HEALING WITH GRACE COUNSELING CENTER

Client Information

Name _____ Date _____

Gender _____ Date of Birth _____ Age _____ Marital Status _____

Address _____

City _____ State _____ Zip _____ Phone _____

Can we call, email, or text you regarding your appointments? ___Yes ___No

Email _____ Referred By/Website _____

Highest Level of Education _____ Occupation _____ Sliding scale/Income _____

Emergency Contact Name _____ Number _____ Relationship _____

Second Party Information (Spouse, Significant Other, Parent, Legal Guardian Etc.)

Name _____ Date _____

Gender _____ Date of Birth _____ Age _____ Marital Status _____

Address _____

City _____ State _____ Zip _____ Phone _____

Email _____ Referred By/Website _____

Highest Level of Education _____ Occupation _____ Sliding scale/Income _____

Emergency Contact Name _____ Number _____ Relationship _____

Payment Information (Credit Card)

Name as it appears on card _____Zip code (billing address) _____

Credit Card number _____ Exp Date _____/_____ Vcode _____

Your card will automatically be billed for each session & for cancellation fees (without 24-hour notice). Sign to accept:

Signature _____ Date _____

Background Information on Immediate Family Members (use back of sheet if space is needed)

Name	Relationship	Age	Living In Home Y/N

Have you had any treatment with a Neurofeedback coach, psychiatrist or therapist in the past? _____Yes _____No

If yes, name of psychiatrist/therapist/practitioner _____ Was it helpful? _____Yes _____No

Current Prescriptions/Medications _____

Religious Affiliation/Church _____ Do you want spiritual/religious issues to be a part of your therapy? _____Yes _____No

Briefly explain why you are seeking counseling _____

_____

Please describe any complaints associated with the problem _____

_____

When did the problem start? _____ How long do you think it will take to resolve the problem(s)? _____

What are your goals for therapy? _____

Are you currently at risk of harming yourself or someone else? _____Yes _____No _____Unsure

Have you attempted to harm yourself in the past? (Please list dates) _____

Following is a list of common obstacles that often lead people to seek counseling. Please check all that apply:

___Anxiety	___Communication	___Self Esteem	___Depression
___Addiction	___Grief	___Eating Problems	___Insomnia
___Alcohol	___Drugs	___Weight	___Stress
___Smoking	___Gambling	___Work Problems	___Shyness
___Relationships	___Sexuality	___Panic Attacks	___Guilt
___Phobia (Please List)	___Abuse	___Trauma	___Anger
___Suicide Attempts	___Suicidal Thoughts	___Self-Harm (Cutting)	___Pain
___Low Motivation	___Sexual Problems	___Social Withdrawal	___School

Is there a family history of any of the following? Please list family member in space provided (grandparent, father, sister, etc.)

_____Alcoholism _____Drug Use _____Depression _____Anxiety
_____Suicide _____Attempted Suicide _____Medical Problems _____Psychosis
_____OCD _____ Eating Disorder _____Domestic Violence _____Abuse

In the past 2 weeks have you engaged in any of the following?

___Alcohol Frequency_____ Your strengths _____

___Marijuana Frequency_____ Your weakness _____

___Drugs Frequency_____ Your pets & names _____

___Other _____ Frequency_____ Your hobbies _____

Explain how you cope with stress _____

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

Are you currently in a romantic relationship? _____ If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____ List any areas you would like to improve:

_____

_____

What stressful life events have you experienced recently? _____

Is there anything else you feel is important for me to know about you? _____

_____

HEALING WITH GRACE COUNSELING CENTER

Client Rights

1. You have the right to receive information concerning the methods of therapy employed, the techniques used, the duration of therapy and the fee structure for services provided. If services are not appropriate, referrals to other qualified professionals will be provided.
2. You have the right to refuse or terminate treatment at any time.
3. You have the right to seek a second opinion, if needed I can provide you with the names of other qualified professionals.
4. You have the right to know that in a professional psychotherapeutic relationship sexual intimacy between therapist and client is never appropriate.
5. Therapy is a professional relationship. It is extremely important that you and I both believe the relationship is the right fit in order to provide you with the greatest benefit possible. Because I value and appreciate your commitment to therapy, if at any time I believe you would more greatly benefit from seeking the services of another professional, I will inform you immediately and provide referrals.

_____Initials

Confidentiality

The therapeutic relationship is confidential and protected by ethical standards of practice and Nevada statutes. Any information obtained in the therapeutic setting cannot be released without your prior written consent except in the following situations according to Nevada State Regulations and HWG regulations:

a. Cases of suspected child or elder abuse or neglect.
b. Cases of potential harm to self or others or a need for immediate hospitalization – medical/mental health concerns
c. Cases of legal claims or defense required by state of federal law or court ordered by a judge.
d. Cases under investigation by a board of examiners as part of an investigation or hearing.
e. If you are under the age of 18 in the State of Nevada, parents have access to information in regard to their child's medical records.
f. HWG's clinical director and administration have access to information for supervision of interns and administrative purposes.

It is Healing with Grace Counseling Center and my therapist's policy to maintain confidentiality throughout the therapeutic process; therefore, my therapist will not acknowledge clients in a public area unless first approached by client.

_____Initials

Fees, Missed Appointments and Cancellation Policies

All sessions are 50 minutes long. The charge per session is _____ which is due at the time of service. Fees for in-person sessions can be paid with cash, check or major debit/credit card. Fees for teletherapy can be paid with major debit/credit card. We value your time and ask you to value ours. For the initial session, a $25 fee will be charged if cancellation is not given to your therapist within 24-hours of the session start time. After the initial session, your therapist allows one (1) free missed session PER YEAR without the 24-hour notice. Please give a 24-hour cancellation notice to avoid being charged a FULL SESSION FEE for subsequent missed appointments. _____Initials

Emergencies

I understand that my therapist is not a 24-hour crisis intervention provider. If I am faced with a mental health emergency, I agree to call 911 or go to my local emergency room.

_____Initials

Security

I understand that there are cameras facing the front and back doors to the center for surveillance for client and staff protection.

_____Initials

Insurance

I understand that Healing with Grace Counseling Center and my therapist does not accept insurance.

_____Initials

Documents, Letters & Reports

I understand there is an hourly fee of $75, with a minimum charge of one hour per request, for documents, letters or reports that I require from my therapist. Your therapist requires 10 business days' notice with a prepayment of fee. Prepayments are non-refundable and are valid for one (1) calendar year from date of payment.

_____Initials

Court Appearances

*Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that, should there be legal proceedings (such as, but not limited to divorce, custody disputes, injuries, lawsuits, etc.) neither you nor your attorney (s) nor anyone else acting on your behalf will call on Healing with Grace Counseling Center and/or any of its clinicians to testify in court or at any other proceeding, nor will a disclosure of records be requested or provided. By signing this document, you agree not to call Healing with Grace Counseling Center or its clinicians as a witness in any such litigation or any third-party matter or request records for such matter. Only court-appointed experts, investigators, or evaluators can make recommendations to the court on disputed issues. Should you encounter legal proceedings HWGCC clinicians will provide you with referrals for continued services. HWGCC Clinicians are not Court Involved Therapists (CIT) or Court Approved Therapists (CAT).

*Should a HWGCC clinician be subpoenaed or ordered by a judge in a court of law to appear as a witness in an action involving client(s), client(s) agrees to pay directly the HWGCC clinician for any time spent for preparation, travel, or other time in which the HWGCC clinician has made himself or herself available for such an appearance at the HWGCC clinician's usual and customary hourly rate of $450 per hour, paid in advance, for a minimum of eight (8) hours totaling $3600. Additionally, client will be responsible for any other fees incurred by HWGCC clinicians relative to the legal matter including but not limited to HWGCC attorney fees, consulting fees, etc.

*HWGCC clinicians do not engage with any third parties with the exception of other medical and/or mental health service providers that are identified as part of your treatment team and will only do so with a signed release of information.

*HWGCC clinicians do not complete legal forms including FMLA, Workman's Compensation, Disability, etc. I understand and agree with the above mentioned disclosure _____Initials

Teletherapy (Initial if this form of therapy may be utilized)

Though I do my best to protect your confidentiality of electronic messages, please note that I cannot guarantee confidentiality under circumstances that include use of Internet programs (Doxy.Me, VSee, Skype, Facetime), cellular phone or text message.
I understand that using this medium of teletherapy is not entirely secure. I will not hold Healing with Grace Counseling Center nor my therapist responsible should there be a breach in security on the Internet or phone. I understand that I am responsible for information security on my computer. _____Initials

I understand teletherapy services are not an appropriate treatment modality for everyone and should not continue if my therapist and I feel it is counter-productive. My therapist will suggest other options if needed. I understand that fees and cancellation policy is the same in teletherapy as in-person therapy. _____Initials

Electronic Communications

I authorize Healing with Grace Counseling Center and my therapist to send email and or text messages regarding appointments. _____Initials

I have read and fully understand the nature and limits of the above statements and agree to participate in counseling under these conditions.

Signature _____ Date _____

HIPPA Privacy Statement

I. Uses and Disclosure for Treatment, Payment, and Health Care Operations

Healing with Grace Counseling Center may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. We are required by law to maintain the privacy of health information and to provide you with our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the Revised Notice of Privacy Practices by sending you a copy in the mail upon request at your next appointment.

II. Uses and Disclosures Requiring Authorization
We may use of disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances, when we asked for information for purposes outside of treatment, payment, and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing psychotherapy notes. “Psychotherapy notes” are notes your therapist has made about your conversations during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent Nor Authorization.
We may use of disclose PHI without your consent or authorization in the following circumstances: (1) Child Abuse/Neglect; (2) Elder Abuse/Neglect; (3) Health Oversight (Nevada Licensing Board requesting records); (4) Judicial or Administrative Proceedings (Judge Court Order); (5) Serious Threat to Health or Safety to self or others; (6) Workers Compensation (if you file a claim)

Client Printed Name: _____

Signature: _____

(If a child or adolescent under age 18, parent or legal guardian must sign.)

RELEASE OF LIABILITY FOR COUNSELING SERVICES

FOR AND IN CONSIDERATION OF the receipt of information and counseling services from any of our therapists / practicioners providing services at ***Healing with Grace Counseling Center*** located at 2637 W. Horizon Ridge Suite 100, Henderson, NV 89052 (referred to as HWGCC hereafter), the undersigned, being legally competent and fully authorized and empowered to do so, does **hereby RELEASE, ACQUIT, AND FOREVER DISCHARGE HWGCC, ITS CLINCIAL DIRECTOR AND ALL PARTICIPATING COUNSELORS AND INDEPENDENT CONTRACTORS CONNECTED WITH HWGCC**, from any and all actions, courses of action, claims, demands, injuries, damages, costs, loss of service, expenses and compensation, on account of any and all known and unknown contracting of coronavirus, COVID-19 and/or any other virus/diseases related to the aforementioned "coronavirus" to any person or property resulting from or arising out of or related to counseling services and administrative services provided by HWGCC, its clinical director and/or independent contractors in any way affecting the undersigned parties from this date forward. The undersigned understands that by choosing to meet in-person for therapy at HWGCC's offices, when an alternative, free HIPAA compliant option for teletherapy has been offered to them, the undersigned understands that they are increasing their contact with others outside of their immediate household and increasing their risk of contracting COVID-19.

It is further understood and agreed that this waiver and release constitutes an admission and acknowledgment by this undersigned that they have received no warranty, guarantee, or promise that they are safe from contracting coronavirus and/or COVID-19 at HWGCC, the clinical director, its independent contractors or any other persons associated with HWGCC.

This release contains the entire agreement between the parties hereto, and the terms of this waiver and release are contractual and not mere recital. The undersigned further states they have carefully read the foregoing release, know the contents thereof, are fully competent, and sign the same as their own free act and deed.

_____ _____

Client's full written name Date

_____ _____

Client's signature Date

Consent to treatment: Licensed Intern

I am licensed by the State of Nevada as a Clinical Professional Counselor Intern (CPC). This means that I can work with you as a therapist under the supervision of my Clinical Director and my Primary Supervisor. These professionals are also bound under the same HIPAA confidentiality standards as I am. Under the supervision agreement, I may discuss client cases for professional consultation. The format of my supervision is both individual and group supervision with other licensed intern professionals. You may contact my supervisor at any time to discuss questions or concerns that you may have.

Supervisor's Name Christina Gaglione Supervisor's Number (702) 815-1550

Clinical Director's Name: Kana Nootenboom Clinical Director's Number (702)772-9552

- By signing this form, you acknowledge that my work as a clinician is supervised and I may discuss your case with my supervisors. This is to improve my therapeutic skills and provide the best level of care.
- By signing this form, you acknowledge that you have the right to change to a licensed clinician if you do not want to have your case discussed with an outside source.
- By signing this form, you acknowledge your rights as a consumer and that your case will be discussed in the strictest confidentiality unless one or more of the following criteria are met. Our therapeutic relationship is confidential except under the following conditions:

    a. If you threaten bodily harm or death to yourself or another person
    b. If you reveal information about physical abuse, sexual abuse, or neglect regarding a child or elderly person.
    c. If you are in court-ordered therapy.
    d. If a court of law issues a legitimate court-ordered subpoena by a judge or a judge breaks your confidentiality.
    e. If you are under the age of 18, in the State of Nevada, parents have access to information regarding their child's medical records.

Printed Name of Client: _____ Date: _____

Signature: _____

Parent or Guardian Name _____

Parent or Guardian's Signature_____
(If client is under the age of 18):