MARIA STANSBURY, LMSW

(Under the supervision of Mrs. Kimberley Evans)

Valley Christian Counseling

5151 Research Drive NW Huntsville, AL 35805, (256)722-8091

ADULT CLIENT INTAKE FORM

Please provide the following information for our records. Leave blank any question you would instead not answer or prefer to discuss with your therapist. The information you provide here remains confidential.

CONTACT INFORMATION

Name: ____

Date of Birth:______________

Address:____

City:__________________________ **State:**________ **Zip:** ______________

Email: ____

Cell Phone: ______________ **May we leave a message?** __________

Home Phone: ______________ **May we leave a message?** __________

In case of an emergency, please contact: ______________________________

Relationship: ____________________

Phone: ______________________

Occupation____

Do you consider yourself religious? ______________________________

Please describe the main issue, reason, or event that brought you here today:

____

____

____

____

What is your goal for seeking counseling?

____

____

____

MEDICAL HISTORY

List the name and specialty of your doctors:

Name:____________________________ **Specialty:** ___________________________________

Name: ___________________________ **Specialty:** ___________________________________

Name:____________________________ **Specialty:** ___________________________________

Name: ___________________________ **Specialty:** ___________________________________

Do you have a serious diagnosis? _________ **What is it?**_________________________________

Have you ever had surgery? ____________ **What kind?** _______________________________

Do you take prescription medicine? ______ **What for? / Name** _________________________

Do you have physical complaints now? (Explain)____

How often do you deal with that? ____

When did it start? ____

Have you ever been in a car accident, a fire, or a catastrophic event?

____

If so, tell me more please: ____

____

Do you take daily pain medicine?_____ **Name:**_______________ **How much daily?**______________

SOCIAL/RELATIONAL HISTORY

Relationship status (Check all that apply):

□ Married □ Separated/Divorced □ Live with partner □ Single □ Widowed

Employment status and title:

____

Do you have children? ________ **How many?**_________ **What are their ages?** __________________

Are you in a romantic relationship?

____

If so, are you satisfied with it?

____

Have you been the victim of an abusive relationship?

____

How many people in your household? _______

Name their Age and relationship with you:

____

____

____

____

Is there someone locally that you can fully trust when times get rough? Who?

____

Can you trust someone in another city when times get rough? Who?

____

Do you have a friendly/loving relationship with your parents?

____

Are you happy with your current social life? Explain:

____

____

What does your social/relational life look like in a perfect world for you?

____

____

LIFE STYLE

Do you exercise?______ How often:__________ For how long each time:_____________

Do you sleep well? ____ If not, how often do you not sleep well? _______

Do you consider having good eating habits? ____________________________________

Has your weight changed a lot in the last six months? __________________________

Do you smoke?___ How much?_____________________ For how many months/years?________

Do you have an addiction to illegal drugs, or have you ever been addicted to anything in the past (current/past use, how much/often, last time used):

____

____

____

Any dramatic changes in lifestyle in the last two months?

- **Change of jobs: ___________________________________**
- **Unable to find a job: ______________________________**
- **Retirement: _______________________________________**
- **Moved houses or cities: ___________________________**
- **Lost a child or someone dear to you: ___________**
- **Divorce or separated: _____________________________**
- **Other (explain): ____**

MENTAL HEALTH HISTORY

Have you or your mother or father ever experienced any of the following?

Symptom	Circle	If yes, please explain (include frequency)	By whom?
Extremely depressed mood	Yes/ No		
Dramatic mood swings	Yes/ No		
Extreme anxiety	Yes/ No		
Panic attacks	Yes/ No		
Phobias	Yes/ No		
Sleep disturbances	Yes/ No		
Hallucinations	Yes/ No		
Unexplained losses of time	Yes/ No		
Unexplained memory lapses	Yes/ No		
Eating disorder	Yes/ No		
Body image problems	Yes/ No		
Repetitive thoughts (e.g. obsessions)	Yes/ No		
Repetitive behaviors	Yes/ No		
Thoughts of hurting yourself	Yes/ No		
Thoughts of hurting others			

Have you ever received mental health services?____
When?____

Have you personally experienced or witnessed any of the following? If yes, were you the victim or the witness?

- **Physical abuse________ - When?_____________________ -By who?________________________**
- **Sexual abuse_________ - When?______________________ -By who?________________________**
- **Neglect______________ - When?______________________ -By who?_________________________**
- **Emotional abuse______ - When?______________________ -By who?_________________________**
- **Financial abuse_______ - When?______________________ -By who?_________________________**

Are you taking prescription mental health medicine? (name and doses)

____

____

If so, for what and for how long have you been in this medicine?
____

Do you use social media? ______________ How many hours per day? ______________________________

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VALLEY CHRISTIAN COUNSELING INFORMED CONSENT

The following information is to assist you in establishing your expectations for psychotherapy and functions as an agreement between you and your therapist. Please read the next carefully and complete all sections before the first session. Please feel free to call with any questions or concerns throughout treatment.

Sessions
Therapy appointments are approximately 50-55 minutes; however, longer sessions are available upon advanced request. Depending on the client's needs, the therapist and the client determine the number of sessions.

Cancellation Policy:
A scheduled appointment means that time is reserved only for you. If an appointment is missed or canceled without 48 hours' notice, the clinician reserves the right to charge you a missed/canceled appointment fee equal to your agreed-upon session rate.

Confirmation Calls
To better serve our clients, our staff strives to provide confirmation calls to remind you of your appointment approximately 48 hours in advance. However, please try to set self-reminders if we cannot place a call.

Emergency Options and Additional Resources
If you cannot reach our office during regular business hours and are experiencing a crisis or medical emergency, please call 911 or head to your nearest emergency room.

Records
Your professional records may include information regarding your reason for seeking therapy, a description of the impact your problems may have on your life, your treatment goals and your progress toward said goals, your medical and social history, your billing records, and any reports from other clinicians. You have the right to review your papers at any time; however, it is recommended that the documents be reviewed in the presence of your therapist before viewing them individually.
A fee may be applied to the request for your records. Your records are stored in a locked filing cabinet behind two locked doors and will be stored for seven years (per requirements of the Alabama Board of Social Work) before being properly destroyed.

Offsite Consultation
Consultations are sometimes requested by other professionals involved in your care. If you or another professional requests a consultation, your clinician reserves the right to bill at the hourly rate for consultation services. It is important to note that billable time may also include travel and prep time.

Minors and Parents
Children under 14 cannot consent to therapy independently; however, in the State of Alabama, a minor child over 14 may seek therapeutic services without the consent or knowledge of their parents/guardians. Children over 14 have the right to privacy, and the parents are not privy to confidential information unless a release has been obtained. The Clinician will strongly urge the teenager to sign the said release, as treatment is often inhibited when guardians are not involved in the process. Clients under 14 cannot consent for themselves and, therefore, need a guardian's permission to seek therapeutic services. If a child is in danger or is a danger to someone else, the therapist will notify the parents of this concern and the appropriate authorities if necessary. Before giving sensitive information to parents, the clinician will discuss the matter with the child, if possible, and do their best to mitigate any objections and explain the benefits of guardian support.

Contacting your Clinician
If you need to contact your clinician, please call Valley Christian Counseling Center and leave a message with the receptionist or on the appropriate extension. Your therapist will periodically check messages and return your call immediately.

Release of Information
Valley Christian Counseling is not a HIPAA-covered entity; however, your therapist is subject to all ethical and legal standards that protect your confidentiality. We will only disclose your personal information given legal obligations due to a duty to report or given your written authorization.

Limits on Confidentiality

1. Occasional consultations with other mental health professionals about a case are helpful or necessary to provide quality care. We make every effort to ensure your confidentiality during this process.
2. If you or a minor in your care are a harm to yourself or others, I have to report to prioritize your safety.
3. The following are some examples of situations in which I may be required or legally permitted to disclose information without your consent or authorization:
    a. Requests made from court order
    b. If I become the defendant in a case filed against me, I have the right to release privileged information that may be relevant to my defense.
4. I am considered a mandatory reporter, meaning I must report to the appropriate authorities if I suspect any vulnerable population is being abused and neglected.

____ ____________
Print Client Name Date

____ ____________
Client Signature Date

____ ____________
Clinician's Signature Date

*The above signature certifies that I understand that I am consenting to counseling services and the limits of confidentiality within those services.

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VALLEY CHRISTIAN COUNSELING
CLIENT RIGHTS

As a client, you can expect:
- Humane care and treatment, with respect and consideration
- Privacy and confidentiality when seeking or receiving services except in the case of life-threatening situations or conditions
- Confidentiality of your health records
- Accurate information concerning diagnostic impressions, treatment, and risks
- Active participation in decisions regarding your treatment
- Accessible information regarding the scope and availability of services
- Information about any legal reporting requirements regarding any aspect of screening or treatment
- A copy of your records upon request and written authorization
- Ability to file a complaint with the director of VCC regarding any concerns related to the privacy, confidentiality, or security of your medical record
- Competent treatment in a respectful environment that acknowledges your dignity and worth
- To gain knowledge regarding strategies and therapy techniques used to aid in your treatment
- Participation in establishing and reestablishing goals throughout therapy
- Option to participate in or refrain from services (except when mandated)
- Ability to request referrals for alternative services

Print Client Name	Date
Client Signature	Date
Clinician's Signature	Date

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VALLEY CHRISTIAN COUNSELING
Financial Agreement

Thank you for choosing Valley Christian Counseling to be your mental health provider. We are committed to providing the best care possible. You must understand that payment for services is part of your treatment; therefore, the following information explains our financial policies. We ask that you sign this form indicating that you have read and agree with the information presented.

Reimbursement/Insurance Coverage. Your clinician does not accept insurance. However, you may submit to your insurance for reimbursement as your clinician would be considered an Out-of-Network Provider. Your clinician needs to determine how your insurance will reimburse counseling services; that is between you and your insurance company. Your clinician's fees are subject to change, and you will have advance notice of those changes as they arise.

Methods of Payment. We ask that you pay in full upon the time of services unless previously agreed upon by you and your therapist. We accept most forms of payment, including cash, check, or credit card.

Unpaid Balance. If you accrue an unpaid balance, we ask that you make arrangements to pay the balance within 30 days. If we cannot reach you to collect a payment, Valley Christian Counseling may pursue reimbursement by submitting a claim to a small claims court or hiring a collections agency. Payment plans may be offered when requested with approval from the director of VCC. Confidential information may be shared in claims court or a collections agency as needed.

Late Cancellation/No Show Fees. If cancellations have not been made within 48 hours of the appointment or the client does not show up for the session, the client is subject to a no-show fee.

Exceptions are made in cases of emergencies. Late cancellation/no-show fee is $55.00; however, the clinician reserves the right to charge the entire session fee of $110.00 if the client is a repeat offender. Grace is often offered, especially in unforeseen circumstances. Your practitioner asks for communication, and in response, fees may be waived at your practitioner's discretion.

Court-Related Fees. Clients who require court-related services can expect a rate of $200 per hour. Court-related work can include but is not limited to, consultations, phone calls, travel time, depositions, and time spent at court. A minimum retainer fee of $1000 to appear/testify in court. Payment must be received 48 hours before the court appearance. Subpoenas must be received within 48 hours ' notice, or the client may be subject to an additional charge of $200. If the court date is rescheduled within less than 72 business hours, the clinician reserves the right to charge an additional fee of $300 in addition to any previously accrued fees. It is important to note that any given testimony may not result in your favor. You will still be responsible for court-related fees if you lose your case.

Statement of Understanding. I certify that I understand the above statement and agree to its terms. By signing below, I have read and agree with the financial fees set by my practitioner. I understand that Valley Christian Counseling and/or my practitioner reserve the right to adjust or lower that fee on an as-needed basis.

____________________________________ __________

Print Client Name Date

____________________________________ __________

Client Signature Date

____________________________________ __________

Clinician’s Signature Date