Healing Heart Ministry
Heather R. Hart, MS, LPC
Adult Client Information Form

Client Name: ____Date: ________________
Address: ______________________________________City: ________________ State:____
Zip: _________ Email: ____
Birth date: _______________Age: ___________
Home Phone#: ___________________ Cell# _______________________________________
Occupation: ____________________________________Employer: ____________________
Marital Status: _______________________ Spouse's Name: _________________________
Spouses's Birth date: ________
Name and Age(s) of Child(ren):

____
____
____

Please read the following questions and answer to the best of your ability by placing a checkmark in the appropriate boxes or fill in the blank as directed. Your cooperation is appreciated.

Referred by: ____
OR
___ Internet ___ Yellow Pages/Phone Book ___ Church/Pastor

Please state in your own words why you have come to this office today:

____
____
____
____
____
____

Client Information form

Please check ALL of the following symptoms or thoughts that apply to you AT THIS TIME or during the past six months:

___ Depressed mood
___ Diminished interests or pleasure
___ Sleep disturbance
___ Fatigue
___ Change in appetite
___ Hopelessness
___ Pleasure in few activities
___ Weight change
___ Agitation
___ Excessive worry
___ I feel like I am losing control.
___ Irritability
___ Poor Concentration
___ Tension
___ Feelings of panic
___ Socially withdrawn
___ Use of alcohol
___ Use of other drugs
___ Use of tobacco
___ Anxiety in social settings
___ Makes careless mistakes
___ Does not complete tasks
___ Difficulty organizing
___ Forgetful
___ Confusion
___ Disorientation
___ Compulsive checking / counting
___ Indecisiveness
___ People talk about me.
___ Some people want to hurt me.
___ I feel emotionally distant from others.
___ I hear voices or sounds others do not hear.
___ I see things others do not see.
___ I smell things others do not smell.
___ Racing thoughts
___ I do risky or dangerous things.
___ Little interest in sexual activity

___ Sexual problems
___ Gender concerns
___ I don't like my body.
___ Binge eating
___ Self-induced vomiting
___ Laxative abuse
___ Excessive fasting
___ Intense fear of weight gain
___ Impulsive
___ I think about hurting myself.
___ I have tried to hurt myself.
___ Sometimes I wish I were dead.
___ I think about hurting someone else.
___ Exposed to a significant traumatic event
___ Recurrent distressing dreams

VII. Family Medical History:

___ Sudden death
___ Heart disease (especially dysrhythmias)
___ Diabetes mellitus
___ Obesity
___ Narrow Angle Glaucoma
___ Seizures
___ Other
____

Family Psychiatric History:

Has any member of your family been treated for depression, bipolar disorder, schizophrenia, anxiety, suicidal thoughts, alcohol or other drug problems, learning disabilities or ADD/ADHD, etc.? Yes No
If yes, please explain: ____

Social / Family History:

Biological parent's marital status (circle):
Married to each other
Divorced
Separated
If divorced from one another, has either remarried? Mother Yes No
Father Yes No

List all relatives who presently live in the same household as you (if more than 5, please list on back of this sheet):
Name – Relationship - Type of Employment / Student - Grade Level

1. ____
2. ____
3. ____
4. ____
5. ____

Please check any of the following stressors that presently affect you:

___ Family financial problems
___ Family relationships
___ Legal problems
___ Child rearing problems
___ Drug or alcohol problems
___ Abuse behavior
___ Health problems
___ Employment problems
___ School problems
___ Peer relationships
___ Frequent change of household
___ Frequent moves
___ "Other" problem ____

Psychiatric History:

I have received treatment for: Substance abuse ▫ Mental health issues ▫ Both ▫
The treatment occurred at:
▫ Private psychiatrist ▫ Private counselor/therapist ▫ Mental Health Center
▫ Hospital ▫ Other facility
Are you presently being treated? Yes ▫ No ▫ If yes, by whom? ____________________
____

Medical History:
Your current weight ___________ Height in inches ___________
Name of your primary care doctor ____
Phone: _______________________________ Date last seen: _______________________

Do you have a history of any medical problem? Yes □ No □ If so, what? ____________
____

Are you presently being treated for any medical problem? Yes □ No □ If so, what?
____
____
____

Past surgeries:
____
____
____
____

Date of last Menses: _____________________
What form of birth control do you use? ________________

Have you ever been treated for a nutritional problem? □ Yes □ No
Do you make yourself sick because you feel uncomfortably full? □ Yes □ No
Do you worry you have lost control over how much you eat? □ Yes □ No
Have you recently lost more than 14 pounds in a 3 month period? □ Yes □ No
Do you believe yourself to be fat when others say you are too thin? □ Yes □ No
Would you say that food dominates your life? □ Yes □ No

Are you experiencing any physical pain? Yes ___ No ___
Please list any medications you are presently taking. (Over the counter, prescription and/or recreational drug use (whether the drug is legal or illegal)

____
____
____
____
____
____

How often do you use alcohol? Circle the most appropriate response:

Never Occasionally Weekly Daily

Please list any current legal issues: ____
____
____
____

Client Contract and Disclosure Statement

Your therapist is a Christian Counselor with experience in individual, marriage, family, and group counseling. She is a licensed counselor in the State of Alabama and has earned a Masters Degree.

Counseling requires effort on the part of the client. Homework will be decided on collaboratively between the client and the counselor and will be determined by the nature of the presenting problem(s). Clients are expected to show up for scheduled sessions, pay for scheduled sessions in a timely manner, do homework, and keep the identity of other clients confidential.

Your therapist's responsibility is to keep confidences as prescribed by law, not share any information that is learned through counseling unless someone is going to harm him/her self, someone is going to harm someone else, and if a child is being abused, and/or required by law. All records are confidential and clients must sign a release before case information can be given to anyone. In marriage and family counseling, the release must be signed by **ALL** family members involved. Your therapist does not provide expert testimony in court proceedings. If required by law to testify, she will testify only to the process and content of therapy as prescribed by law.

As a service to the community, Healing Heart Ministry provides professional counseling at a reduced fee compared with other agencies and private practitioners.

The first session evaluation fee is $100.00. Additional session fees will follow the schedule below:

SCHEDULE OF FEES:

60,000 - and Below	**$70**
61,000 - 70,000	**$80**
71,000 - 90,000	**$90**
91,000 and over	**$100**

The fees are proportionate to your total family income and are payable prior to your session with the therapist.

NO SHOW AND CANCELLATION POLICY

This appointment time is reserved for you. If you must cancel your appointment, it will be necessary for you to give 24 hours notice.

1. Clients who forget an appointment or for some other reason do not come for an appointment and fail to give prior notice will be responsible for their full fee with payment due on the date of missed appointment.

2. Clients who call and give less than 24 hours notice of cancellation will be responsible for 1/2 fee unless the counseling center is able to fill that hour.

3. Unless otherwise notified, the therapist are obligated to wait only 15 minutes for a late client.

4. Your signature confirms your understanding of all these policies explained on this intake form.

Signatures:

____ **Date:** ____________________

____ **Date:** __________________

<u>**Limits of Confidentiality**</u>

Information discussed in counseling sessions is held confidential and will not be shared without your permission except under the following circumstances:

1. The client threatens suicide or other physical harm to self.

2. The client threatens physical harm to another individual.

3. The client is a minor under 18 years of age and reports behavior indicative of child abuse, including but not limited to physical and sexual abuse.

4. The client reports sexual exploitation by another medical or mental health professional.

State law requires that mental health professionals must report these situations to the appropriate persons and or agencies.

Records are also required to be released when a subpoena or other court order is received ordering the release of records.

Further, when consultation and/or supervision of therapy is required, counseling sessions will be discussed confidentially with a supervisor or professional colleague as deemed necessary.

Communication between the counselor and the client will otherwise be deemed confidential as stated by the laws of the state of Alabama.

<u>Having read and understood the above, I agree to these limits of confidentiality.</u>

____

Client/Parent/Legal Guardian Date

____

Client/Parent/Legal Guardian Date

____

Counselor Date

NOTICE OF PRIVACY PRACTICES

This notice describes how your personal health information (PHI) may be used and disclosed and how you can get access to this information. **Please review it carefully.**

YOUR RIGHTS

- Request and receive a copy of your paper or electronic treatment record (appropriate fees may apply).
- Request confidential communication: *You must sign a Release of Information Form in order for us to communicate with friends, family, coworkers, attorneys, etc.*
- Ask us to limit the information we share: *You may specify your requests on a Release of Information Form.*
- Pay full price for your therapy and request that your counselor keep session notes and diagnoses private from your health insurance provider.
- Get a list of those with whom we've shared your information.
- Get a copy of this privacy notice,
- File a complaint if you believe your privacy rights have been violated.
    - If you feel we have violated your rights, your complaint should be addressed to Heather Hart, MS, LPC at healingheartministry@hotmail.com.
    - You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights
    - We will not retaliate against you for filing a complaint.

OUR USES AND DISCLOSURES

We may use and share your information as we:

- **Treat you**: *We may obtain records from other medical or mental health professionals that you have previously seen.*
- **Run our organization**: *directors, office managers, and business associates may access your information in order to collect payment, schedule appointments, or communicate with you or those you give us permission to contact.*
- **Bill for your services**: *Business Associates of Healing Heart Ministry or your counselor may contact your health insurance provider or a designated payer to obtain payment for services*
- **Comply with the law**: **We are required to report suspected abuse, neglect, or intent to harm self or others.**
- **Address law enforcement and other government requests**
- **Respond to illegal behavior, lawsuits, and legal actions**: *We are required to respond to court orders by providing session notes and by possibly testifying in court. We will contact local authorities should illegal activity occur on our premises.*

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information. We will never disclose your PHI for marketing or fundraising activities: *All counselors and business associates of Healing Heart Ministry utilize HIPAA- compliant electronic communication services. All paper and digital PHI records are stored, secured, and disposed of as outlined in HIPAA guidelines.*
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

NOTICE OF PRIVACY PRACTICES:

ACKNOWLEDGEMENT OF RECEIPT

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge the receipt of the Notice of Privacy Practices of Healing Heart Ministry and your counselor. This Notice of Privacy Practices provides information about how HHM and all HHM business associates may use and disclose your protected health information. We encourage you to read it in full.

This Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting Healing Heart Ministry at healingheartministry@hotmail.com.

If you have any questions about our Notice of Privacy Practices, please contact:

Heather Hart, MS, LPC at healingheartministry@hotmail.com.

I acknowledge the receipt of the Notice of Privacy Practices of Healing Heart Ministry.

Client's Name: ____

Signature:____ Date: __________________

(client/parent/conservator/guardian)