The Hope Center

206 South 28th Avenue
Hattiesburg, MS 39402

Client Information Form

Please provide the information below as it applies to the *client*.

Name _____
Last **First** **Middle**

Address _____
Street or P.O. Box **City** **State** **Zip**

Home Phone _____ **Important: May we leave a "return call" message at this number? ____Yes ____No**

Work Phone _____ **Important: May we leave a "return call" message at this number? ____Yes ____No**

Cell Phone _____ **Important: May we leave a "return call" message at this number? ____Yes ____No**

E-mail Address _____ **Important: May we communicate with you via e-mail? ___Yes ___ No**

Date of Birth _____ **Years of Education** _____

Emergency Notification

_____

Name **Address** **Phone** **Relationship**

_____

Name **Address** **Phone** **Relationship**

Referred by _____
Newspaper, Phone Book, Physician, Friend, etc. (Give person's name if applicable.)

Family Physician _____
Name **Address** **Phone**

What other professionals (doctors, lawyers, etc.) might we need to talk to about your case? (We would get written permission first)

_____

_____

Is there a possibility that your case will involve court proceedings? ___Yes ___No

I have read and I understand the statement of "Client Rights and Responsibilities" in this packet. All the information given in this form is true and complete to the best of my knowledge.

Signature_____ **Date** _____
Witness _____ **Date** _____

FEES AGREEMENT

THE HOPE CENTER
206 South 28th Avenue
Hattiesburg, MS 39402
601-264-0890

1. **I, _____, understand that fees for services are as follows:**

Dr. Smallwood:		**Thomas Pough, MS, LPC:**	
$175.00	**1 diagnostic hour**	**$155.00**	**1 diagnostic hour**
$165.00	**1 hour**	**$145.00**	**1 hour**
$149.00	**¾ hour**	**$131.00**	**¾ hour**
$ 99.00	**½ hour**	**$ 87.00**	**½ hour**
$ 50.00	**¼ hour**	**$ 44.00**	**¼ hour**

2. **I understand that a therapeutic hour is <u>50 minutes</u>. This allows your therapist time to complete documentation and schedule your next appointment. This is standard practice in the mental health profession.**
3. **These fees apply to therapy sessions, telephone consultations, records review, consultations with lawyers and other professionals, and letter/report preparation.**
4. **I also understand that payment for outpatient services is DUE AT THE TIME SERVICES ARE RENDERED. I further understand that insurance is a method of reimbursement to me for my payment to the clinic and is not considered a substitute for payment. Should I wish to file insurance, I understand that I will be givin the proper forms so that I may collect for covered services.**
5. **I hereby give my consent to release pertinent information (i.e., diagnosis codes, procedure codes, summary of treatment, etc.) to my insurance company or managed care company, should they request it.**
6. **I further understand that I will be charged full fee for any missed appointment should I fail to cancel my appointment at least one business day in advance (i.e., I must cancel Monday appointments by 5 p.m. the preceding Friday; and Tuesday through Friday appointments must be canceled 24 hours in advance). I also understand that I will be charged for any portion of time spent in therapy over my scheduled session length. In addition, any phone calls in excess of 15 minutes will be charged accordingly, at quarter-hour increments.**
7. **I am aware that some psychological testing may be necessary for treatment, and that fees for such testing are available upon request and will be discussed with me by my therapist.**
8. **I further understand that if my account should become delinquent, legal action for collection may be undertaken. I hereby give my consent to release necessary information; hat is, name, address, account number, phone numbers, amount due, action taken to date, place of employment, for taking such action.**

Signature of client or legal guardian _____
Signature of witness _____
Date _____

PARENTAL CONSENT FORM

I (We) hereby give my (our) consent for psychological treatment for my (our) minor child at The Hope Center. I (We) understand that, as an adjunct to my (our) child's treatment at The Hope Center, I (we) may be asked to participate in treatment.

I (We) understand that I (we) retain responsibility for my (our) child while he/she is in treatment at The Hope Center. I (We) understand that in the event of an emergency situation, as determined by the staff of The Hope Center, I (we) am expected to respond promptly to requests for assistance from the staff. I (We) understand and agree that should I (we) be unable, for any reason, to respond to such a request, The Hope Center should and will take whatever steps the staff deems necessary and appropriate to resolve the situation.

I (We) understand that, in situations where relevant, the non-custodial parent has legal access to clinical records of The Hope Center, without the custodial parent's consent. I (We) understand that records previously held by The Hope Center are subject to this release policy.

Name of Minor	**Date**
Signature of Parent or Guardian	**Date**
Signature of Parent or Guardian	**Date**
Witness	**Date**

ADOLESCENT PRE-COUNSELING QUESTIONNAIRE
(To be completed by parent or primary caregiver)

Person Completing Form_____
Relationship to adolescent_____

We are looking forward to working in partnership with you to address the problems your adolescent has been experiencing. Your insights and observations are crucial to the therapy process. You will be actively involved in helping to create the kind of home environment that supports positive changes in your adolescent's behaviors and emotions.

Because we like to have as much information as possible to assist us in assessment and treatment planning, we ask you to provide us with a "picture" of what has been happening with your adolescent and the "worlds" in which he/she lives. Though this questionnaire requires time, please keep in mind that this can save therapy time in obtaining the needed comprehensive history.

We appreciate your valuable assistance.

I. GENERAL INFORMATION

Adolescent's name _____Birthdate_____Age_____
Address_____
Telephone_____Sex ____ M ____F

II. PRESENTING PROBLEMS

A. What is currently concerning you about your adolescent or family?

B. When did the problems start?

C. How are these problems affecting the other family members?

D. What else was going on in the family or other aspects of the adolescent's life at that time (whether you know these are related to the current problem)?

E. How do you think you or other significant caregivers may have contributed to the problems?

F. Describe your relationship with your adolescent and what you would like to change about your relationship.

G. What other strategies have been tried to correct the problems? How did they work?

H. What other professionals/agencies have been involved in trying to correct the problem?

I. How do you think your adolescent will describe the problem?

J. How have you talked with your son or daughter about coming to Counseling? What was his/her reaction?

III. FAMILY

A. Father's Name_____Age_____
Address_____
Occupation (Job title, company, location)
_____

B. Mother's Name_____Age_____
Address_____
Occupation (Job title, company, location)
_____

C. Siblings

Brothers Names	**Age**
_____	_____
_____	_____
_____	_____
Sisters Names	**Age**
_____	_____
_____	_____
_____	_____

D. Are biological parents divorced? _____If so, when?_____
Custody & visitation arrangements?

How did the adolescent handle the divorce?

E. Have there been, or are there, court battles over some aspect of the the divorce or custody? _____ If yes, please describe.

Is there a possibility that the therapist might be called upon for testimony in this case? _____ If yes, explain.

F. Names of step-parents, if applicable_____
_____

Names of step-siblings, if applicable_____
_____

G. Other significant adults in your adolescent's life:
Name Relationship
_____
_____
_____

H. Please describe the adolescent's relationship/reactions to parents and other significant adults (significant as perceived by the adolescent, e.g. step-parents, grandparents, adult friend, special teachers, etc.)
Father
_____
Mother
_____
Other significant adults
_____
_____
_____
_____

I. Please describe the adolescent's relationship with siblings and step-siblings.
Name Relationship Description
_____
_____
_____
_____
_____

J. How is this child different from your other children (step-children)?

K. Are there any other significant factors that are stressors in the family, in general, that you could share?

IV. SCHOOL

A. In what grade is your adolescent? _____ School_____
B. How long has your adolescent attended this school? _____
C. What kinds of grades is your son/daughter making in school? _____
D. Is this a change from his/her typical performance? _____
E. Do you think he/she is performing at the level of which he/she is capable? Explain.

F. Has he/she repeated a grade? _____
Which one(s)? _____
G. What do your adolescent's teachers tell you about his/her academic performance or conduct?

H. If there are problems at school, what has been done to correct them? How did it work?

I.	**Teachers' names**	**Subjects**	**Amount/type of Parent-Teacher contact**

J. Are there other important school issues of which we need to be aware?

V. SOCIAL RELATIONSHIPS

A. How would you describe your adolescent's ability to make friends? Keep friends?

B. Describe your adolescent's friendships.

Name	**Age**	**Relationship Description**

C. Describe your son/daughter's dating patterns/history.

D. Is he/she dating anyone special right now? _____ Name_____

E. What particular concerns do you have about your son/daughter's peer relationships?

VI. EXTRACURRICULAR ACTIVITIES

A. Please list your adolescent's favorite non-school hobbies, interests, activities, and games (other than sports):

B. Please list your adolescent's favorite sports:

C. In what extracurricular school activities is he/she involved?

VII. MEDICAL (Use additional sheet if necessary)

A. What medical conditions does the adolescent currently experience?

B. What treatment is he/she currently receiving?

Medical problem	**Treatment**	**Provider**	**Medicines**

C. Who is the adolescent's "primary doctor"? (family doctor, pediatrician)

D. Past medical problems? When?

VIII. DEVELOPMENTAL

A. Was there anything unusual or significant about his/her early development?

B. Complications at birth?

C. Early childhood illnesses?

D. Motor development?

E. Language development?

IX. PROBLEM CHECKLIST

You've given us a tremendous amount of valuable information already to help us planning for your adolescent's treatment, and we appreciate it. Will you now take just a few more moments to complete this behavior checklist? Check the item if it has been a problem with your adolescent in the past six months. Thank you!

_____ Behavior that is immature for his/her age
_____ Allergies (describe)

_____ Talks back/argues
_____ Behavior like the opposite sex
_____ Excessive boasting
_____ Lack of concentration
_____ Clinging or overly dependent behavior
_____ Fearful
_____ Loneliness
_____ Acts confused, like in a "fog"
_____ Does not obey parents' rules/wishes
_____ Gets into trouble at school
_____ Eating problems
_____ Has difficulty getting along w/others
_____ Gets into fights
_____ Shows little/no guilt after misbehavior
_____ Overly jealous
_____ Fears (describe)
_____ Resists going to school
_____ Is a perfectionist
_____ Feels or complains that no one loves him/her
_____ Feels others are "out to get him/her"
_____ Feels worthless or inferior
_____ Is teased by others
_____ Chooses friends who get in trouble
_____ Hears sounds/voices that aren't there (describe)

_____ Crying
_____ Cruelty to animals
_____ Cruelty to others
_____ Day-dreaming
_____ Talks about death
_____ Deliberately harms self
_____ Demanding of attention
_____Destroys his/her things
_____ Destroys things belonging to his/her family or other children
_____ Picks nose, skin or other parts of body (describe)
_____ Physical problems w/out know medical causes
___Aches or pains
___Headaches
___Nausea, feels sick
___ Problems w/eyes
_____ Academic problems
_____ Prefers playing w/older children
_____ Prefers playing w/younger children
_____ Refuses to talk
_____ Repeats certain acts over & over again (describe)

_____ Impulsivity, acts w/out thinking
_____ Chooses to be alone a great deal
_____ Lying or cheating
_____ Bites fingernails
_____ Nervous or tense
_____ Nervous movements or twitching (describe)

_____ Nightmares
_____ Not popular w/other children
_____ Has a habit of feeling guilty
_____ Overeating
_____ Overweight
_____ Excessive fatigue

_____ Runs away from home
_____ Screams a lot
_____ Overly secretive (keeps things to self)
_____ Sees things that aren't there (describe)

_____ Self-conscious or easily embarrassed
_____ Sets fires
_____ Sexual problems (describe)

_____ Physically attacks people
_____ Shy or timid
_____ Stares in space for significant periods
_____ Speech problems (describe)
_____ Threatens people
_____ Steals outside the home
_____ Stores up things he/she doesn't need (describe)

_____ Strange behavior (describe)

_____ Strange ideas (describe)

_____ Stubborn, sullen or irritable
_____ Sudden changes in mood or feelings
_____ Sulking
_____ Swearing or obscene language
_____ Talks about suicide
_____ Talks or walks in sleep (describe)

_____ Talks too much
_____ Temper tantrums or hot temper
_____ Thinks about sex too much

_____ Showing off or clowning
_____ Sleep problems (too much or too little)
_____ Steals at home
_____ Overconcerned with neatness or cleanliness
_____ Skips school
_____ Slow moving, lacks energy

_____ Depressed or sad

_____ Loud
_____ Uses alcohol or drugs for nonmedical purposes (describe)

_____ Vandalism
_____ Bedwetting
_____ Whining
_____ Worrying

Please write in any problems your adolescent has that were not listed above:

_____
_____
_____
_____

Thank you so much for your help in providing this information. I look forward to collaborating with you to help your adolescent get back on track and become all that he or she can be.

CLIENT'S RIGHTS AND RESPONSIBILITIES

IMPORTANT-PLEASE READ!

The Hope Center
206 South 28th Avenue
Hattiesburg, MS 39402
Phone (601) 264-0890

To be an effective consumer of psychological services, it is important that you know about your rights and responsibilities and about our obligations to you. Please read this statement carefully before signing the "Client Information Form," and discuss any questions with your therapist.

OUR COMMITMENT TO YOU:

We are dedicated to providing quality counseling, testing, and consulting services. We work hard to assure that each client receives competent, considerate, prompt, and respectful services regardless of race, ethnic background, religion, sex, age, sexual or affectional preference, or disability. When necessary, and with your written permission, we consult with other specialists, and we may refer you to additional sources of help.

We welcome you, your questions, and your concerns. Our administrative policies are set up to allow us to work smoothly and efficiently. We welcome your feedback as to how they work for you.

RIGHTS

When you be come our client, you have the rights to:

1. ***Confidentiality*: It is our policy to respect your privacy and to protect the confidentiality of your relationship with us. It is also our policy to inform you of the limits we have in protecting this right to confidential care. Some limitations are imposed by state statute and others come from the ethical standards for therapists. They are:**
    - **A. Ethical standards encourage therapists to confer with other professionals when helpful and appropriate, provided you have signed a written release of information.**
    - **B. We are obligated by law to inform relevant parties when there is a clear and imminent danger to an individual or to society. We also must report to appropriate authorities when there is evidence of child abuse or abuse of vulnerable adult.**
    - **C. By law we must comply when ordered by court to supply records.**
    - **D. Parents (including non-custodial parents) have the legal right to information concerning a minor child. However, from a therapeutic standpoint, it is important for the child or adolescent to develop a trusting relationship with the therapist. Therefore, we request that parents grant the child's confidentiality subject to the above limitations. We will, of course, consult with the parents regarding their involvement in the treatment process.**
    - **E. Except in the circumstances outlined in A, B, and C above, we will not release to others any information regarding you and/or our services to you unless you request and authorize its release with your signature. We encourage you to discuss any questions you may have about confidentiality or release of information with your therapist.**

2. ***Cost of Services Information*: You have the right to be informed of the cost of professional services before receiving the services. This is described in the Fees Agreement.**
3. ***Informed Consent:* As our client, you have the right to know the nature of our services you are receiving. In the first session, you and your therapist will discuss goals and design a plan to meet your needs. We encourage you to be active in those discussions.**

YOUR RESPONSIBILITIES

1. **You are responsible for supplying accurate and complete information about yourself: your problems and their history, your past illnesses, previous counseling, medication, and family and work history when appropriate.**
2. **You are responsible for honoring your financial agreement with us. Fees for groups, workshops, and organizational consultation are negotiated on a situation-by-situation basis. Our clinic operates on a *cash check, or credit card basis.* You must make payment each time you receive services.**
   Psychological services are covered under many health insurance plans. We advise that you check your insurance policy or the benefits department at your place of employment to confirm that you do, indeed, have such coverage. Your service ticket, given to you upon each visit, will provide all of the information you will need so that you can process your claims. Insurance is considered a method of reimbursing the fees paid to the therapist, not as a substitute for payment.
3. **You are responsible for keeping appointments. *Missed appointments, except in emergencies, will be billed at the normal rate*. To avoid billing, you must cancel one business day prior to your appointment; that is, you must cancel Monday appointments before 5 p.m. the preceding Friday, and Tuesday through Friday appointments must be canceled at least 24 hours in advance. You may cancel by calling (601) 264-0890. We are also available at this number to answer your questions.**

If any of these rights and responsibilities seem unclear to you, please feel free to ask your therapist for clarification. We look forward to working with you!

_____	_____
Date	**Signature of Client**
_____	_____
Date	**Signature of Witness**