



CLIENT INFORMATION—ADULT

Today's Date: _____

Referring Agency/Person: _____

Client Name: _____ Form Completed By: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Alternate Phone (cell) (work): _____

E-Mail: _____ (Confidentiality of email communication cannot be guaranteed.)

Date of Birth: _____ Social Security #: _____

Gender: Male _____ Female _____ Ethnicity: _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Employment: Full-time _____ Part-time _____ Not employed _____ Student _____

Occupation _____ Employer _____ How Long? _____

Emergency Contact: _____

Relationship: _____ Phone Number: _____

Family of Origin Information

Mother's Name and Age _____ Education/Occupation _____

Number of Marriages _____ How did marriage(s) end? _____

Father's Name and Age _____ Education/Occupation _____

Number of Marriages _____ How did marriage(s) end? _____

How would you describe your mother? _____

How would you describe your father? _____

Were you adopted? Yes No

If yes, please describe adoption process: _____

Please fill in the blanks: I was (born) the _____ of _____ children and felt _____ about my siblings because _____.

Family of Choice Information

To which relatives do you currently feel closest and why? _____

Spouse/Significant Other Name: _____

Describe your current relationship: _____

Please give names and ages of any children, half-children and/or step-children members:

_____	_____
_____	_____
_____	_____
_____	_____

Medical Information

Doctor: _____ Telephone Number: _____

Are you currently under a doctor's care: Yes No

If yes, please explain: _____

Addiction Information

What is your current alcohol/drug usage: _____

Do you have a history of substance misuse and/or abuse: Yes No

If yes, please describe: _____

Do you have a history of other addiction issues? (eating disorders, gambling, sexual, etc.)? Yes No

If yes, please describe: _____

Abuse Information

Have you experienced any emotional abuse? Yes No

If yes, please describe: _____

Have you experienced any physical abuse? Yes No

If yes, please describe: _____

Have you experienced any sexual abuse? Yes No

If yes, please describe: _____

Spiritual Information

With what spiritual beliefs were you raised? _____

What are your current spiritual beliefs? _____

How would you describe God? _____

How do you believe God would describe you? _____

Presenting Information

What is the problem for which you are seeking counseling? _____

What changes would you like to occur as a result of counseling? _____

What about your life is currently most stressful and why?

What counseling/treatment have you had in the past? _____

Client Signature

Date

Pastoral Counselor Signature

Date



TREATMENT GOALS AND PHILOSOPHY

New Life Counseling is a Christ-centered counseling ministry of Arizona Baptist Children's Services. We serve individuals, children, couples and families who are looking for new answers to old problems. Our goal is to help clients move beyond their old life of problems and stress to a new life of peace and healing by providing effective solutions and coping strategies. These strategies are based on Christian principles, integrated with recognized counseling techniques, aimed at pointing people to a loving and caring God.

AVAILABLE SERVICES

New Life Counseling is an outpatient provider that employs treatment modalities which assist individuals, couples, and families in resolving their difficulties. Pastoral counseling and psychological counseling services are available. **Counseling sessions are 45 to 50 minutes in length.**

CANCELLATION NOTICE or "NO SHOW" APPOINTMENTS

A 24-hour notice is required when canceling or rescheduling an appointment. A \$25 fee will be assessed for any missed and rescheduled appointment with less than 24 hour notice or "no show" appointments. Arriving 15 minutes or more late for a scheduled appointment will be considered a "no show" appointment. If payment for services is handled through a third-party and the third-party does not cover cancellation or "no show" fees, the fee will be assessed to the client. Failure to cancel in advance two times or two "no show" appointments may result in termination of services.

FEE FOR SERVICES

Payment is expected at the time of service. Case management services (ie. staffings, communication with other professionals involved with client/family, consultations, report writing) will be prorated based on counseling fee with a 15 minute minimum. **Because we are committed to God's healing and redemption in our client's lives, we do not voluntarily provide forensic services, that is assessments, treatments or recommendations to the courts and legal community. In the unfortunate event that a judge's order is issued for our counselor's records and/or testimony, the therapeutic counseling relationship will be ended and a referral to another professional will be made.** Cases requiring court-ordered involvement with the legal and judicial system (ie. communication with attorneys, forensic research, judge-ordered court appearances) will also be prorated on twice the counseling fee with a 15 minute minimum.

CLIENT RIGHTS

The rights and concerns of our clients are a primary concern to the professionals of New Life Counseling. We strive to provide quality care to our clients in caring and ethical atmosphere. Each client accepted for services shall be afforded the basic right to:

- Treatment and services under conditions that support personal liberty and restrict such liberty only as necessary to comply with treatment needs
- A reasonable explanation of all aspects of one's own condition and treatment

- Be informed in advance of charges for services
- All available services without discrimination because of race, creed, color, sex, age, handicap, national origin, or marital status
- Refuse treatment at any point in the treatment process
- Confidentiality of records; within guidelines of state law
- Be informed, in appropriate language and terms, of rights including the right to legal counsel and other requirements of due process
- Referral, as appropriate, to other providers of behavioral health and other services

URGENT/EMERGENCY CARE

Arizona Baptist Children’s Services/New Life Counseling does not provide crisis services. If you are in need of crisis services, please contact the 24-hour Crisis Line at 520-323-9373 or Southern Arizona Mental Health Center at 520-622-6000. In an after-hours emergency, please call 911 for assistance.

PARENT RESPONSIBILITY

Parents/guardians are responsible for supervising their children at all times while at the New Life Counseling office. Parents/guardians are financially responsible for any damages their children may cause while in the office or public restrooms.

NO WEAPONS POLICY

No weapons are allowed on the premises of New Life Counseling or in your possession during sessions with representatives of New Life Counseling. Our staff will take the necessary reporting steps in the event that you are found to be in possession of any type of weapon. This strict policy is designed to ensure the safety of everyone.

NO ALCOHOL OR STREET DRUGS

Do not attend counseling sessions if you have taken alcohol or street drugs.

CUSTOMER SATISFACTION SURVEY

When you are discharged you will be asked to fill out a client satisfaction survey or it will be mailed to you. This allows you to comment on the quality of your services at New Life Counseling. We strongly encourage you to honestly fill out this survey to provide us with information to improve the quality of our services.

Client Signature

Date



FINANCIAL AGREEMENT

Current counseling fees range from \$40 to \$80 an hour based on a sliding scale. NEW LIFE COUNSELING is a non-profit ministry and it is our desire that no one be turned away because of finances. We will negotiate and arrange a suitable payment schedule for you.

Payment is expected at the time of service unless other arrangements have been made. Third-party payments will be billed as agreed upon between myself and my counselor. If an agreed upon third-party does not pay, I will be responsible to pay the sliding scale fees. I understand that I will be informed in advance of any changes in the agreed upon fees for service.

Checks are to be made payable to ABCS/NEW LIFE COUNSELING. Donations to ABCS/NEW LIFE COUNSELING are tax deductible, but counseling fees are not.

If you must cancel a scheduled appointment, you must provide at least 24 hours notice. If you experience a scheduling emergency, call your counselor as soon as possible. If you do not provide adequate notice or attend your scheduled appointment, you will be billed \$25.00 for the missed appointment.

<u>Yearly Gross Income</u>	<u>Payment per Session</u>
____ less than \$30,000	\$40
____ 30,001 – 35,000	\$45
____ 35,001 – 40,000	\$50
____ 40,001 – 45,000	\$55
____ 45,001 – 50,000	\$60
____ 50,001 – 55,000	\$65
____ 55,001 – 60,000	\$70
____ 60,001 – and above	\$80

I _____ agree to pay \$ _____ for each session.
 I have read, understand and agree to the above financial policies.

 Client Signature

 Date

 Pastoral Counselor Signature and Credentials

 Date



INFORMED CONSENT

The following information is for your benefit so you can enter a cooperative pastoral counseling partnership in an informed manner. Pastoral counseling is a helping relationship, which you are voluntarily seeking for yourself/your family for assistance with specific and stated problems. While pastoral counseling should end through mutual agreement once desired goals have been reached, you have the right to end pastoral counseling at any time. Understand that you have the right to refuse any recommended services, and to be advised of the consequences of that refusal.

CONFIDENTIALITY

Legal Confidentiality

The pastoral counselor considers all information and issues presented in the course of pastoral counseling as confidential by law. Confidential information may be released only with the written consent of the person being treated or that person's legal guardian. State law also requires the release of confidential information under the following conditions:

1. The client threatens suicide.
2. The client threatens harm to another person(s), including murder, assault, or other physical harm.
3. The client is a minor (under age 18) and reports suspected child abuse, including but not limited to, physical beatings, and sexual abuse.
4. The client reports abuse of the elderly.
5. The client reports sexual exploitation by a counselor.

In addition, in certain circumstances, a judge may court-order treatment records or require a deposition or testimony from a pastoral counselor. The contemplation or commission of a crime or harmful act is not considered confidential communication.

Consultation and Professional Training

In accordance with ethical standards, the pastoral counselor is required to participate in direct supervision. The pastoral counselor requires your consent to obtain professional supervision or collegial consultation outside our ministry when he/she feels it will facilitate my work with you/your family. Your name and any uniquely identifying information about you/your family will be deleted or changed to protect your identity. **Your signature on this form indicates your consent. Please let your pastoral counselor know if you are withholding consent.**

Professional Records

The laws and standards of pastoral counseling require the keeping of case records. Records are locked and kept on site. You are entitled to receive a copy of your records or a summary of your care if you make a written request. Because these are professionally-held records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, it is recommended that you review them with the pastoral counselor so that the contents can be discussed. You may also ask to amend that record. Your record will not be disclosed to others unless you direct the pastoral counselor to do so or unless the law compels the pastoral counselor to do

so. Communications between the pastoral counselor and client will otherwise be deemed confidential as stated under the laws of this state. You will be charged an appropriate fee for any professional time spent in responding to your request for information and meetings will be scheduled at mutually convenient times.

AUTHORIZATION TO TREAT

Authorization for Treatment

My signature below indicates that I have read and understand this policy statement and its limits and have had my questions answered to my satisfaction. I accept, understand and agree to abide by the contents and terms of this agreement and further, I am voluntarily consenting to my pastoral counseling for specific and stated problems.

Client Name

Client Signature

Date

Pastoral Counselor Signature

Date



ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

Presented to: _____
Client Printed Name

For: _____
Client Printed Name

Presented by: _____
New Life Staff Printed Name

I, _____, hereby acknowledge that I have received and read the Notice of Privacy Practices for Arizona Baptist Children’s Services and that their staff was available to answer any questions I had and to offer further clarification of the contents of the Notice. * *You may refuse to sign this acknowledgment**

Signature: _____ **Date:** _____
Client Signature

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ___ Individual refused to sign
- ___ Communications barriers prohibited obtaining the acknowledgement
- ___ An emergency situation prevented us from obtaining the acknowledgement
- ___ Other (Please Specify) _____

Arizona Baptist Children’s Services Staff Signature: _____

Arizona Baptist Children’s Services
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