



# Grace Wellness Center

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## Counseling Intake Form

**Date of Intake:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**Name of Caller:** \_\_\_\_\_ **Relationship to Client:** \_\_\_\_\_

**Name of Client:** \_\_\_\_\_

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

**Street**

**City**

**State/Zip**

**Phone:** \_\_\_\_\_ **Cell:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Gender:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Birth date:** \_\_\_\_\_ **Marital Status:** \_\_\_\_\_

**Insurance Provider:** \_\_\_\_\_ **Primary Insured:** \_\_\_\_\_

**ID Number:** \_\_\_\_\_

**Insurance Phone #:** \_\_\_\_\_ **MH Coverage (Y/N):** \_\_\_\_ **Co-Pay:** \_\_\_\_

**Presenting Issues:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Location:** \_\_\_\_\_ **Counselor:** \_\_\_\_\_

**Education: Last Grade Completed:** \_\_ **College:** \_\_ **Graduate School:** \_\_ **Occupation:** \_\_\_\_\_

**Children: Name:** \_\_\_\_\_ **Age:** \_\_\_\_ **In/Out of Home** **His/Hers/Ours/Other**

**Name:** \_\_\_\_\_ **Age:** \_\_\_\_ **In/Out of Home** **His/Hers/Ours/Other**

**Others living in the home:** \_\_\_\_\_

**Referred to Grace Wellness Center By:** \_\_\_\_\_



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## **BRIEFLY ANSWER THE FOLLOWING QUESTIONS:**

1. Please describe the current problem for which you are seeking counseling:
2. What have you attempted to do to alleviate the problem (if anything)?
3. What do you hope to achieve through the counseling process? Briefly list two or three goals:
4. Have you sought other outside help? If so, from whom?
5. Who is your current Primary Care Physician and when was the last time you saw him/her?
6. Please list any pertinent/relevant medical conditions or medications you are currently taking:

## **CHURCH AFFILIATION**

1. Are you a believer in Jesus Christ? YES NO (Circle one)
2. Please explain how one reaches heaven as you understand in the space provided below:



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3. Are you a member of a local church? YES NO (Circle One)

4. If so, how long have you attended this church? \_\_\_\_\_

5. Do you believe being an active part of a community of believers is important to reach your goals in counseling? Why or why not?

## ASSESSMENT

1. Please check all the following that apply to you at this time:

- |   |   |
|---|---|
| <input type="checkbox"/> I feel depressed                 | <input type="checkbox"/> I feel anxious                 |
| <input type="checkbox"/> I have mood swings               | <input type="checkbox"/> I struggle with my parents     |
| <input type="checkbox"/> I am having marital problems     | <input type="checkbox"/> I struggle with my in-laws     |
| <input type="checkbox"/> I have children                  | <input type="checkbox"/> I struggle as a parent         |
| <input type="checkbox"/> I abuse alcohol                  | <input type="checkbox"/> I use illegal drugs            |
| <input type="checkbox"/> I use prescription drugs         | <input type="checkbox"/> I abuse prescription drugs     |
| <input type="checkbox"/> I view pornography               | <input type="checkbox"/> I struggle sexually            |
| <input type="checkbox"/> I feel hopeless                  | <input type="checkbox"/> I feel fearful                 |
| <input type="checkbox"/> I feel angry                     | <input type="checkbox"/> I struggle with anger          |
| <input type="checkbox"/> I am a poor communicator         | <input type="checkbox"/> I feel sad                     |
| <input type="checkbox"/> I struggle with bitterness       | <input type="checkbox"/> I feel worthless               |
| <input type="checkbox"/> I do not attend church regularly | <input type="checkbox"/> I do not read my Bible often   |
| <input type="checkbox"/> Jesus is important in my life    | <input type="checkbox"/> I don't think about Jesus much |



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- I strongly fear rejection
- I have been physically abusive
- I have been sexually abusive
- I have been verbally abusive
- I am a loving husband
- I am currently or have been suicidal or had suicidal thoughts
- I have felt unsafe in past relationships
- I feel unsafe in one or more current relationships
- I have been sexually abused
- I have been verbally abused
- I have been physically abused
- I am a respectful wife

Is there anything else about your medical history, mental health history, or health and safety issues that you would like to tell us about?

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### **Provider/Client Service Agreement and Treatment Contract**

Welcome to The Grace Wellness Center. This document addresses many important aspects of therapeutic treatment such as specific information about my services and my practices, as well as more generalized information concerning your rights and privacy as a client as outlined in HIPAA and HITECH laws that most professionals follow. Although this document may be long and have a lot of information that you may even have seen before, it is important that you review the entire document, and sign off on the appropriate signature lines. If at any time during treatment you have any questions about this document, we can review it together in session. Signing this document serves as an agreement between us, however we can revisit or discuss aspects of this document at any time during treatment.

#### **Psychological Services:**

Therapy is difficult to define concisely, but generally refers to a relationship between a professional and a client that has clearly defined boundaries and rules, with outlined goals to be completed or issues to be discussed during time of treatment. As a client in the therapeutic relationship, you have many rights and responsibilities that may be maintained throughout treatment. I too as the provider must adhere to certain responsibilities, and our respective rights and responsibilities are listed throughout the document.

#### *Risks and Benefits*

Psychotherapy has both benefits and risks associated with treatment. Risks typically center around negative feelings that are brought up in conjunction with discussing situations or memories, such as sadness, guilt, anger, frustration, or stress. Because therapy often deals with discussing somewhat uncomfortable topics, these feelings are prone to arise. The goal would be to work through these feelings together as a team,



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and minimize the risks while maximizing the benefits gained through therapy. Benefits may include reduction in current symptoms such as feelings of anxiety, anger, or depression. They may also include increased coping skills to handle situations, relationships or feelings occurring presently or in the future. Lastly, therapy may allow you to resolve some past issues or feelings in an effort to move on in your journey. There are no guarantees that these benefits will occur, and if at any time you feel that the risks of therapy are outweighing the benefits, we can discuss and readjust our treatment process.

### *Therapeutic Style and Appointments*

As counselors, we tend to utilize various treatment styles and approaches, often integrating various techniques and tools. Essentially, therapy is centered on you, the client, in an effort to best address your needs. We will be completing a plan of action near the beginning of our relationship that we will be checking in on throughout our work, and this plan will largely be generated by you. If you have any further or specific questions concerning my treatment style, please feel free to ask me at any time throughout treatment.

Initial Intake Appointments are typically 60 minutes long, and in this appointment we will review all initial paperwork, and discuss the details of therapy. We will also establish a scheduled appointment time for future dates if possible. Subsequent sessions typically last between 50-60 minutes, and will take place at the same office as the intake, unless noted. *If you cannot attend your allotted time slot, or wish to reschedule, please provide me with 24 hours notice. If you do not provide me with 24 hours notice, barring any unforeseen emergencies, you will be responsible for a "No-Show Fee" that will be determined upon our first session.* Lastly, you are responsible for respecting the time constraints of our sessions. If you are late to a meeting, the scheduled end time will still be upheld.

### **Professional Fees**

The standard fee for the Intake appointment is \$100.00 and all subsequent appointments will be charged at \$85.00, unless otherwise discussed before treatment.



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You are responsible for payment at time of service, unless previous arrangements are made, and may pay by cash, credit card, or check. If there are other services that you may incur during treatment such as report writing, telephone calls lasting longer than 15 minutes, or attending of meetings you have requested, we will discuss a fee for that before the service is completed. If a court case comes up that requires my involvement with this case, we will thoroughly discuss options and my involvement. If you know of potential court involvement before we begin therapy, please notify me as this deals with your confidentiality. You will be responsible for fees that come with court time if we get to that as well. If your balance exceeds \$200 without being paid, we will need to suspend services until the balance is met.

### *Sliding Scale:*

There is an option for an income based sliding scale that may be discussed before the Initial appointment as well. This amount will be based on your income and other factors that can be discussed before the initial appointment. If this scale needs adjusted at any point throughout treatment, we may also discuss that in or out of session and reevaluate.

### **Insurance:**

If you have health insurance that I participate with as a provider that covers your treatment, we are able to bill our treatment dates to that insurance for reimbursement. With your permission, my billing associate and I will assist you in understanding the insurance billing process and sending your claims to your insurance to be billed accordingly. We will assist you if possible, but it is ultimately your responsibility to know the details of your Insurance plan such as copayment or co-insurance amount, deductible amount and progress, sessions approved per year, and yearly renewal time. If you choose to utilize insurance, insurance companies do require me to provide them with certain pieces of information in order to be properly reimbursed. Such information typically includes your name, a diagnosis, a date of service, and session length in minutes. Occasionally, insurance companies may need more information such as treatment plans or goals, or copies of records. If the insurance



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company requires extensive information, you will be made aware of this. Insurance companies are mandated to abide by the same privacy laws outlined in HIPAA and HITECH, but once your information is sent to the company, I am no longer responsible for said information. Occasionally, as a client you may need assistance filing a grievance if your insurance company refuses to pay. If our billing department is able to help you with this, we will do our best. If not, it is your responsibility to contact the appropriate person at your insurance company.

If your insurance requires you to pay an amount such as a copayment, coinsurance, or dollar deductible amount, that will be collected at time of service as well. If you have questions about your insurance plan, we can discuss them at our first meeting. By signing below this segment, you are authorizing me to provide the insurance company with the information needed to properly bill your insurance.

*Client Signature* \_\_\_\_\_ *Date:* \_\_\_\_\_

### **Contacting Me:**

As most professionals will be seeing clients most days, it is unlikely that you will be able to reach us immediately by using our work number. If the message is not urgent or emergent, such as calling to cancel, calling to reschedule, or calling to check on an appointment time, you are encouraged to call my work phone and leave a message. I will check this message between client times, and contact you back within 24 hours to confirm the message. If for any reason you cannot contact me directly, or have not heard back from me for a non-urgent matter, you are encouraged to call our main office line (724) 863-7223 and leave a general message or speak to the administrator on call.

**Emergencies:** In the event of an emergency, please first either go your emergency room or call 911 and ask to speak to the mental health worker on call. You may also need to contact your Primary Care Physician's office, or, if you feel you are unable to keep yourself safe, contact either **the Resolve Crisis hotline: (888) 796-8226**, or the **Westmoreland County Crisis Hotline (724) 830-3000**, depending on your county.



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I will make every possible attempt to make you aware of unplanned absences on my part. If the absence will be extended, I will also provide you with an interim mental health professional in my practice as a contact for you.

## **Confidentiality**

Confidentiality is of utmost importance in a therapeutic relationship, and in order for progress to be made, confidentiality must be upheld and maintained throughout your treatment. Generally speaking, all of our communication is protected by Law and reinforced by the Ethics code by which I abide, (specifically outlined in the ACA code of Ethics, Section B). We operate under the idea of counselor-client privilege and that privilege is to be upheld except in extreme circumstances. In most cases, I am only able to release information about your treatment with your written and signed permission. However, there are some exceptions to this confidentiality and those are as follows:

*Intention to Harm oneself or others:* If in session it is made evident to me that you intend to harm yourself or harm someone else, I am ethically and legally required to warn appropriate supports in an effort to provide you with as much help as possible. This may include but is not limited to: emergency contacts, the intended victim you are looking to harm, police enforcement, or the hospital. This will be discussed as much as possible between us, but action will be taken appropriately.

*Elder or Child Abuse:* If it comes to light through our sessions that I believe a child or an elderly person is being abused or has been recently abused, I will need to report that to the appropriate state agency.

*Client request:* As previously stated, you are able to request copies of your records or request that a release be signed to release your records to various organizations such as other care providing agencies, or disability services. I would warn you however that once your records are out of my possession, I



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do not have control over their use, so I would discuss all releases with me before completing a request.

### *Confidentiality and Technology:*

Throughout treatment, there are multiple ways in which technology may be incorporated, and confidentiality is applicable in those instances as well. I have a work number that you will be provided with for purposes of rescheduling, canceling, or work hour emergencies (emergency procedures will be further explained in a following sections). This work phone is kept with me in my office during work hours. I will do my best to keep this confidential, but in the case that the phone would be stolen, I encourage you to leave as little personal information in a message as possible. First names alone should be fine, specifically if you are calling to cancel or reschedule. I will be keeping notes on a web-based software that is covered and insured, and I will obviously be obligated to tell you in the unlikely circumstance that the software would be compromised. In terms of social media, to keep with the confidentiality of your treatment, I will not be accepting any interactions on any social media sites. This is not personal, but rather to maintain our professional Therapist/Client relationship and increase the benefits possible in therapy.

### **Professional Records**

As part of our therapeutic relationship, as well as to uphold requirements from institutions like insurance companies, I am required to keep records of your treatment. You will have a paper file that will be kept in a locked file cabinet in a locked file room of this office which will include your Intake Paperwork, this signed document, the Notice of Privacy Practices document, and a Contact Log that will be signed at each session for insurance purposes. In addition to this file, I will be keeping electronic treatment plans and progress notes stored on a secure medical health record database through a mental health record keeping software entitled Theranest. The notes I keep each week are brief, and are typically a concise summary of what was discussed in session, a general update on your progress and techniques used, as



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well as a basic plan for the next session. Treatment plans, as discussed, are co-created with you, and re-evaluated every sixty days in an effort to keep them updated. These plans include long term and short term goals, as well as some action steps you may take to complete said goals. Unless it is a situation in which doing so would cause you harm, you have the right to view your records. Because some of the language may be unfamiliar to those not in the mental health field, I recommend that if you do want to view your records, you review them with me, or have them forwarded to another mental health professional before looking at them alone. If you decide to end treatment with me and begin services with another mental health professional, you have the right to request that I send your records to the new provider.

### **My Professional Affiliations:**

As you are aware, I am a counselor in a private practice with multiple co-workers. As is the nature of most mental health practices, outlined in the ACA Code of Ethics Section F, I am involved in both Individualized Supervision with a Supervisor, and group supervision once a month with other mental health colleagues. During these times, we are encouraged to discuss topics we are seeing in our current cases and receive supervision if necessary. While it is possible that I may discuss your issue, I will do so with the focus being maintaining client confidentiality and use my discretion appropriately. Supervisors and co-workers are held under the same confidentiality codes when it comes to hearing other cases as well.

### **Other Client Rights and Terminating Therapy:**

As a client, we have outlined the many rights you have and are entitled to. In addition to these rights, you are entitled to discuss it with me as your Therapist if you are at any time unhappy with what is happening in our sessions. I encourage this discussion either as a way to improve our sessions, or as a venue for me to provide you with a referral for a different therapist. At any time, I will do my best to have various referral sources that may be applicable for you.



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You also have the right to terminate counseling at any time. In an ideal situation, therapy ends when our agreed-upon goals are met or at least sufficiently discussed. If you would like to terminate therapy before said goals are completed, I would appreciate a session to discuss termination and properly refer you to another professional.

As your therapist, I will not treat or discuss issues outside of my professional ability, and if those would arise, I would be ethically bound to refer you to a more suitable professional. If for any other reason I am unable to complete treatment, this will be discussed as clearly as possible, and various referrals will be offered to you as the client.



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## **Consent to Treatment**

**Your signature below indicates that you have READ and REVIEWED this document, and are agreeing to abide by its terms and conditions. This signed form will be saved as a part of your personal file, and can be reviewed and discussed at any point throughout treatment.**

\_\_\_\_\_  
**Client Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Guardian/ Representative Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
***Relationship to Client if signed by a Guardian***

\_\_\_\_\_  
**Therapist Signature**

\_\_\_\_\_  
**Date**



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## **GRACE WELLNESS CENTER BELIEF STATEMENT**

### **THE BIBLE**

The Bible being verbally and plenary inspired by God is inerrant. It is the authority for all matters of faith and practice (2 Timothy 3:16; 2 Peter 1:21; 3:16).

### **GOD**

God is eternal, needing no introduction (Genesis 1:1). God is beyond description or comprehension (Isaiah 55:8-9); I AM Exodus 3:14). There is only one God, but in the unity of the Godhead there are three eternal and coequal Persons, the same in substance but distinct in subsistence (Matthew 28:19; 2 Corinthians 13:14).

### **JESUS CHRIST**

Jesus Christ is 100% man and 100% God (Philippians 2). His purpose in coming to earth is to seek and save that which is lost (Luke 19:10). Salvation was made possible through His death, burial and resurrection (1 Corinthians 15:3-5).

### **THE HOLY SPIRIT**

The Holy Spirit is God (John 14:16; Romans 8:15; 1 Corinthians 6:11). The Holy Spirit illuminates the minds of the believer (John 16:13-15; 1 Corinthians 2:10-13; 3:2) and convicts the mind of the unbeliever (John 16:7-11).

### **SALVATION**

Salvation is by grace through faith, not of works (John 3; Ephesians 2:8-9; Titus 3:5)

### **SIN**

All men have a sin nature resulting from man's participation in Adam's first sin (Romans 5:12). The sin nature is the capacity and inclination to do those things that can in no way commend us to God (Romans 1:18-3:20; 2 Corinthians 4:4; Ephesians 4:18).

### **THE CHURCH**

The church is an organism of which Christ is the Head and is composed of all regenerated people (Colossians 1:18). As an organization it appears in many different forms.

### **SANCTIFICATION**

Sanctification has three aspects. Positionally, set apart to God (1 Corinthians 6:11; Hebrews 10:10). This is as we are today in the eyes of God. Practically increasingly we are set apart from sin to God in our daily lives (1 Peter 1:16). Potential sanctification is being fully set apart to God when we are brought into perfect accord when we see Christ and become as He is (1 John 3:1-3).