NewHope
COUNSELING

P.O. BOX 2323
Gainesville, GA 30503
678-947-2881
FAX 678-947-2921

CLIENT INFORMATION SHEET

Name_____

Address_____

_____

Home #_____ OK to leave message?_____

Cell #_____OK to leave texts/ messages? _____

Email _____ OK to leave email notifications? _____

Sex_____ DOB_____ Current Age_____ Marital Status _____

Employer Name_____ Referred by: _____

Emergency Procedures Specific to Mental Health Services

There are additional procedures that we need to have in place specific to Mental Health services. These are for your safety in case of an emergency and are as follows:

- We require an Emergency Contact Person (ECP) who we may contact on your behalf in a life-threatening emergency. Please write this person's name and contact information below. Either you or we will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or we determine necessary, the ECP agrees to take you to a hospital. Your signature at the end of this document indicates that you understand we will only contact this individual in the extreme circumstances stated above. Please list your ECP here:
  Name: _____ Phone: _____
- You agree to inform your counselor or our office of the address where you are at the beginning of any emergency phone call.
- You agree to inform your counselor of the nearest hospital to your primary location that you prefer to go to in the event of a mental health emergency. Please list this hospital and contact number here:
- Hospital:_____ Phone: _____

☐ Are you ***currently*** having thoughts of harming yourself or someone else? Yes No

☐ Have you had thoughts/ intents ***in the past*** of harming yourself or someone else? Yes No

☐ Have you been in therapy before?_____If yes, for how long? _____

Please describe any previous professional counseling:_____
_____
_____
_____
_____

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Please describe your reason for seeking professional counseling:

Please describe what you hope to achieve in the counseling process:

Please describe any medical conditions or any medication you are currently taking:

GENERAL INFORMATION & TREATMENT CONSENT

Please read the following information. If you have any questions or concerns, I will be happy to address them before we begin our session together.

- Information discussed during our sessions will be kept confidential unless the following circumstances apply: 1) clear or imminent danger to you or to others, 2) suspected child or elder abuse, and/or 3) a court order.
- Therapy sessions are fifty (50) minutes.
- **Your session is your personal reservation for that week. If you must cancel an appointment, please call me no later than 24 hours before your session so that we can try to reschedule your appointment to another time. You will be charged for scheduled sessions that are not canceled within 24 hours.**

_____ please initial

- Messages are checked frequently and you will be called back as soon as possible. If you have an emergency that cannot wait for a return call, please call 911 or seek immediate attention at the nearest hospital emergency room or mental health center.
- If you request that I share information with someone, you will be asked to sign a release of information. NO information will be shared with any person or agency without a signed release.
- Electronic communications with your therapist though confidential, <u>are **NOT HIPAA Compliant**</u> (ie. Telephone, text, and email).

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- Ethical standards for counseling include avoidance of dual relationships outside of counseling (ie. friendships or business) in order to protect your right to confidentiality and any possible conflicts of interest. In addition, any chance meetings in public will be deferred to the client to acknowledge that a relationship exists between us. It is suggested that introductions state that we know each other as a business contact, or through a social event, church, or other common function.

- **Fees are payable at the time of service.**

_____please initial

- This form documents that you, the client, have consented to treatment with New Hope Counseling, including, but not limited to, psychotherapy and counseling. This allows the professional staff at New Hope Counseling, to provide services to you.

- This form provides evidence that no guarantee is made by any professional at New Hope Counseling concerning the outcome of treatment. There is no guarantee that treatment will be successful.

- This form also provides evidence that consent is given only after a full explanation has been provided by the staff at New Hope Counseling.

- I am aware that the practice of medicine, psychiatry, clinical psychology, clinical social work, and other therapy by a licensed professional is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation or treatment.

- I am aware that I am an active participant in the counseling process and that I share responsibility for my treatment. My responsibilities in treatment include informing the therapist of any information that may be relevant to the problems or conditions being treated, assisted in setting goals for treatment, following therapeutic advice to the best of my ability, and ending treatment in a responsible way.

I, _____, do hereby voluntarily consent to care and treatment by New Hope Counseling, their assistances and/or designees. I acknowledge that this form has been fully explained to me and I certify that I understand its contents. I also understand that it is my sole responsibility to ask any questions or obtain any clarification necessary to my understanding this form fully. A copy of this will be gladly provided upon your request.

_____ _____

Signature of client, or person authorized to consent (relationship) Date

_____ _____

Signature of Clinician Date