insurance Card** of responsible party return to us before you first session. Below is a checklist to help you determine if you have all items needed before sending it to us. Please do not forget to Sign your forms before sending.

Registration Packet Checklist:

_____ Patient Registration Packet (15 pages)

_____ HIPAA Notice of Privacy Practices (4 pages)

_____ Couples Intake Forms (10 Pages) (Both parties MUST Complete) (10 pages)

_____ Couples Intake Form (10 pages) (Both parties complete)

_____ Copy of Driver's License (Responsible Party)

_____ Copy of Insurance Card (Responsible Party) ***Have you met your Deductible? _____What is your Co-Pay? _____**

_____ Your preferred method of Payment

___ Cash ___ Debit/Credit ___ CashApp ___ Vemno ___ PayPal

___ Invoice (provide email) _____ (provide phone)_____

Please **Fax** your completed Registration Packet to **601-202-1798** or email it to Carlisle Counseling & Consulting Services' (carlisleforgrowth@yahoo.com) or Provider. You can also bring completed Registration Packet Checklist with you to your first session. If you choose to do this, you **MUST** arrive at least 15 minutes prior to your scheduled appointment.

Payment for Service

Payment is due at the time of service. Please be prepared to submit payment for your session upon arrival. This includes your Copay/Cost Share if you are using insurance. If paying with Cash, please have the exact amount. We do not keep cash in the office, so we will not be able to provide change.

If you are using insurance, contact your insurance to verify the following:

- Is Carlisle Counseling & Consultant Services/Dr. Sholanda Carlisle is a supported provider?
- Have you met your deductible? (if applicable)
- What is your Co-Pay for Behavior Health/Mental Health Services?

We accept all major Credit/Debit Cards, PayPal (carlisleforgrowth@yahoo.com), CashApp and Vemno. You also have the option to be invoiced prior to your sessions. Telehealth/virtual sessions **must** be paid at least 24 hours prior to your scheduled session.

We accept all forms of Medicaid, Chips, Ambetter, BlueCross BlueShield, United HealthCare and Cigna. Sorry, we do not currently accept Medicare or Tricare. This list is subject to change without notice, therefore please check back for updates or contact us at 601-559-0599 or 769-300-1681.

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357 Towne Centre, Suite 402, Ridgeland, MS 39157 Office : 601 -559-0599

Registration Form

Contact Information:

Last Name: _____ First Name:_____ MI:_____
Preferred Name:_____
DOB:_____ SSN#_____
Street Address:_____
City/State/Zip:_____

Communication:
Phone Home: _____ Cell:_____
Is it OK to leave messages regarding appointments, results, etc. on the above numbers? Y N

Email address: _____
Is it OK to send messages about your appointments, results, etc via email? Y N

Emergency Contact:
Who should be contacted in case of an emergency?

Name: _____
Relationship:_____
PhoneHome:_____Work:_____Cell:_____
Address:_____

Insurance Information:

Name of Primary Insurance Company: _____

ID/Policy #: _____Group#_____

Who is the subscriber? Please check: Self _____Parent_____Spouse_____

Subscriber's Full Name:_____

Subscriber's DOB_____

Subscriber's Employer: _____

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Consent For Treatment

I have chosen to receive mental health services in the form of counseling/therapy for myself and/or my child Carlisle Counseling & Consulting Services. My decision is voluntary, and I understand that I may terminate these services at any time unless my participation has been mandated by a court of law.

Nature of Mental Health Services
I understand that during the course of treatment I may need to discuss material of any upsetting nature to resolve my problems. I also understand it cannot be guaranteed that I will feel better after completion of treatment.

Compliance with Treatment Plan
I agree to participate in the development of an individualized treatment plan. I understand that consistent attendance is essential to the success of my treatment. Frequent "no shows" and/or late cancellations may be grounds for termination of services, as well as failure to follow my treatment plan in any form.

Supervision
I understand there are certain circumstances which may require Carlisle Counseling & Consulting Services provider (s) to receive supervision. These circumstances include, but are not limited to the following:

- State licensure regulations may require our therapists or service providers to receive ongoing supervision.
- Accreditation organizations, as well as insurance companies, may require our treatment plans to be reviewed.
- The standards of care which guide most mental health professionals recommend that supervision and/or consultation be obtained in high-risk situations such as threats and/or acts of harm to self or others.

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Client Rights

- The right to be treated with dignity and respect by all staff
- The right to be involved in the planning and/or revision of my treatment plan
- The right to know about my treatment progress or lack thereof
- The right to reject the use of any therapeutic technique, and to ask questions at any
- time about the methods used
- The right to be spoken to in a language that is fully understood
- The right to a clean and safe environment
- The right to refuse to be videotaped, audio recorded, or photographed

Emergencies
I understand I may reach my service provider directly or Shalonda Carlisle at 601-559-0599. If not available, I can leave a message and my call will be returned as soon as possible. If I have a life-threatening emergency, I may call 911 or go to the nearest emergency room for evaluation and treatment.

Patients must give voluntary consent for mental health treatment. Your signature (or that of your legal guardian) will demonstrate consent for receiving mental health treatment from the Carlisle Counseling & Consulting Services. I voluntarily consent to mental health treatment as performed by the Carlisle Counseling & Consulting Services and its staff. This treatment may include but not limited to: assessment, screening, consultation and recommendations, psychotherapy, holistic services and psychiatric medication management. I understand that mental health treatment may involve certain risks and benefits and I understand these risks and benefits. I also understand the risks and benefits of declining treatment. I am also aware that I have the right to request information about alternative treatment options, should they exist. I have read the above information and I authorize the Carlisle Counseling & Consulting Services to provide mental health services to myself or this patient (if guardian).

I have read, discussed and understood all of the above.

_____

Signature/ Date

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Financial Policy Agreement

Consent to File Insurance
Payment for services provided by the Carlisle Counseling & Consulting Services is due at the time that services are rendered. If the client is covered under insurance, payment of any applicable copayment, co-insurance, or deductible is due at the time of service. If Carlisle Counseling & Consulting Services is not contracted with the insurance, payment for services is due in full at the time that services are rendered.

As the patient/guarantor, you are financially responsible for any fees and costs associated with all services you receive from our office.

As the patient/guarantor, it is your responsibility to know your insurance benefits and to provide our office with accurate and current insurance information. You are strongly encouraged to verify your benefits and coverage to ensure you fully understand what is covered. If your specific insurance plan requires a referral, it is your responsibility to obtain the referral from your primary care physician. If you arrive for an appointment without a referral on file, you have the option to reschedule the appointment or to pay in full for all services rendered.

We will bill your insurance as applicable, however, you are ultimately liable for any fees and costs not covered or paid by your insurance. Questions about non-payment should be directed to your insurance company.

You agree that it is your responsibility to inform the practice of any changes to insurance plan prior to each of your visits, or you may be responsible for the full fee. Some services may not be covered by health insurance. You agree to be fully responsible for payment for all services that are not covered by your health plan. This may include charges for telephone consultations, written correspondence, or reports in connection with a client's evaluation or treatment, including consultation or correspondence with the client, family members, past or current treatment providers, educational professionals, attorneys, courts, agencies, or others. If these charges are excluded from your coverage by your health plan, they will be your responsibility. There will be a charge of $40.00, including applicable fees from the financial institution(s) for returned checks or disputed credit card payments. All patients are required to have a credit card on file to initiate or continue care. It is your responsibility to update any expired cards. All outstanding balances are expected to be paid within 60 days. Payment plans can be provided upon request.

Fees Not Billed to Insurance/Professional Services

Carlisle Counseling & Consulting Services may provide, on a case-by-case basis consultations with family members, past or current medical providers, educational professionals, attorneys, courts, agencies or others. Limited telephone consultation is part of routine patient care and is undertaken without charge. However, when extensive or other than routine telephone consultations, written correspondence or reports are requested or required, a charge for these services will be applied. To comply with federal laws including HIPAA, this office must have a signed authorization from the patient, or responsible party stating who we are authorized to release information to. You can contact our office or visit our website for a copy of the form. If these charges are excluded from your coverage by the health plan, they will be your responsibility.

Requesting Records from Carlisle Counseling & Consulting Services for self/provider/ other entities

To request records from the Carlisle Counseling & Consulting Services for yourself, another provider or entity we require that you complete the "Authorization to Release Medical Records from Carlisle Counseling & Consulting Services" form in entirety. Incomplete forms will not be processed and will delay your request. The cost is a $15.00 minimum processing fee and 25 cents per page to fax or copy your record and additional cost for required certified mail (postage and handling included in invoice paid prior to receipt). We do NOT email records. Processing is 8-10 business days for most circumstances. Please be aware, although you may have signed a release for communication, if you are requesting that we send records, you will need to complete the above process each time you request records to yourself or to be sent to any provider or entity, which includes primary care or change of psychiatric provider upon termination.

Patient/Guardian Responsibility

I understand and agree that I am financially responsible for all charges for all services rendered by Carlisle Counseling & Consulting Services for myself and/or my child.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any co-pays or unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

I agree to inform the office o f any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare or Medicaid patient, I understand that I need to provide the office both my Medicare or Medicaid ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke this Consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent.

Appointment Cancellation, No-Show, and Late Arrival Policy
Carlisle Counseling & Consulting Services' policy requires patients to cancel 1 day (24 hours) in advance of their appointment to avoid a cancellation fee. Clients are expected to arrive on time for their scheduled appointments out of courtesy to the other clients and providers/clinicians. Clients who arrive more than 15 minutes late for an appointment may not be seen and will be charged a late cancellation fee. Carlisle Counseling & Consulting Services charges a $40.00 fee for all late cancellations, no-shows, or late arrivals.

If you miss two appointments without prior cancellation (24 hours when possible, or prior to appointment time on the same day in emergency situation), you will be required to pay a $40.00 deposit prior to scheduling further appointments. This is a good-faith deposit to reserve your appointment time. When the appointment is kept, this $40 fee will be applied to your office visit fees or refunded as appropriate. If the appointment is missed without proper notice of cancellation, the deposit becomes non-refundable.

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Carlisle Counseling & Consulting Services makes every attempt to remain on time for appointments, however, occasionally circumstances arise that may result in an appointment delay. For new patients' first appointments, a no show or late cancellation will result in a full charge of the new patient fee

How to **Cancel Your Appointment**
If you need to cancel your appointment, please call your provider or our office **at 601-559-0599** between the hours of 4:30 pm and 8:00 pm. If necessary, you may leave a detailed voicemail or text message. We will return your- call as soon as possible.

Discharge Policy
At the discretion of Carlisle Counseling & Consulting Services, a client may be discharged from the Practice and their insurance notified if any of the following guidelines are not followed:

- Patient's failure to follow the recommended treatment plan or medical instructions including the Controlled Substance Agreement, if applicable.
- Patient fails to meet financial responsibilities.
- The provider cannot provide the level of care necessary to meet the patient's needs.
- The member and/or member's family is abusive to the provider and/or staff.
- The patient or provider moves out of the service area.

Confidentiality
Confidentiality is a basis of mental health treatment and is protected by the law. Aside from emergency situations, information can only be released about your care with your written permission. A release is not needed for providers of Carlisle Counseling & Consulting Services to consult with other providers within the Practice. If insurance reimbursement is pursued, insurance companies also often require information about diagnosis, treatment, and other important information in the Disclosure of Health Information as a condition of your insurance coverage. Several exceptions to confidentiality do exist that require disclosure by law:

(1) danger to self – if there is threat to harm yourself, we are required to seek hospitalization for the client, or to contact family members or others who can help provide protection;

(2) danger to others – if there is threat of serious bodily harm to others, we are required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization;

(3) grave disability or impairment – if due to mental illness, you are unable to meet your basic needs, such as clothing, food/water, medical care, and shelter, we may have to disclose information in order to access services to provide for your basic needs;

(4) suspicion of child, elder, or dependent abuse – if there is an indication of abuse to a child, an elderly person, or a disabled person, even if it is about a party other than yourself, we must file a report with the appropriate state agency;

(5) certain judicial proceedings – if you are involved in judicial proceedings, you have the right to prevent us from providing any information about your treatment. However, in some circumstances in which your emotional condition is an important element, a judge may require testimony through a court order. Although these situations can be rare, we will make every effort to discuss the proceedings accordingly.

(6) in the event of a national emergency such as a global pandemic, terrorism, wartime or any other catastrophic event, Carlisle Counseling & Consulting Services will follow the Governor's Orders of each state of the patients' residence to ensure continuation of health care for reasonable amount of time.

* We also reserve the right to consult with other professionals when appropriate. In these circumstances, your identity will not be revealed, and only important clinical information will be discussed. Please note that such consultants are also legally bound to keep this information confidential.

Contacting Your Provider

Providers are not immediately available by office telephone, please call your provider directly or via the office at 601-559-0599. Calls are generally returned within 2 business days. Always leave a phone number where you can be reached along with any updated contact information. As we are an outpatient practice, we do not service walk ins or provide crisis services. If your call is an emergency, please call 911 immediately instead of calling the office. Emergency mental health services are provided by all hospitals through their emergency rooms and do not require appointments. Emergency room physicians can contact your provider at any time so please provide them with their contact information. When your provider is unavailable for extended periods of time (i.e., vacation, conferences, etc.), a

trusted colleague will provide coverage, if deemed necessary. Please also note that email should never be used for urgent or emergency issues.

Appointment Confirmations
Carlisle Counseling & Consulting Services will attempt to confirm appointments via email and text upon your consent, however, it is your responsibility to know the date, time and location of your appointment. Carlisle Counseling & Consulting Services has no control in regard to your phone or email connection or reliability. Inability or failure to receive a reminder or appointment confirmation via text or email is not a reason for waiver of fees.

Communication for Appointment Reminders
Carlisle Counseling & Consulting Services may need to use your name, phone number, email address ("Contact Information") to contact you with appointment reminders via phone, text or email. If this communication is made by text, a text message will be left on your phone. You have the right to refuse to give Carlisle Counseling & Consulting Services your consent to use your telephone number and/or email address for appointment reminders. If you chose to give your consent, you have the right to revoke it, in writing, at any time in the future. Should you agree to communicate via email, telephone or any electronic method of communication, Carlisle Counseling & Consulting Services cannot guarantee that those communications will remain confidential. There is a risk that the electronic or telephone communications may be compromised. There is never a 100% guarantee that information will remain confidential when transmitted electronically.

Legal
Legal matters requiring the testimony of a mental health professional can arise. This, however, can be damaging to the relationship between a patient and their provider. As such, we generally recommend that you hire an independent forensic mental health professional for such services. Please review our Fees for Court Appearance Policy.

Recording Sessions
Patients are not allowed to record sessions or providers/clinicians under any circumstances.

Controlled Substances
At Carlisle Counseling & Consulting Services, we do not prescribe controlled substances.

Our medication providers will not treat patients who are prescribed controlled substances from another provider. All patients are subject to urine drug testing per discretion of medical provider.

Inclement Weather

The Carlisle Counseling & Consulting Services closes for inclement weather per the discretion of the Practice and will offer telehealth sessions if able to given weather circumstances. If the Practice closes for inclement weather, it will be posted on the website. Patients are instructed check the website for updates and will be contacted via phone if their appointment requires rescheduling

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Telebehavioral Health Treatment Consent

What is Telebehavioral Health?
"Telebehavioral health" means, in short, services delivered via telebehavioral health rely on a number of electronic, often Internet-based, technology tools. These tools can include video conferencing software, email, text messaging, virtual environments, specialized mobile health ("mHealth") apps, and others.

Your Telebehavioral Health Environment:
You will be responsible for creating a safe and confidential space during sessions. You should use a space that is free of other people. It should also be difficult or impossible for people outside the space to see or hear your interactions with your provider during the session. If you are unsure of how to do this, please ask your provider for assistance.

Client Understanding
I understand that Telebehavioral health services are completely voluntary and that I can withdraw this consent at any time.

I understand that none of the Telebehavioral health sessions will be recorded or photographed.

I agree not to make or allow audio or video recordings of any portion of the sessions.

I understand that the laws that protect privacy and the confidentiality of client information also apply to Telebehavioral health, and that no information obtained in the use of Telebehavioral health that identifies me will be disclosed to other entities without my consent.

I understand that Telebehavioral health is performed over a secure communication system that is almost impossible for anyone else to access. I understand that any internet-based ommunication is not 100 % guaranteed to be secure.

I agree that the therapist and practice will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.

I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.

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I understand that I or my therapist may discontinue the Telebehavioral sessions at any time if it is felt that the video technology is not adequate for the situation.

I understand that if there is an emergency during a Telebehavioral health session, then my therapist may call emergency services and/ or my emergency contact.

I understand that this form is signed in addition to the Notice of Privacy Practices and Consent to Treatment and that all office policies and procedures apply to Telebehavioral health services.

I understand that if the video conferencing connection drops while I am in a session, I will have an additional phone line available to contact my therapist, or I will make additional plans with my therapist ahead of time for re - contact.

I understand a "no show" or late fee will be charged if I miss an appointment or do not cancel within 24 hours of scheduled appointment. I understand credit card or other form of payment will be established before the first session.

I understand my therapist will advise me about what Telebehavioral health platform to use and she will establish a video conference session.

Client Consent

Client Name: _____

I hereby give my informed consent for the use of Telebehavioral health in my care.

Email: _____ **Phone Number:** _____

Client Signature: _____

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FEES FOR COURT APPEARANCE

Fees for Court Preparation and Appearance

Please note that my fee to appear in court is $1,500 (one thousand-five hundred dollars), per appearance. In the event that I receive a subpoena to appear in court to testify on the behalf of you, your child, or any other family member, there will be a fee of
$1,500. I do not voluntarily testify in court cases. Other fees include $225 per hour to prepare records for submission to court, $225 per hour for depositions and phone contacts, and all attorney costs incurred by therapist as result of legal action.

Note that this fee is payable 7 days prior to your court date. Since I will be required to clear my calendar of all appointments and prior engagements so that I may be available to appear in court, this fee is non-refundable. If your court date is postponed and I must again clear my calendar to attend court, you will again be charged the full fee. If your court date is cancelled this fee is non-refundable.

No further appointments will be scheduled until this fee is paid in full. If this payment is not paid in full within one calendar month it will be brought to collections.

Divorce/Custody Cases

Please be advised that, if I receive a subpoena to testify in a divorce/custody case, I will not make a custody recommendation, or a recommendation of where a child should live, nor will I make a determination as to one's fitness as a parent.

Confidentiality

Your rights to privacy and confidentiality are important to me, and I work hard to protect them. There are also laws in place to protect you. Please note there are situations during court and legal proceedings where they may be compromised. Examples of this include you waiving confidentially by agreeing to disclosure the client's mental health records in a lawsuit for emotional distress; your decision to pursue a lawsuit where the client's mental or emotional condition is relevant or critical, if the client's records are

requested by a valid subpoena or court order. It is your responsibility to learn how to confidentially and privacy may be compromised as a result of legal or court proceedings.

Non-Payment

If you have not paid your court-related fees and do not respond to my attempts to contact you and work out a payment plan, I have the option of using legal means to secure the payment. This involves hiring a collection agency or going through small claims court. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of the services provided, and the amount due. A late fee of 20% of the unpaid balance will be charged each month that a balance remains unpaid.

Clients Statement of Agreement

I have read this notice and fully understand the statement. I agree to pay the full fee of $1,500, seven (7) days in advance, for any court appearance this therapist may need to make on behalf of myself, my child, or any other family member. I understand that my therapist is not responsible for the outcome, or any judgments made, regarding my court case.

Client/Legal Guardian Signature:

_____

Client Name (Please Print):

_____

Date:

_____

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Policies & Procedures/Acknowledgment Agreement Signature Form

Acknowledgement of Receipt of Carlisle Counseling & Consulting Services' Policies

By signing this agreement, you agree that you have read, agree with and understand the Carlisle Counseling & Consulting Services' Policies which include, but not limited to, information on Carlisle Counseling & Consulting Services' consent for treatment policy, financial policy, professional fees, cancellation/no-show/late arrival, discharge policies, confidentiality, contacting your provider, confirmation and communication for appointment reminders, legal, recording sessions, controlled substances, inclement weather, telehealth treatment, fees for court appearance and you agree to abide by its terms during our professional relationship. Please look at our website to review our annually updated policy form.

Acknowledgement of Receipt of Notice of Privacy Practices

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

Consent Form for Communication of Protected Health Information

I CONSENT to the communication for appointment reminders via text, email or phone. Cell phone number _____ Other contact number_____
Email Address _____

I have carefully reviewed this document. My signature indicates my full understanding and agreement of Carlisle Counseling & Consulting Services Policies & Procedures, Agreements and Consent documents.

_____ _____ _____
Please print patient's name here Signature of patient/parent/legal guardian Date

For Office Use Only: We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient, but it could not be obtained because:
□ The patient refused to sign
□ Due to an emergency, it was not possible to obtain an acknowledgement
□ We could not communicate with the patient
□ Other (Please provide specific details): _____

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Date file opened: _____
Chart #: _____

COUPLES THERAPY INTAKE FORM

Please complete this form individually

First name: _____ Last name: _____

Age: _____ Birth day: _____ Month: _____ Year: _____

Ethnicity: _____ Religion: _____ Marital Status: _____

Sex/gender: _____ Number of children: _____ Ages of children: _____

Home address: _____

Who do you live with? _____

Cell #: _____ Home #: _____

Work #: _____ Email: _____

Name of emergency contact: _____ Phone: _____

EMPLOYMENT INFORMATION:

☐ On sick leave, as of this date: _____ Return to work date: _____

I was: ☐ Full-time or ☐ Part-time at: _____ Position: _____

☐ Full-time at: _____ Position: _____

☐ Part-time at: _____ Position: _____

☐ Not working because: _____

HOW YOU FOUND CARLISLE COUNSELING:

☐ Word of mouth ☐ I'm a former client ☐ Employer ☐ Social Media ☐ Google, ☐

Other: _____

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PSYCHIATRIC AND MEDICAL HISTORY

Please list any ***psychiatric or "mental"*** problems you have been diagnosed with:

_____

_____

_____

Please list any ***medical or "physical"*** problems that you have been diagnosed with:

_____

_____

_____

Please list any **medications you currently take**, and what you take them for:

_____

_____

_____

_____

Name of **Family doctor:** _____ Phone: _____

Last check-up was during the month of: _____ Year: _____

Results: _____

_____

Name of **Psychiatrist:** _____ Phone: _____

Last visit was during the month of: _____ Year: _____

Results: _____

_____

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MENTAL HEALTH TREATMENT HISTORY

Have you ever been **hospitalized for psychological or psychiatric reasons?** ☐ Yes ☐ No

If yes, please describe when and where you were hospitalized, and for which reasons.

_____

_____

_____

Have you **received prior couple counselling**? And, if yes, for what problems? ☐ Yes ☐ No

If yes, when:_____ Where:_____

By whom:_____ Length of treatment:_____

Problems treated:_____

_____

Was the outcome successful? ☐ Very ☐ Somewhat ☐ No change ☐ Got worse

Have you ever been in **individual counselling before?** ☐ Yes ☐ No

If yes, give a brief summary of concerns you addressed_____

_____

CURRENT HABITS

Please describe your ***current*** habits in each of the following areas:

Smoking:
Gambling:
Drinking:
Drug use:
Caffeine intake:
Exercise:
Eating:
Sleeping:
Fun and relaxation:

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STRESSFUL LIFE EVENTS

Please describe any significant or stressful life events that you have been experiencing:

	No	Yes	If yes, please describe
Economic problems?			
Difficulty accessing health care?			
Legal issues or crime?			
Cultural issues?			
Family conflict or lack of support?			
Social problems?			
Educational or occupational difficulties?			
Housing problems?			
Grief or bereavement?			
Other?			

RELATIONSHIP THAT YOU ARE SEEKING HELP FOR

For how long have you been married, cohabiting, separated, or divorced: _____

Please rate your **current level of relationship satisfaction** by circling the number that corresponds with your current feelings about the relationship:

(extremely unsatisfied) 1 2 3 4 5 6 7 8 9 10 (extremely satisfied)

What are your **expectations for counselling:** _____

_____

_____

_____

_____

_____

_____

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What are your **treatment objectives** (check all that apply):

- □ Improve communication
- □ Problem solving
- □ More quality time together
- □ More respect/understanding
- □ More social contacts
- □ Other (specify):
- □ Conflict resolution
- □ More intimacy (emotional)
- □ Resolve individual issues
- □ Power and control issues
- □ More sharing of the chores
- □ Parenting skills
- □ More intimacy (sexual)
- □ More autonomy
- □ More hobbies
- □ Help for children's behaviour

What have you already tried to address these difficulties?_____

_____

_____

Whose idea was it to come to therapy? _____

Was there a prompting event that led someone to make this call? **(Why seek help now?)** _____

_____

_____

_____

What are your **biggest strengths** as a couple?_____

_____

_____

_____

Please make at least three suggestions as to something ***you*** **could personally do to improve** the relationship regardless of what your partner does: _____

_____

_____

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Do either you or your partner **drink alcohol** or **take drugs** to intoxication? ☐ Yes ☐ No

If yes for either, who, how often and what drug/alcohol? _____

_____

_____

_____

Have either you or your partner **physically restrained, harmed, or injured** the other person?

E.g., pushed, shoved, grabbed, or slapped, etc. ☐ Yes ☐ No

If yes for either partner, who, how often and what happened? _____

_____

_____

_____

Has either of you **threatened to separate/divorce** as a result of the current relationship problems?

☐ Yes ☐ No If yes, who? ____Me ___Partner ___Both of us

If married, have either of you **consulted with a lawyer about divorce?**

☐ Yes ☐ No If yes, who? ____Me ___Partner ___Both of us

Do you perceive that either you or your partner has **withdrawn from the relationship?**

☐ Yes ☐ No If yes, who? ____Me ___Partner ___Both of us

Have you or your partner **ever emotionally or physically cheated on each other?**

☐ Yes ☐ No ☐ Unsure If yes, who? ____Me ___Partner ___Both of us

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How satisfied are you with the **frequency of your sexual activities?** (circle one)

(extremely unsatisfied) 1 2 3 4 5 6 7 8 9 10 (extremely satisfied)

How satisfied are you with the **quality of yours your sexual activities?** (circle one)

(extremely unsatisfied) 1 2 3 4 5 6 7 8 9 10 (extremely satisfied)

What is your current level of **stress (overall)?** (circle one)

(No stress) 1 2 3 4 5 6 7 8 9 10 (extremely stressed)

What is your current level of **stress in the relationship?** (circle one)

(No stress) 1 2 3 4 5 6 7 8 9 10 (extremely stressed)

Name the **top three concerns** that you have in your relationship with your partner ("1" being the most problematic):

1. _____
2. _____
3. _____

How important is it to you to improve the quality of your relationship?

(not important) 1 2 3 4 5 6 7 8 9 10 (extremely important)

How willing are you to make "working on this relationship" a priority in your life?

(not willing) 1 2 3 4 5 6 7 8 9 10 (extremely willing)

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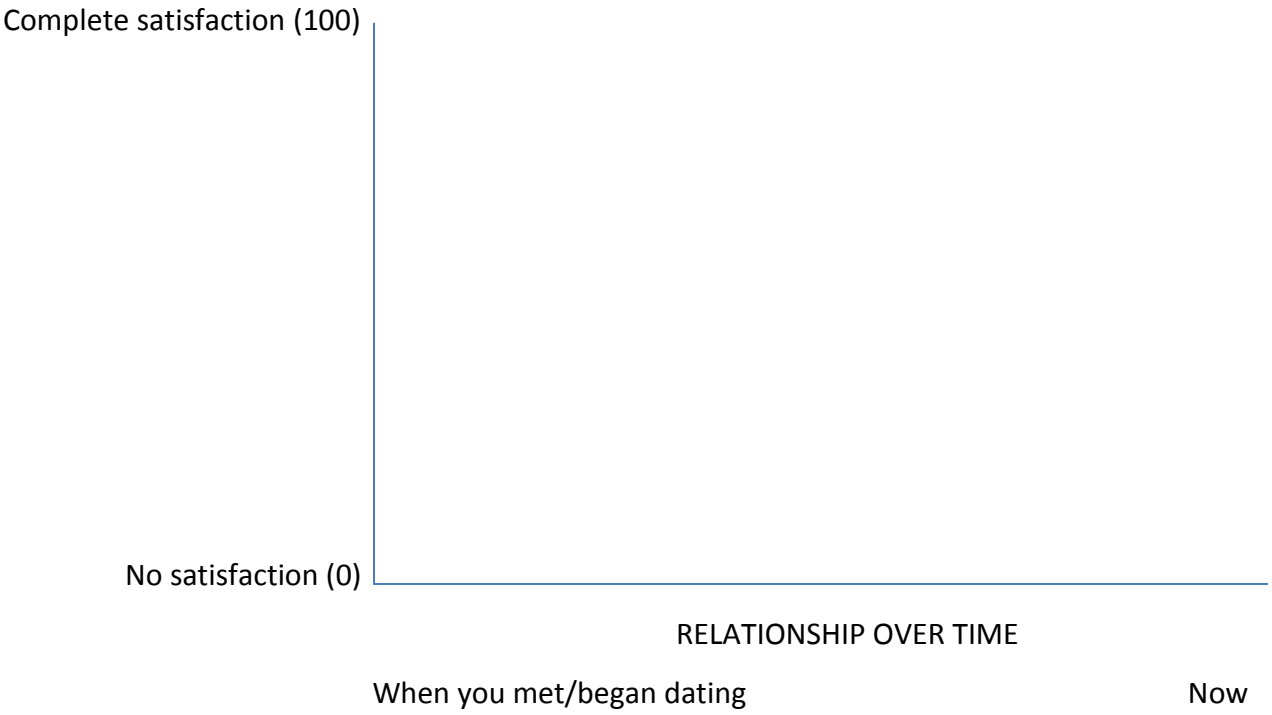
Lastly, please **draw a graph indicating your level of relationship satisfaction** beginning with when you met your partner. Mark pivotal/significant events in your relationship (e.g., birth of your child, one of you cheated, one of you moved out, etc.).



Is there **anything else** that you would like to mention? _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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CONSENT TO RECEIVE PSYCHOLOGICAL SERVICES: ***Clinic Copy***

This consent form explains the nature of the psychological services that you are about to receive. As consent is an ongoing process, any changes that may influence your consent will be discussed with you.

Approach: Your therapist will complete an intake assessment to understand how your current difficulties may have developed and are maintained within the various contexts of your life. The results of this assessment will be shared with you, and a treatment plan will be developed including some potential goals for therapy, and the strategies that may be used to help you reach your goals. Throughout the therapy you are invited to share any concerns or questions that you may have about the therapy process. This helps the therapist to personalize the treatment strategies to better match your unique needs. *Services are by appointment only; in an emergency please call 911 or go to the emergency room.*

Fees and payment: Sessions are approximately 45-50 minutes in length. Every attempt is made to see clients on time. To work towards this goal, payment is due at the *start* of each session, and sessions are to end no later than 10-minutes to the hour. Payments can be made by cash, debit, or credit card. **TWENTY-FOUR (24) hours' notice *is required to* CANCEL OR RESECHEDULE *an appointment to avoid being billed for the full fee of the missed session.* THE ONLY EXCEPTIONS ARE UNEXPECTED ILLNESS OR EMERGENCIES.**

Confidentiality: Psychological records may include items such as personal information, progress notes, and evaluations, and will be shredded 7 years after your file has been closed. No information about you can be released to a third party without your prior written consent, or verbal consent in the case of an emergency. Exceptions include: (1) when children are under 14 years of age, and their parents/legal guardians want access to the file, (2) risk of imminent danger, such as suicide, death, risk of a child running away, or serious bodily harm to an identifiable person or group, (2) suspected or known abuse or neglect of a child or older adult, (3) unsafe operation of a motor vehicle, (4) requests ordered by a court of law or the Order of Psychologists of Quebec, or (5) access is required by other personnel (e.g., administrative staff) to carry out their professional duties. Therapists must, as soon as the interest of their client so requires, receive supervision, consult another therapist, a member of another professional order, or another competent person. Disclosure of identifying information will be minimized, and names will not be released without consent.

Mutual rights and responsibilities: The relationship must remain limited to a respectful therapeutic framework. You may refuse any therapeutic suggestions offered to you, or to suspend or cease treatment at any time without penalty. *If you decide to stop treatment for any reason, please notify your therapist so that your file can be closed and/or you can be*

referred to another resource. If you stop treatment without an explanation, your file will automatically be closed after 30 days.

Consent to treatment: I have read and understood the above information, and any questions that I had have been answered. I agree with the above consent form, and freely consent to receive psychological services.

Name of client: _____ Signature: _____ Date: _____

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CONSENT TO RECEIVE PSYCHOLOGICAL SERVICES: *Client Copy*

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Approach: Your therapist will complete an intake assessment to understand how your current difficulties may have developed and are maintained within the various contexts of your life. The results of this assessment will be shared with you, and a treatment plan will be developed including some potential goals for therapy, and the strategies that may be used to help you reach your goals. Throughout the therapy you are invited to share any concerns or questions that you may have about the therapy process. This helps the therapist to personalize the treatment strategies to better match your unique needs. *Services are by appointment only; in an emergency please call 911 or go to the emergency room.*

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Name of client: _____ Signature: _____ Date: _____