Outside of the Box Therapy

115 E Montgomery Street
Gaffney, SC 29340
864-597-9493

CLIENT INFORMATION

Date of First Session: _____

NAME	DATE OF BIRTH	FAMILY ROLE	SOCIAL SECURITY #

***Please star the name of the client being provided services*

Street Address (Physical Address):

_____

City: _____ State: _____ Zip:_____

Mailing Address (If different than street address):

_____

City: _____ State: _____ Zip:_____

E-mail address: _____

Please identify, if a child, the parents and/or guardian's name: _____

Telephone Numbers for client and/or guardian:

	CLIENT	GUARDIAN 1	GUARDIAN 2
HOME			
WORK			
CELL			
OTHER			

May we identify ourselves and leave a message? ☐ Yes ☐ No

Emergency Contact:

Name: _____ Relationship: _____

Phone Number: _____

I give my permission for this person to be contacted by Outside of the Box Therapy in case of an Emergency: **Initials:**_____

How did you find us? (Please check all that apply)

☐ Online Search ☐ Yellow Pages ☐ Word of Mouth

☐ Agency referral ☐ Direct Referral by: _____

Days and Times you can best schedule appointments: _____

Have you seen a therapist before? ☐ Yes ☐ No

If yes, who? _____

Are you here today for a legal problem or situation? ☐ Yes ☐ No

If yes, please explain_____

Are you here today because you need someone to testify for you in court? ☐ Yes ☐ No

If yes, are you aware there are extra fees involved in court testimony? ☐ Yes ☐ No

Are you in here today to begin the process to apply for disability? ☐ Yes ☐ No

Does a report of today's meeting need to be sent to someone? ☐ Yes ☐ No

For demographic purposes only:

Relationship status:

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

☐ Cohabiting ☐ Other: _____

Ethnicity:

☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other: _____

Employment Status:

☐ Student ☐ Part-Time ☐ Full-Time ☐ Unemployed ☐ Disabled

Medical Information

Primary Care Physician: _____ Telephone number: _____

Psychiatrist: _____ Telephone number: _____

Health History (please check all that apply):

☐ Asthma ☐ Cardiac Event ☐ Diabetes ☐ Enuresis/Encopresis

☐ Fibromyalgia ☐ Migraines ☐ Recent Illness ☐ Stroke

☐ Surgery ☐ Thyroid Disorder ☐ Traumatic Brain Injury

☐ Medication allergies (if checked, please describe): _____

☐ Other (if checked, please describe): _____

☐ None of the Above

MEDICATION	DOSAGE	FREQUENCY	PRESCRIBED BY	EFFECTIVE

Medical Health Insurance Information:

Primary Insurance Company: _____

Address: _____

Phone Number: _____ Employee ID (SS#): _____

Group #: _____ Employer: _____

Are you aware of the professional credentials required for your insurance company to recognize a provider of mental health care? ☐ Yes ☐ No

If so, what are they? _____

Confirmation

My signature indicates that:

- ☐ All of the information I have given is accurate and to the best of my knowledge.
- ☐ I have been given a copy of the "Important Information for Our Clients" packet which includes:
  - Disclosure statement
  - General Information
  - Emergency contact Information
  - Notice of Privacy Practices
  - Social Media Policy
- ☐ I have been given the opportunity to ask any questions I might have regarding this information.

Client: _____ Date: _____

Client: _____ Date: _____

Therapist: _____ Date: _____

* * * * *

New Client Information Policy Statement and Informed Consent for Treatment

Please read the following information and sign below. If you have any questions, I would be happy to review the information with you.

GENERAL INFORMATION:

Our areas of training are the systemic treatment of individuals, couples and families. This approach takes into consideration all immediate family members in a family therapy session. Together, we will decide which family members (if any) need to be included in therapy. Various goals will be established together with you at the outset of therapy.

Therapy naturally involves activities such as identifying emotions and revealing secrets. There may be risks associated with your disclosures to other family members, or other family member's disclosures during the course of therapy, as well as exploration of issues. Decisions to disclose will be made by you except where mandated by law. It is expected that some uneas-

iness or painful emotions may occur as you are involved in therapy. Discussing painful issues will naturally create discomfort. Your participation in therapy is essential toward helping you address your concerns. The Board of Examiners for the Licensure of Professional Counselors, Marriage and Family Therapists and Psychoeducational Specialists requires that all clients be informed that all forms of dual relationships, such as business ventures and sexual intimacy, are prohibited.

Please be aware that there is a higher incidence of divorce if only one partner in a relationship is involved in therapy. It is also important that you understand that there is no guarantee all of your concerns/ issues/problems, etc. will be successfully resolved. I cannot guarantee outcomes. The outcomes may vary from your expectations. You may discontinue participation in therapy at any time. However, before you do, I encourage you to share your concerns with me if you are dissatisfied with the course of therapy.

TREATMENT:

I understand the following services may be available:

- Behavioral assistance for common adolescent concerns.
- Diagnostic Assessment (DA) Services which identifies the client's needs, concerns, strengths and deficits and allows the beneficiary and his or her family to make informed decisions about the treatment.
- Service Plan/Plan of Care Development which is a face-to-face interaction between the client and his approved family members and a qualified clinical professional, or a team of professionals, to develop a plan of care based on the assessed needs.
- Therapy Services (individual, family, and group) which are planned face-to-face interventions intended to help the beneficiary achieve and maintain stability.
- Medication Management which is to educate the client about his or her medication, to determine any physiological and/or psychological effects of medication(s) on the client and to monitor the compliance with his or her medication regime.
- Crisis Management is face-to-face or telephonic short-term service is to assist a client who is experiencing a marked deterioration of functioning related to a specific precipitant, in restoring his or her level of functioning.

CONFIDENTIALITY:

Confidentiality is the foundation for effective counseling and therapy. Developing trust and confidence in those who listen and help is paramount to successful therapeutic experience. Shared personal information is strictly confidential and will not be revealed unless you, or a parent, in the case of a minor (less than 18 years old), give specific written authorization to release information. The office will be discreet if they must contact you at your home or office. If you do not wish to be contacted at home or the office, please let me or my office staff know so it can be recorded in your records. In addition, please let me or the office know how you wish to be contacted.

EXCEPTIONS TO CONFIDENTIALITY:

Although shared personal information is confidential there are exceptions to these confidences such as: (1) Suicidal threats or attempts. (2) To prevent a clear and immediate danger to another person. (3) Suspected child abuse or neglect. (4) Suspected abuse or neglect of a vulnerable adult. (5) If it is determined that you are in need of hospitalization. (6) Or otherwise mandated or allowed by law or ethical codes for which I am responsible. I am subject to subpoena.

NOTICE OF PRIVACY PRACTICES:

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are required by law to keep your information private. Your therapist will give you a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) which will explain your rights as a therapy client. If you have any questions about this notice or our privacy policies, please contact Dr. Rogers-Larke at 864-597-2054.

APPOINTMENTS:

Appointments are usually scheduled with the therapist. Appointments are approximately 50 minutes each. However, we can decide to meet for a longer or shorter period of time.

CANCELLATION OF APPOINTMENTS:

Therapy centers differ in many respects from medical centers. Unlike physicians, dentists and other professionals who operate on more flexible and inexact schedules, therapists commit a specific time period for each person. Thus, it is important that you appreciate the fact that a block of time has been set aside just for you. I understand that conflicts can occur after an appointment has been scheduled. However, my time is as valuable as yours. Please notify me 24 hours in advance if you must cancel or reschedule an appointment. **IF YOU FAIL TO SHOW FOR AN APPOINTMENT WITHOUT CALLING, EXCEPT IN THE CASE OF AN EMERGENCY, YOU WILL BE CHARGED A FEE ($60) FOR YOUR APPOINTMENT TIME.**

FEES:

We will accept insurance for payment of counseling services. It is your responsibility to obtain authorization from your insurance company for services. Your co-pay is due at the time of the appointment. Please be sure that you have met your deductable. For people who do not have insurance, appointments are based on a sliding scale fee based on income and therapist availability. If there is a hardship, please consider how much you can afford and discuss this with your therapist. You may pay by cash, check or credit card. **If you are unable to pay for a session, please notify the therapist before the session. At times, this becomes a therapeutic issue and appointments need to be rescheduled until you are able to take responsibility for your fee.** All billing, insurance and fees are handled through Medical Billing of the South who will send you a bill for services. If you do not receive a bill, or dispute a bill, please notify the therapist so they check into the matter for you. Thank you.

CONSENTS:

I give consent for treatment and understand that, by signing consent, I will be a part of my individual plan of care process.

_____ _____

Signature of parent/guardian/emancipated minor Date

_____ _____

Signature of Therapist Date

I have been educated about confidentiality as it pertains to electronic communications. Although my therapist will take significant steps to ensure confidentiality and privacy of online communication(s), these actions, in whole or in part, cannot guarantee the security of internet transmissions. I permanently agree to release and indemnify Outside of the Box Therapy and its therapists from all suits, claims and other actions origination from psychotherapy.

I ☐ do ☐ do not authorize my counselor to leave voice mail messages regarding appointment times, respond to my texts or participate with me in virtual therapy sessions.

_____ _____

Signature of parent/guardian/emancipated minor Date

_____ _____

Signature of Therapist Date