



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: \_\_\_\_\_

**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

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 \_\_\_\_\_

Please be aware that any record copies, preparation, travel time and testimony fees are not billable to insurance and are payable upfront prior to going to court.

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

# 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

Medical Health Insurance Information:

Primary Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Employee ID (SS#): \_\_\_\_\_

Group #: \_\_\_\_\_ Employer: \_\_\_\_\_

Secondary 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? \_\_\_\_\_

\*\*\*Please note if you have Medicaid as a secondary insurance you **must** provide us with the primary insurance information. Failure to do this will result in a denial from Medicaid and fees out of pocket.\*\*\*

# 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 uneasiness 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 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 Ashley Hoover or Dr. Rogers-Larke at 864-597-9493.

### **CUSTODIAL/LEGAL PAPERWORK:**

In order to stay in compliance with state law, we require a copy of custodial agreements in the event that both biological parents do not reside together in the home, or the signature of both parents on the intake form within two visits or we will be unable to provide services for minor children. We realize that there are situations where an external agency or outside party may have custodial rights. In those situations, we will need approval of that agency or party to provide services.

### **APPOINTMENTS:**

Appointments are usually scheduled with the therapist, or Ashley Hoover (864-597-9493). Appointments are approximately 50 minutes each, unless otherwise arranged with your therapist. In an effort to provide high quality service, we will try to provide the option of set appointment times. These recurring appointment times would remain consistent throughout service. However, due to the impact to the therapist's schedule, failure to consistently attend those appointments will result in being removed from a rotating schedule and seen as the therapist's schedule allows.

\*\*Recurring appointment times, once set, will have another form for signature.

Due to insurance guidelines, as well as ensuring that our therapists can provide services to all, late arrival to appointments (15 minutes or more) may result in your therapist being unable to see you during that time period. We will attempt to schedule you in as quickly as possible. If you fear that you may be late, please attempt to notify the office.

### **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. We understand that conflicts can occur after an appointment has been scheduled and, should that happen, please notify the office 24 hours in advance if you must cancel or reschedule. Although you can also notify this via the text reminder call, we ask that you do not call or text that number back as it will not reach our office. Although we give grace the first time you fail to show up or notify the office, after that a charge of \$60 will be applied to your account and must be paid by the next session unless a payment arrangement has been established with your therapist.

**\*\*Three no shows, no contacts may result in your therapist releasing you from service with them.**

### 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 deductible. If you have not met your deductible you will be responsible for the fee for the session until the deductible is met.*** 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 our Office Manager who will send you a bill for services. If you do not receive a bill, or dispute a bill, please contact our Office Manager, as she will help you with any billing issues. 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.

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Signature of parent/guardian/emancipated minor \_\_\_\_\_ Date \_\_\_\_\_

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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.

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Signature of parent/guardian/emancipated minor Date

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Signature of Therapist Date