Kimberly A. Kellum, MS,MFT, MA, CC, LPC 4022

Big Hatchie Counseling Center
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Thank you for choosing Kimberly A. Kellum, LPC. Today's appointment will take approximately 50 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need.

The Counseling Process

Counseling is a process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. If involved a relationship between you and a trained counselor who has the desire and willingness to help you along your journey of reaching your individual goals.

Counseling involves sharing sensitive, personal and private information that may at times be distressing. During the course of counseling, there may be increased anxiety and confusion. The goal of counseling is for each client to meet their goals, however, the level of satisfaction is not always predictable and no guarantees can be made.

Confidentiality

All client information is confidential, except in the following circumstances.

- Mandated reporting of physical or sexual abuse of children.
- Any intent to inflict harm on yourself and/or others.
- Counseling records may be subpoenaed in court cases.
- Sessions involving minor children.
- Cases where the client signs a release of information.
- Clerical works who could handle client's files and appointments.
- Diagnosis and dates of service shared with the client's insurance company (if billing insurance) to collect payments.
- Consultation with other counseling professionals.
- If client needs financial assistance from the Big Hatchie Association, a release must be signed.

Any information shared by Kimberly A. Kellum, MS, LPC with physicians, psychiatrists or other persons or agencies requires a separate permission form signed by the client.

Emergency Situations

In case of an emergency situation apart from a normal counseling appointment, the client should call 911 or go immediately to the nearest hospital emergency room.

_____ _____

Signature of client, parent, guardian date

Patient Registration Form

Therapist: _____

Patient Demographic Information

Patient Name:	**Social Security #:**
Street Address:	**Date of Birth:**
City, State, Zip Code:	**Home Phone:**
Gender:	**Work Phone:**
Email Address:	**Mobile Phone:**
Primary Physician:	**Psychiatrist (if any):**
Emergency Contact Person:	**Emergency Contact Phone:**
How did you hear about us?	**Marital Status:**

Responsible Party is the person who will be paying the per-session fee for services (leave blank if same as patient)

Responsible Party:	**Home Phone:**
Street Address:	**Work Phone:**
City, State, Zip Code:	**Mobile Phone:**
Relationship to Patient:	**Responsible Party SSN:**

Kimberly A. Kellum, LPC

CLIENT INTAKE FORM

Please provide the following information for our records. Leave blank any question you would rather not answer, or would prefer to discuss with your therapist. Information you provide here is held to the same standards of confidentiality as our therapy.

TREATMENT HISTORY

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ( ) yes ( ) no

Have you had previous psychotherapy?
( ) no
( ) yes, with (previous therapist's name)_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)? ( ) yes ( ) no

If yes, please list: _____

Prescribed by: _____

HEALTH AND SOCIAL INFORMATION

Do you currently have a primary physician? ( ) yes ( ) no

If yes, who is it? _____

Are you currently seeing more than one medical health specialist? ( ) yes ( ) no

If yes, please list: _____

When was your last physical? _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.: _____

_____

Are you currently on medication to manage a physical health concern? If yes, please list: _____

_____

Are you having any problems with your sleep habits? ( ) yes ( ) no

If yes, check where applicable:
( ) Sleeping too little ( ) Sleeping too much ( ) Poor quality sleep
( ) Disturbing dreams ( ) other _____

How many times per week do you exercise? _____

Approximately how long each time? _____

Are you having any difficulty with appetite or eating habits? ( ) no ( ) yes

If yes, check where applicable: ( ) Eating less ( ) Eating more ( ) Bingeing
( ) Restricting

Have you experienced significant weight change in the last 2 months? ( ) no ( ) yes

Do you regularly use alcohol? ( ) no ( ) yes

In a typical month, how often do you have 4 or more drinks in a 24 hour period?

_____

How often do you engage recreational drug use? ( ) daily ( ) weekly ( ) monthly
( ) rarely ( ) never

Do you smoke cigarettes or use other tobacco products? ( ) yes ( ) no

Have you had suicidal thoughts recently?
( ) frequently ( ) sometimes ( ) rarely ( ) never

Have you had them in the past?
( ) frequently ( ) sometimes ( ) rarely ( ) never

Are you currently in a romantic relationship? ( ) no ( ) yes

If yes, how long have you been in this relationship? _____

On a scale of 1-10 (10 being the highest quality), how would you rate your current relationship? _____

In the last year, have you experienced any significant life changes or stressors? If yes, please explain: _____

_____

Have you ever experienced any of the following?

Extreme depressed mood	Yes / No
Dramatic mood swings	Yes / No
Rapid speech	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
Alcohol/substance abuse	Yes / No
Frequent body complaints	Yes / No
Eating disorder	Yes / No
Body image problems	Yes / No
Repetitive thoughts (e.g. obsessions)	Yes / No
Repetitive behaviors (e.g. frequent checking, hand washing	Yes / No
Homicidal thoughts	Yes / No
Suicidal attempts	Yes / No If yes, when?

OCCUPATIONAL INFORMATION

Are you currently employed? ( ) no ( ) yes

If yes, who is your currently employer/position? _____

If yes, are you happy with your current position? _____

Please list any work-related stressors, if any _____

_____

_____

RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious? ( ) no ( ) yes

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? ( ) no ( ) yes

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

Difficulty	**Yes / No**	**Family member**
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	Yes / No	
Panic attacks	Yes / No	
Schizophrenia	Yes / No	
Alcohol/substance abuse	Yes / No	
Eating disorders	Yes / No	
Learning disabilities	Yes / No	
Trauma history	Yes / No	
Suicide attempts	Yes / No	
Chronic illness	Yes / No	

OTHER INFORMATION

What do you consider to be your strengths? _____

_____

_____

What do you like most about yourself? _____

_____

What are effective coping strategies that you have learned? _____

_____

_____

What are your goals for therapy?

_____

_____

_____

_____

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INFORMATION AND CONSENT FORM

What is Counseling?

The process of counseling may include, but is not limited to:

- Helping you to resolve personal issues
- Education concerning the root of personal difficulties
- Learning and applying new skills
- Rejecting destructive ways of thinking and behaving
- Gaining knowledge and insight concerning personal motivations
- Working through issues of woundedness and unforgiveness
- Learning to develop healthy relationships with yourself or others

Counseling may also incorporate the use of techniques from a variety of therapeutic approaches such as Insight Oriented, Object Relations, Cognitive Behavioral, Psychoeducational, as well as the application of your personal faith principles.

No guarantee is made that the counseling you receive will affect the desired results. Individual success largely depends on the intentional application of the insights, skill and knowledge the client gains through the counseling process and their willingness to be active, open, honest and as consistent as possible with their therapist.

No one else can solve your problems for you, but through gaining knowledge, insight, understanding and wisdom you can experience increased success in your life and relationships.

What your therapist expects from you: _____ (initial)

- Express concerns, ask questions
- Complete assignments
- Come to counseling free from the influence of any substances
- Pay your fees upon arriving to your session (have checks made out in advance)
- Be on time for your appointments
- Cancel 24 hours in advance (by phone or email) unless you have a serious illness or emergency
- (No shows and cancellations made less than 24 hours in advance are billed at the per session rate)

What is counseling like?

- A safe place where you will be accepted no matter what your struggle or difficulty
- An opportunity to grow personally and spiritually
- Personally challenging
- Teaches responsibility for the things you have control over
- Most sessions are 50 minutes in length for the clinical hour.

What to expect from your therapist:

- Return your calls within 24-48 hours in most cases
- Continue to update her skills and obtain ongoing training for him/herself
- Treat you with kindness and respect
- Develop a plan with you to help you achieve your goals and objectives
- Discuss discharge planning with you as soon as clinically appropriate
- Seek confidential consultation with other professionals when appropriate
- Help you to find an appropriate referral if necessary

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INFORMATION AND CONSENT FORM

Discharge and Termination _____ (initial)
The client has the right to terminate the counseling relationship at any time. However, it is in the client's best interest to discuss and plan for discharge with your counselor.

Counseling may be terminated for consistent failure to complete assignments, failure to pay fees, and failure to consistently show for scheduled appointments.

If there is a lapse in treatment for 1 month, unless arrangements have been made with your counselor, you will automatically be discharged from treatment.

Couples Therapy _____ (initial if applicable)
Successful marriages are based on trust. Therefore openness and honesty is the best policy. For successful therapy there can be no secrets within couples counseling. However, sometimes there are issues that are disclosed during individual sessions that may be difficult for one spouse to disclose to the other. When that is the situation, you and your counselor will work together on the best way to share that information with your spouse.

Records and Confidentiality_____ (initial)
The code of ethics for counselors and the state laws regulating most kinds of counseling consider personal information you discuss to be confidential. Except in a small number of situations, the helping professional may not reveal any information about you to another person without your explicit permission. Records of your treatment will be kept for seven years after your final session.

One exceptions to this rule includes if your fees are paid by a third party such as an insurance company, certain details of your treatment (e.g. dates of treatment, diagnosis, symptoms, progress) may be required to be revealed in order to obtain reimbursement. Most insurance companies allow you to file claims directly with them so that your employer will not see the information.

In cases where a court order has been issued and records have been subpoenaed the counselor has a legal responsibility to comply.

Suicidality and Abuse _____ (initial)
Another exception where counselors are legally required to disregard confidentiality involves situations where there is a potential for suicide or homicide. For example, if you reveal information that indicates a clear danger of injury to yourself or others the counselor will need to contact the appropriate authorities or family members.

Another exception to confidentiality is that all helping professionals are required by law to report any knowledge of abuse or neglect of a child or an incompetent or disabled person including suspected abuse.

Your counselor will be happy to discuss any concerns you have about the protection of the information you provide.

Fees and insurance reimbursement: _____ (initial)
Your insurance company may reimburse you for part of your fee; however it is your responsibility to pay your fee upfront at the beginning of each session. If you cannot pay the full fee, please ask for a sliding scale fee evaluation form and submit it to your therapist. Your fee will not be changed until the form is fully filled out and returned to your therapist for evaluation. Your fee reduction is based on the information you have provided. If you are having difficulty keeping up with the charges please notify your counselor, and he/she will be glad to reevaluate at any time.

Fees for court appearances, phone sessions, copies of records etc. will be discussed with you by your therapist as the need arises. I will not make recommendations on child custody issues in court. You

understand there is a fee not only for the subpoena but also for the cost for losing clients for the duration of the court appearances that will cost for lost services. Phone consults initiated by the client, that exceed 10 minutes will be billed in quarter hour increments based on the per session fee. _____ **(initial)**

Your fee will be collected at the beginning of each session. Checks, cash and credit cards are accepted. If you are going to use a check please have it ready when you come in to save time. When approved ahead of time you may use your credit or debit card and pay through PayPal for a small additional fee.

By your signature below you are indicating that you have read and understood this Information and Consent Form and/or that any questions you have had about this statement have been answered to your satisfaction. Your signature also indicates that you are over 18 years of age and legally competent. If you are under 18 years of age you must have your parent or guardian's signature as well. **Please sign one copy and return to your counselor and keep one copy for yourself.**

_____ _____

(Client's signature/date) (Parent/guardian's signature/date)

_____ _____

(Client's signature/date) (Parent/guardian's signature/date)

_____

(Witness signature/date)