SCREENING/REQUEST FOR SERVICES

Last Name: _____ First Name: _____ MI: _____

What would you like to be called? _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Alt. Phone: _____ Best way to contact: ☐ phone ☐ mail ☐ txt

DOB: _____ Age: _____ Gender: ☐ Female ☐ Male SSN: _____

Ethnicity: _____ What language do you speak at home? _____

Have you been homeless at any time in the past 3 years? ☐ Yes ☐ No If yes, # of times: _____

Are you currently homeless? ☐ Yes ☐ No If yes, how long? _____

PERSON RESPONSIBLE FOR CARE/Emergency Contact

Last Name: _____ First Name: _____ MI: _____

Relationship to Patient: _____ Willing to participate in services? ☐ Yes ☐ No

Address (if different than above): _____ City: _____ State: _____ Zip: _____

Phone: _____ Alt. Phone: _____ Best way to contact: ☐ phone ☐ mail ☐ txt

If not available may we leave a message with others in the home or at that number? ☐ Yes ☐ No

REASON FOR REQUEST

Request for services prompted by any of the following? ☐ OJA ☐ DHS ☐ DA ☐ PO ☐ School ☐ Other: _____

What would you like help with (reason for seeking services/referral)? _____

_____

How long has this been a problem of concern for you and what is the past history of this problem if recurring? _____

_____

What are your immediate/urgent needs? _____

_____

Do you have current thoughts of harming yourself or others or engage in risk-taking behavior? ☐ Yes ☐ No If yes, please describe:_____

_____

What services and supports can we provide that would be most helpful to you? _____

_____

What type of service do you prefer (Check all that apply): ☐ Individual ☐ Family ☐ Group _____

What areas of your life or personal characteristics would you like to change/improve? What goals do you have for treatment?

_____

_____

How do you hope that services can help you and your family? _____

_____

MENTAL HEALTH SCREENING

Within the past 90 days (3 months) have you had a significant period in which you have experienced:

Hallucinations (seen, heard, or felt things others did not)?	☐ Yes	☐ No
Serious depression (sadness, hopelessness, change in appetite or sleep, loss of interest)?	☐ Yes	☐ No
Serious anxiety or tension (felt uptight, worried, and/or unable to relax)?	☐ Yes	☐ No
Trouble controlling violent behavior?	☐ Yes	☐ No
Thought of harming yourself?	☐ Yes	☐ No
Attempted suicide?	☐ Yes	☐ No
Being prescribed medication for psychological or emotional problems?	☐ Yes	☐ No
Difficulty getting along with parents, teachers, peers, or co-workers?	☐ Yes	☐ No
Feeling alone or concerned about your body or appearance?	☐ Yes	☐ No

SUBSTANCE ABUSE SCREENING

During the past 12 months have you:

Been pre-occupied with drinking alcohol and/or using other drugs?	☐ Yes	☐ No
Tried to stop drinking alcohol and/or using other drugs, but couldn't?	☐ Yes	☐ No
Had problems related to your alcohol or drug use but continued to use?	☐ Yes	☐ No
Found the need to use more alcohol or drugs to get the same effect you used to?	☐ Yes	☐ No
Used alcohol or other drugs more than you intended?	☐ Yes	☐ No
Used alcohol or other drugs to alter how you feel?	☐ Yes	☐ No
Gave up hobbies, interests, activities, and/or friends because of alcohol or other drug use?	☐ Yes	☐ No
Are you misusing any prescription or over-the-encounter medication?	☐ Yes	☐ No
Do you now or have you ever injected drugs using needles?	☐ Yes	☐ No

TRAUMA EXPERIENCES

During the past year (12 months) have you:

Experienced a traumatic event, natural disaster, war, accident, or loss of loved one?	☐ Yes	☐ No
Ever been afraid of your partner and/or a family member?	☐ Yes	☐ No
Ever been hit, slapped, kicked, or threatened by a family member or other adult?	☐ Yes	☐ No
Ever been seriously emotionally hurt by another person?	☐ Yes	☐ No
Ever been touched sexually or forced to have sex when you did not want to?	☐ Yes	☐ No
Ever witnessed domestic violence (adults in the home physically or verbally fighting)?	☐ Yes	☐ No
Do you feel that you were neglected as a child or are being neglected now?	☐ Yes	☐ No

If yes on any of the previous questions, please describe: _____

_____

_____

_____

_____

_____

BEHAVIORAL ASSESSMENT

EDUCATION AND WORK EXPERIENCES

Highest level of education completed: ____________________ Estimated Reading Grade Level: ______________________________

Do you currently have an IEP? ☐ Yes ☐ No Are you in any special education classes? ☐ Yes ☐ No

Do you have any learning disabilities? ☐ Yes ☐ No If yes, list? ____

Number of school absences in past 90 days: ________________ Number of school suspensions in past 90 days: _________________

Currently employed? ☐ Part-Time ☐ Full-Time ☐ Not Employed If employed, where? __________________________

Length of employment at last/current job: _________________ Longest time steadily employed: __________________________

Do other members of your family work? ☐ Yes ☐ No If yes, who and where: ____

FAMILY HISTORY

Present living arrangement: ☐ Alone ☐ Single Parent ☐ Two Parent ☐ Step-Parent & Parent ☐ Spouse/Significant Other

☐ Homeless ☐ Other Relative: ______________________________ ☐ Community Placement: ______________________

Total number staying in the home: ______________________________

		Relationship Status
Biological Mother: ____________________________________	Age: _____	☐ Very Good ☐ Good ☐ Fair ☐ Poor
Biological Father: ____________________________________	Age: _____	☐ Very Good ☐ Good ☐ Fair ☐ Poor
Step-mother: ____________________________________	Age: _____	☐ Very Good ☐ Good ☐ Fair ☐ Poor
Stepfather: ____________________________________	Age: _____	☐ Very Good ☐ Good ☐ Fair ☐ Poor

Other significant adults in your life prior to the age of 18:

____	☐ Very Good ☐ Good ☐ Fair ☐ Poor
____	☐ Very Good ☐ Good ☐ Fair ☐ Poor
____	☐ Very Good ☐ Good ☐ Fair ☐ Poor

Brothers & Sisters: ☐ N/A

Name	Age	
____	______	☐ Biological ☐ Step ☐ Half ☐ Adopted
____	______	☐ Biological ☐ Step ☐ Half ☐ Adopted
____	______	☐ Biological ☐ Step ☐ Half ☐ Adopted
____	______	☐ Biological ☐ Step ☐ Half ☐ Adopted
____	______	☐ Biological ☐ Step ☐ Half ☐ Adopted
____	______	☐ Biological ☐ Step ☐ Half ☐ Adopted
____	______	☐ Biological ☐ Step ☐ Half ☐ Adopted
____	______	☐ Biological ☐ Step ☐ Half ☐ Adopted

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: ______________________________________

How would you describe your cultural background (cultural orientation): _____

_____

Spiritual beliefs: _____

How would you like spirituality addressed during treatment? _____

HEALTH HISTORY

Current general health condition: ☐ Good ☐ Fair ☐ Poor Are you pregnant? ☐ Yes ☐ No ☐ N/A

Are your immunizations current? ☐ Yes ☐ No Referral needed? ☐ Yes ☐ No ☐ N/A Exercise regularly? ☐ Yes ☐ No

Are you currently under the care of a physician? ☐ Yes ☐ No If yes, describe: _____

_____

_____

Do you have any medication or food allergies or adverse reactions? ☐ Yes ☐ No

If yes, list: _____

Describe past and current medical problems, disabilities, or disorders (including prenatal issues): _____

_____

Describe ability to adjust to disabilities/disorders (including adherence to meds & treatment recommendations): _____

_____

Primary care physician: _____

Address: _____ Phone: _____

Preferred Hospital: _____

Address: _____ Phone: _____

Medications: List all medications currently prescribed and include all past mental health meds:

Medication	**Dosage**	**Effectiveness/Side effects**	**Prescribed for**	**How long taken**

SUBSTANCE USE HISTORY

Drug	**Method of Use**	**Frequency/Intensity**	**Last Used**	**Age of First Use**

Impact of substance use: _____

_____

Describe history of substance use for other family members: _____

_____

HISTORY OF TRAUMA

Has the person seeking services experienced any of the following (check all that apply):

Trauma	Yes	No	Victim	Perpetrator
Domestic violence	☐	☐	☐	☐
Physical Abuse	☐	☐	☐	☐
Emotional Abuse	☐	☐	☐	☐
Sexual Abuse	☐	☐	☐	☐
Neglect	☐	☐	N/A	N/A
Loss of family member or close friend	☐	☐	N/A	N/A
Witness to violent act or crime	☐	☐	N/A	N/A

If any box marked yes, provide details of trauma experience: _____

_____

_____

_____

_____

_____

TREATMENT HISTORY

Report all previous mental health, substance abuse, or trauma treatment:

Facility/Agency	Type of Services	Dates of Service	Diagnosis/Reason	Effectiveness
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you ever been diagnosed with a mental health or substance use disorder? ☐ Yes ☐ No

If yes, describe: _____

_____

_____

If medication was included in previous mental health/substance abuse treatment, describe your perception of current or previously used medication: _____

_____

_____

What do you need me to know right now?

INFORMED CONSENT/RELEASE OF CONFIDENTIAL INFORMATION

I UNDERSTAND THAT RECORDS ARE PROTECTED UNDER Federal and State Confidentially Law and Regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I/we hereby authorize J. ERIN EDMONDSON, M.A., LPC, LADCmh ( )to release to ( ) to receive from _____ the following information/records regarding: (Name of Client)_____, D.O.B. _____-_____-_____.

_____Social and Social Services Information (history & current)
_____Psychosocial/Psychological/ Diagnostic Evaluation Information (history & current)
_____Health & Drug Information, Including Immunizations (history & current)
_____Educational Evaluation/Planning, Including Related to Special Needs (history & current)
_____Mental Health Treatment, Planning and Treatment Progress Information (history & current)
_____Drug/Alcohol Abuse and Related Treatment Information (history & current)
_____Acknowledge the consumer is a client of Erin Edmondson/mutual clients.
_____All Records and Information

Period of time covered: _____ Purpose: Continuity of Care

The information authorized for release may include information which may indicate the presence of a communicable or venereal disease which may include, but is not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea, and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

Re: Psychiatric Records-Oklahoma State Law (76 O.D. Supp. 1986, Section 19) provides that psychological or psychiatric records may be provided to a Client if the treating physician or practitioner consents to the release or upon receipt of a court order, issued by a court of competent jurisdiction. Therefore, psychological or psychiatric records will not be released to Clients, their guardians or agents (including attorneys) except with the consent of the treating physician or upon receipt of a court order, issued by a court of competent jurisdiction.

Re: Drug/Alcohol Abuse Records-Confidentially of drug/alcohol abuse records is protected by Federal Law. Federal regulations (42CRF Part 2) prohibits making any further disclosure of this information unless further disclosure is expressively permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CRF Part 2. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol/drug abuse Clients.

I/we understand that I/we may revoke this consent at any time except to the extent those actions have been taken in reliance on it. This consent shall expire one (1) year from the date of my signature(s) or upon the following date: _____.

I/we do not authorize further release to any other party. I/we understand that the individual entities involved in providing services-and their employees, offices, and directors-cannot be responsible for confidentially of information disclosed after information has been released pursuant to this authorization, and I/we thereby release them from any liability arising from such disclosure.

This consent is being given freely and voluntarily; I understand that treatment services are not contingent upon or influenced by my decision to permit the release of information.

_____ _____
CLIENT DATE PARENT/GUARDIAN DATE

_____
PROVIDER DATE

CLIENT RIGHTS

The Client Rights below were taken from the Oklahoma Administrative Codes Title 450 Chapter 15 Client rights. Section 450: 15-3-27. Synopsis of the bill of rights.

A copy of the synopsis shall be prominently posted in each client treatment unit and in client admissions, visiting and public areas.

Programs providing treatment or services without the physical custody or detention of clients shall support and protect the fundamental human, civil, and constitutional rights of the individual client. Each client has the right to be treated with respect and dignity and will be provided the synopsis of the Bill of Rights as listed below.

1. Each client shall retain all rights, benefits, and privileges guaranteed by law except those lost through due process of law.

2. Each client has the right to receive services suited to his or her condition in a safe, sanitary and humane treatment environment regardless of race, religion, gender, ethnicity, age, degree of disability, handicapping condition or sexual orientation.

3. No client shall be neglected or sexually, physically, verbally, or otherwise abused.

4. Each client shall be provided with prompt, competent, and appropriate treatment; and an individualized treatment plan. A client shall participate in his or her treatment programs and may consent or refuse to consent to the proposed treatment. The right to consent or refuse to consent may be abridged for those clients adjudged incompetent by a court of competent jurisdiction and in emergency situations as defined by law. If the client permits, family shall be involved.

5. Every client's record shall be treated in a confidential manner.

6. No client shall be required to participate in any research project or medical experiment without his or her informed consent as defined by law. Refusal to participate shall not affect the services available to the client.

7. A client shall have the right to assert grievances with respect to an alleged infringement on his or her rights.

8. Each client has the right to request the opinion of an outside medical or psychiatric consultant at his or her own expense or a right to an internal consultation upon request at no expense.

9. No client shall be retaliated against or subjected to any adverse change of conditions or treatment because the client asserted his or her rights.

10. Client may choose to have a treatment advocate present through treatment planning and discharge planning as permitted by law.

_____ _____

CLIENT/GUARDIAN SIGNATURE DATE

_____ _____

PROVIDER SIGNATURE DATE

❒Client Bill of Rights provided in synopsis

❒Client Bill of Rights provided verbally

❒Full Client Bill of Rights provided in writing

OFFICE POLICY

As a participant of services with J. ERIN EDMONDSON, M.A., LPC, LADCmh, by my signature below, I agree to the following:

_____I agree to pay a fee of **$125** per 50/55-minute session (self-pay clients) or my co-pay if I am using insurance and I understand that payment is due at the time service is provided.

_____Cancellations or no-shows within the 24-hour window will be charged 50% to the full session rate depending on each situation. As a client, I agree to pay this fee and I understand that subsequent late cancellations or no shows may result in termination of services

_____I understand that missing three consecutive scheduled appointments can result in discharge. Payments are expected to be current. If you are more than three sessions behind, services will be suspended until an acceptable resolution is reached.

_____ I understand that the office follows **the Edmond Public School District's policy on inclement weather and holidays. If the district closes schools, the office will be closed as well. *Erin may or may not always contact you to confirm cancellation, so please be aware of this policy.**

_____I will notify my clinicians of any changes to my address or phone number.

_____I understand that Erin does not make recommendations to courts in domestic matters. If I am involved in litigation or in a custody battle, I agree not to ask Erin to testify. It is office policy not to testify in such cases because experience and research show that this the client-therapist relationship.

RATES

First Session (90791) 60-90 minutes $225
The first meeting is about information gathering. It is an opportunity to discuss responsibilities and goals and complete initial paperwork.
Individual and Family Sessions (90837) $125-$200
Individual sessions are usually scheduled for 55 minutes but can be scheduled for 85 minutes if needed or requested. Family sessions are usually scheduled for 85 minutes.
55-minute video counseling session (90837)- $125
Video sessions are always an option and are treated/billed the same as in-person.
No Show – Cancellation Fees – 50% to full rate.

PAYMENT
Payment is expected at the time of services unless other arrangements have been made. I accept cash, check and all major credit cards. Payment(s) and payment plans are setup via Square.

CLIENT ACKNOWLEDGEMENT OF RECEIPT

I have received copies of applicable documents at intake session which include all signature pages and licensure disclosure.

CLIENT (14 OVER)	DATE
GUARDIAN SIGNATURE	DATE
PROVIDER SIGNATURE	DATE

SOCIAL MEDIA POLICY

FRIENDING

I do not accept friend or contact requests from current or former clients on any social networking site such as Facebook or LinkedIn. I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

FACEBOOK

As of 2017, I deleted my Facebook Page after concluding that the potential risks of maintaining such a page outweigh any potential gains.

FOLLOWING

I intend to keep my website updated with current articles in the future and I post psychology news on Twitter. I have no expectation that you, as a client will want to follow either of these. However, if you use an easily recognizable name on Twitter and I happen to notice that you've followed me there, we may briefly discuss it and its potential impact on our working relationship. My primary concern is your privacy. No matter the form of media, note that I will never follow you back or look you up on social media. I believe casual viewing of clients' online content outside of the therapy hour can create confusion in regard to whether it's being done as a part of your treatment or to satisfy my personal curiosity. In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share with me, please bring them into our sessions where we can view and explore them together, during session.

INTERACTING

Please do not use messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact me. These sites are not secure and I may not read these messages in a timely fashion. Do not use Wall postings, @replies, or other means of engaging with me in public online if we have an already established client/therapist relationship. Engaging with me this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. The best way to contact me is email, phone or text (if you have agreed to policy) for any administrative issues such as changing appointment times. See the texting and email sections below for more information regarding messaging interactions.

TEXTING

Clients have asked me about texting and emailing as a way to communicate. It is important for you to know that electronic communication is not HIPPA compliant, messages could be recorded/stored by the cellular company mail service and anyone who has access to your electronics could potentially have access to the message. It should also be known that anyone who has access could send me a message and I will assume it is you. By signing this document, you are acknowledging that I will only respond to a message that you initiate unless it is an appointment reminder or informational in nature.

I utilize my work cell phone actively in my practice both for calls and texting. As such, I will save client numbers (first names last initial) for convenience. HIPAA guidelines require that I inform you of this and, as noted above, that I also inform you it may not be as secure as other forms of communication. If you are uncomfortable with this, please let me know and I will not save your number. Although I allow for texting and calling outside of session, please do not rely on this method of communication in an emergency situation as I am not on call and do not have an on-call service. **If you are experiencing a mental health emergency, please contact 911 or go to the nearest emergency room**.

EMAIL

Generally speaking, I try to keep email strictly for arranging and modification of appointments. Please do not email me content related to your therapy sessions as email is not completely secure or confidential even though I utilize a HIPAA compliant service. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails I receive from you and any responses that I send to you become a part of your legal record.

SEARCH ENGINES

It is NOT a regular part of my practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions may be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone, or email) there might be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if I ever resort to such means, I will fully document it and discuss it with you when we next meet.

BUSINESS REVIEWS

You may find my psychology practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client.

The American Psychological Association's Ethics Code states under Principle 5.05 that it is unethical to solicit testimonials: "do not solicit testimonials from current therapy clients/patients or other persons who because of their particular circumstances are vulnerable to undue influence." Of course, you have a right to express yourself on any site you wish. But due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. I urge you to take your own privacy as seriously as I take my commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with me about your feelings about our work, there is a good possibility that I may never see it. If we are working together, I hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. None of this is meant to keep you from sharing that you are in therapy with me wherever and with whomever you like. Confidentiality means that I cannot tell people that you are my client and my Ethics Code prohibits me from requesting testimonials. You are more than welcome to tell anyone you wish that I'm your therapist or how you feel about the treatment I provided to you, in any forum of your choosing. If you do choose to write something on a business review site, I hope you will keep in mind that you may be sharing personally revealing information in a public forum. I urge you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection. If you feel I have done something harmful or unethical and you do not feel comfortable discussing it with me, you can always contact the Board of Psychology, which oversees licensing, and they will review the services I have provided.

LOCATION-BASED SERVICES

If you used location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. I do not place my practice as a check-in location on various sites such as Foursquare, Gowalla, Loopt, etc. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at my office on a weekly basis. Please be aware of this risk if you are intentionally "checking in," from my physical office or if you have a passive LBS app enabled on your phone.

CONCLUSION

While this document outlines my policies related to the use of social media, it is logical to assume it will adapt as technology does. Should something change, I will notify you in writing and by updating the policy on my website. If you have any questions about this policy, I encourage you to bring them up when we meet.

Please initial your choices:

It is okay to save my contact information to your phone: _____Yes _____No

Please indicate below the methods by which you would like to communicate with me. You may request another form and change these preferences at any time.

The best (parent/guardian) number/email is: _____

_____

The best (minor child's) number/email is: _____

_____

Please read and initial your understanding:

_____*In an emergency situation, I will call 911 or go to my nearest emergency room*

_____I understand that I should not use texting as a means of contact in a crisis.

My signature below indicates my understanding of the policies provided for interaction via digital and social media.

_____ _____
CLIENT (14 OVER) DATE

_____ _____
GUARDIAN SIGNATURE DATE

_____ _____
PROVIDER SIGNATURE DATE