State of Mind Counseling Centers LLC
52188 Van Dyke Ave, Suite 319
Shelby Township MI 48316

Client Information

Name_____ Age_____ Date of Birth_____

Address_____ City_____ State_____

Zip_____ Email_____ Soc Sec # xxx-xx-_____

Phone_____ I give permission for telephone communication (verbal and text) regarding scheduling

Emergency Contact Information

Emergency Contact_____ Phone_____

I agree to give consent to release information in case of an emergency to the named person.

Insurance Information

Insurance Company_____

Subscriber ID #_____ Group #_____

Subscriber Name_____ Sub Birthdate_____

Authorization Phone Number (on back of card): _____

Present Issues

Please describe the reason for seeking services at this time: _____

_____

_____

When did your problems begin? _____

Please rate the severity of your problems on a scale of 0-10 (0 being low and 10 being high) ___

What areas of your life are impacted by your problems? ☐ Relational ☐ Occupational

☐ Educational ☐ Health ☐ Financial ☐Quality of Life ☐ Social ☐ Familial ☐ Self- regard

☐ Other_____

What are your current goals for treatment? _____

_____

_____

Medical Issues

Medical problems during childhood or adolescence? ☐ No ☐ Yes, please explain: _____

_____

Current medical problems? ☐ No ☐ Yes, please explain: _____

_____

Please circle any of the following terms that may apply to you:

Headaches	Excessive sweating	Frequent use of painkillers
Heart palpitations	Dizziness	Fainting spells
Bowel disturbances	Stomach Trouble	Anxiety
Anger	Fatigue	Insomnia
Nightmares	Use of Sedatives	Increased alcohol use
Feeling Tense	Feeling panicky	Tremors
Feeling depressed	Argue frequently	Use of drugs
Unable to relax	Suicidal thoughts	Discomfort with people
Don't like weekends/vacations	Sexual problems	Problems at home
Difficulty making friends	Overly ambitious	Unable to have a good time
Difficulty keeping a job	Feeling inferior	Difficulty concentrating
Financial problems	Memory problems	Self-harm
	Feeling lonely	

Other: _____

Alcohol and Drug use

	Past use- # of days in an average month	Current use- # of days in the last month		Past use- # of days in an average month	Current use- # of days in the last month
Alcohol			Amphetamines		
Inhalants			Sedatives		
Hallucinogens			Other:		

Previous alcohol & drug treatment? ☐ No ☐ Yes, please explain: _____

_____

Mental Health History

Previous mental health treatment? ☐ No ☐ Yes, please explain: _____

_____

_____

Circle any of the following words or terms that you believe apply to you:

Worthless	Evil	Misunderstood	Confident
Inadequate	Agitated	In conflict	"can't do anything right"
Bored	Ugly	Attractive	
Guilty	Unloved	"Life is Empty"	Morally wrong
Anxious	Unconfident	Naïve	Horrible thoughts
Aggressive	Intelligent	Full of hate	Panicky
Lonely	A "nobody"	Unassertive	Depressed
Confused	Incompetent	Boring	Restless
Sympathetic	Hostile	Repulsed	Vile
Useless	Cowardly	Bored	Worthwhile
Stupid	Unattractive	Full of regrets	Considerate

Other: _____

Family History

Family Members

Name	Relationship	Age	Quality of relationship	Living with you?

Have any of your relatives ever had a serious mental health, alcohol or drug problem?

Relative	Problem

Relationship Status: _____

Have you had any serious conflicts with family members? ☐ No ☐ Yes, please explain: _____

_____

_____

What do you like to do in your free time? _____

_____

Signature Date

State of Mind Counseling Centers
Practice Orientation and Service agreement

Your rights and responsibilities as a client:

- You have the right to receive services from clinicians who adhere to the professional code of ethics of their respective disciplines.
- You have the right to receive services in accordance with Federal and State regulations and accreditation standards governing behavioral health programs.
- You have the right to privacy and confidentiality regarding the service you receive. All information about you and your treatment, whether written or oral, is protected under Federal and State laws, including the HIPAA Privacy Act.
- You have the right to informed consent for services offered to you.
- You have the right to refuse services at any time. You have the right to withdraw your consent to receive services and discontinue services at any time. If you should decide to withdraw your consent for services, you must do so in writing
- You have the right to know treatment recommendations and the possible outcomes if you choose not to follow these recommendations.
- You have the responsibility to assist in planning your treatment at every stage.
- You have the responsibility to arrive for all scheduled sessions, or to notify us 24 hours in advance if you wish to cancel an appointment. You may be charged a practice fee, up to $80, for non-cancelled or late cancelled appointments, when an emergency was not involved, because insurance companies and other third-party payers do not cover missed appointments.
- You are responsible for any fees that may be charged to you at the time of service and, also, for knowing your insurance benefits coverage. We check benefits as a courtesy, but this is not a guarantee of coverage.
- Your case will be closed following 90 days of inactivity, unless other arrangements have been made.
- You have the right to know we may call the police if someone comes to the practice under the influence of drugs or alcohol and tries to leave the practice driving a motor vehicle.
- You have the responsibility to conduct yourself in a non-disruptive and non-aggressive manner while on the premises.
- Treatment may be terminated for the following reasons: Being under the influence of any illegal substance while on the premises, Threatening the safety or rights of any client or staff member, Non-compliance with treatment or an inability of the facility to provide you the care you require, You have two or more subsequent late cancellations (under 24 hour notice), or two or more failures to appear at a scheduled appointment without notice

*In all instances, you have the right to a referral for a different treatment option

Potential Counseling Risk

Counseling can carry both benefits and risks. Often, counseling can lead to a significant reduction in feelings of distress, improved relationships, and/or resolution of specific issues. However, there are no guarantees for a “cure” or improvement of any condition. Risks may involve experiencing uncomfortable feelings (i.e. sadness, guilt, or anxiety) or discussing unpleasant aspects of your life. However, you do have the right to reframe from discussing any matters that may cause you to become distressed.

EMERGENCY

In the event of an emergency please immediately go to your local hospital, call 911 and/or call the national suicide prevention line- 800-273-8255 or contact the nearest crisis center (Oakland County Crisis Helpline @ 248-456-0909 or Macomb County Crisis Helpline @586-307-9100)

CONFIDENTIALITY

Federal and State laws protect the privacy of communications between a client and a clinician, including and not limited to HIPAA. In most situations, release of information about your services/treatment to others can only be done if you sign a written Authorization to Release that meets certain legal requirements. However, there are limits to confidentiality, such as if you intend to harm yourself or others. State laws require reporting of suspected child abuse, child neglect, elder abuse, abuse of vulnerable adults or any imminent harm to yourself of others.

FINANCIAL RESPONSIBILITY

You are expected to pay for service at the time it is rendered, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when requested. A fee adjustment or a payment installment plan may be negotiated with your therapist in circumstances of unusual financial hardship. You are ultimately responsible for knowing your insurance deductible and co-pays and are responsible for paying both in full. Please contact your insurance provider for specific policy details. A $25 charge may be required for returned checks. You may be charged up to $25.00 if you request records to be sent out. If your client balance exceeds $200.00 service may be suspended, and you will be offered a referral to another clinic where you will be able to continue your treatment. If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, legal action may be used to secure the payment. This may involve hiring a collection agency or going through small claims court, which will require disclosure of otherwise confidential information. In most collection situations, the only information released regarding a client's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its cost will be included in the claim

FEE SCHEDULE FOR SUPPLEMENTAL PROFESSIONAL SERVICES

It is our goal to provide the most comprehensive care and coordinated professional services to our clients. The charges outlined in this section are for additional professional services not traditionally covered by insurance companies and other third-party payers. When provided they are billed directly to the client.

1.Phone calls

a. Phone calls lasting under 15 minutes are considered part of ongoing clinical care and are gladly answered and returned by therapists as soon as possible without charge.

b. When phone calls last 15 minutes or longer, your therapist will encourage the scheduling of an appointment to discuss the matter in the context of a traditional face-to-face session.

c. Phone calls lasting between 15 and 30 minutes are subject to a flat fee of $60.00.

d. Phone calls exceeding 30 minutes are subject to a fee of $60.00 for the first 30 minutes, and a $15.00 per charge for each additional 5-minute increment.

e. These rates apply for phone consultations with clients as well as with authorized third-party contacts such as school professionals, attorneys, physicians, psychiatrists, etc.

While therapists will make every effort to address issues of clinical concern over the phone in a concise and time-sensitive manner, phone calls between the client and the therapist lasting longer than 15 minutes suggest the need for a face-to-face session. Phone calls involving third party contacts are at

times needed and/or requested to address important coordination of care concerns.

2. Professional letters and requests for medical documentation:

a. These letters and medical documentation include written communication and/or requested medical documentations to be sent to third parties such as schools, court, attorneys, employers, etc. (This does not include missing work/school letters). This also includes requests of medical documentation for the individual client's use.

b. Letters and/or request for medical documents are subject to a $50.00 fee.

3. Court appearances and/or testimony:

a. Any presence in court or taped disposition is subject to a flat fee of $1200 per (***Please note: In cases where a court-ordered subpoena legally requires the therapist to appear in court and/or provide a deposition, fees for court appearances will be charged, regardless of whether or not the client/client representative signs this documentation agreeing or choosing to decline to privately pay for these professional services).

MINORS & PARENTS

Clients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Parents should also be aware that clients over age 14 can consent to (and control access to information about) their own psychosocial treatment that does not exceed 12 sessions or 4 months. While privacy is very important, particularly with teenagers, parental involvement is often essential to successful treatment. Therefore, it is State of Mind Counseling Center's policy to request (but not require) an agreement from any client between 14 and 18 and his/her parents which would allow the sharing of general information with parents about the progress of treatment and the child's attendance at scheduled sessions.

FAMILY INVOLVEMENT IN TREATMENT:

While family treatment may be useful at times, involvement of family members is to be negotiated with the client and therapist. Unless family therapy is warranted and all members consent to treatment, it is up to the client and therapist to determine the level of family (or other persons) involvement in sessions. In any case, the therapist may not release any information to anyone regarding the client without the client's written consent. In the case of minors, it is strongly suggested to keep most of the client's treatment between the client and therapist and only involve family members in treatment when necessary.

Teletherapy

Teletherapy may be a viable option for your counseling needs. It will be conducted on a HIPAA compliant platform. It is your responsibility to confirm with your insurance company that this is a covered service.

My signature below indicates that I:

- Have been made aware of my rights and responsibilities and potential risks of service
- Have been informed of practice-specific information
- Have been informed of privacy practices, confidentiality, and limits to confidentiality (including limit in use of phone calls, texts, e-mail, and other electronic communication)

My signature below also indicates that I have understood this document and consent to receive services at State of Mind Counseling Centers, and that I understand I may discuss any questions I have regarding services and that I maintain the option to terminate my consent at any time.

Signature Date