

Client-Therapist Agreement

Welcome to Transitions Therapeutic Services. As a first step toward receiving services here, you will meet with a licensed therapist for an intake interview. This meeting is used to discuss your needs and to decide how our different programs can be of service to you.

Confidentiality:

If it is agreed that ongoing counseling would be best, you will be seen on a weekly or bi-weekly basis (or as needed) by a therapist within the organization. There will be no telephone sessions, or sessions over the internet provided. All information provided during the intake, and any future sessions attended, is voluntary. What you choose to share will be kept in strict confidence and will not be released to another person or agency without your written permission. Exceptions to this rule may apply in cases where there is imminent danger to you or others or when past or present child/adult abuse is reported. Your case may be discussed with another licensed therapist within/or affiliated with the organization to ensure that you receive the highest quality of service. The provisions of confidentiality are binding regardless of whom you see.

Fee Schedule:

Transitions Therapeutic Services accepts insurance on a limited basis. Medicaid and EAP services are also accepted. The fees are \$150 for an initial intake interview, \$80 for each subsequent session for individual, \$100 couple/marriage, \$100 family counseling; and \$45 for group sessions. Fees will be collected at the beginning of each session. There is a \$25 fee for all returned checks. A sliding fee scale is available for individuals who do not have the means or financial resources to pay these fees; however, adequate proof of income and/or financial obligations is required to qualify for a reduced fee. Also, sliding fee scaled payments are reassessed every six months with the therapist, and a renegotiation of fees is expected upon the change of a client’s financial status. Consistent attendance at this and future appointments is emphasized. Clients will be charged a full session’s fee for “no shows” or less than 24 hours advance notice of cancellation (unforeseen emergencies are the only exceptions to this policy).

Urgencies and Emergencies:

If it is important that you reach me on an urgent matter, please call me at 240-687-0890. If I do not answer, your call will be sent directly to my voice mail. If you leave a message on my voice mail, I will automatically be paged and I will respond as soon as possible. If your matter is an emergency, please dial 911.

Termination:

You have the right to either terminate therapy or request referral to another therapist at any time. If you are considering either possibility, it is important that you discuss that decision in the therapy session.

I have read and understand the above information. I understand that if for any reason my insurance company does not pay any portion of my bill it will be my responsibility to pay it and I will do so in a timely manner and not more than 60 days from notification by the insurance company of nonpayment. I have received a copy of this document and I agree to abide by the terms set forth herein. Your signature below indicates your informed consent for professional services provided by Transitions Therapeutic Services:

Client’s Signature: _____ Date: _____

Today's Date: _____ Referred by: _____

Name: _____
Last First MI Maiden Name

Address: _____
Street City State Zip Email Address

Telephone: _____
Work Home Cellular Pager

Birth Date: _____ Age: _____ Gender: _____ Social Security#: _____

Marital Status: _____ Racial/Ethnic Background: _____
married/single/separated/divorced/widowed Black/White/Hispanic/Asian/Native Am./Other

Education/Training: _____
Highest level obtained/Year

Employer: _____ How Long? _____ Occupation: _____

Employer's Address: _____
Street City State Zip

Emergency Contact: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION

(Please give us your insurance information even if you are here on an Employee Assistance Plan)

If your insurance company requires prior authorization, have you obtained it? Yes _____ No _____ Not Required _____
authorization code

Insurance Company: _____ Phone: _____

Address: _____
Street City State Zip

Policy Holder: _____ Birth Date: _____ Relationship to Client: _____

Employer: _____ Group Number: _____ ID Number: _____

Secondary Insurance: _____ Phone: _____

Address: _____
Street City State Zip

ID Number: _____ Group Number: _____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE (Required): I authorize the release of any medical or other information necessary to process a claim. I authorize payment of medical benefits to the provider of services. I accept responsibility for paying any amount not covered by insurance.

Signed: _____ Date: _____

Symptoms Check any symptoms that you are having/or have had recently:

Thoughts/Feelings Mood

- | | | |
|---|---|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Sudden mood changes | <input type="checkbox"/> Difficulty with attention and concentration |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Obsessive thoughts | <input type="checkbox"/> Suspicious (distrustful) |
| <input type="checkbox"/> Sadness | <input type="checkbox"/> Thought of hurting yourself | <input type="checkbox"/> See things other people don't |
| <input type="checkbox"/> Fear | <input type="checkbox"/> Legal worries/problems | <input type="checkbox"/> Feeling of hopelessness |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Hear things other people don't | <input type="checkbox"/> Paranoid thoughts |
| <input type="checkbox"/> High Energy | <input type="checkbox"/> Thoughts of hurting others | <input type="checkbox"/> Thoughts of killing yourself |
| <input type="checkbox"/> Financial stress | <input type="checkbox"/> Excessive worry/stress | <input type="checkbox"/> Thoughts of killing others |
| <input type="checkbox"/> Intrusive thoughts | <input type="checkbox"/> Negative thoughts | <input type="checkbox"/> Trouble concentrating |
| <input type="checkbox"/> Anger/frustration | <input type="checkbox"/> Confusion | <input type="checkbox"/> Self-esteem problems |
| <input type="checkbox"/> Not liking self | <input type="checkbox"/> Memory difficulties | |

Behaviors

- | | | |
|---|---|--|
| <input type="checkbox"/> Compulsive behaviors | <input type="checkbox"/> Stealing | <input type="checkbox"/> Lack of energy |
| <input type="checkbox"/> Difficulty with daily routine | <input type="checkbox"/> Avoidant | <input type="checkbox"/> Gender issues |
| <input type="checkbox"/> Let others take advantage of you | <input type="checkbox"/> Controlling | <input type="checkbox"/> Extreme sadness |
| <input type="checkbox"/> Using alcohol/drugs to cope | <input type="checkbox"/> Argumentative | <input type="checkbox"/> Feeling stressed |
| <input type="checkbox"/> Dependency upon others | <input type="checkbox"/> Decreased/lack of sexual interest | <input type="checkbox"/> Easily irritated |
| <input type="checkbox"/> Angry/Hostile | <input type="checkbox"/> Preoccupation with sex | <input type="checkbox"/> Feeling guilty |
| <input type="checkbox"/> Withdrawal from others | <input type="checkbox"/> Lack of enjoyment of usual activities | <input type="checkbox"/> Feeling stressed |
| <input type="checkbox"/> Self destructive | <input type="checkbox"/> Change in sleeping habits | <input type="checkbox"/> Perfectionism |
| <input type="checkbox"/> Abuse of others | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Reckless behavior |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Not getting along with family or friends | <input type="checkbox"/> Suicide attempts |
| <input type="checkbox"/> Not able to relax | <input type="checkbox"/> Increased use of alcohol/drugs | <input type="checkbox"/> Crying spells |
| <input type="checkbox"/> Lying | | <input type="checkbox"/> Acting violently |

Experience in Workplace

- | | | |
|---|---|--|
| <input type="checkbox"/> Pattern of tardiness | <input type="checkbox"/> General satisfaction | <input type="checkbox"/> Difficulty with coworkers |
| <input type="checkbox"/> Absenteeism | <input type="checkbox"/> Negative feelings about work | <input type="checkbox"/> History of work problems |
| <input type="checkbox"/> Decreased work performance | <input type="checkbox"/> Difficulty with supervision | <input type="checkbox"/> Trouble performing your job |

Physical Functioning

- | | | |
|--|--|--|
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Hyperventilation | <input type="checkbox"/> Sleep disturbance |
| <input type="checkbox"/> Stomach or bowel problems | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Appetite disturbance |
| <input type="checkbox"/> Abdominal pain/vomiting | <input type="checkbox"/> Easily fatigued | <input type="checkbox"/> Weight changes/problems |
| <input type="checkbox"/> Changes in urinary patterns | <input type="checkbox"/> Back pain | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Changes in menstrual cycle | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Chronic weakness |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Hearing/vision problems | <input type="checkbox"/> Shakiness/trembling | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Sweating | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Muscle tension/aches |

Goals for Therapy

What are your goals for treatment?

1. _____
2. _____
3. _____
4. _____
5. _____

What medical health problems do you have? (Please explain)

Do you have any allergies (e.g. prescription meds, over-the-counter meds, other things)? Yes No

What are you allergic to and what kind of reaction do you have?

Have you seen a doctor within the past year? Yes No

Name of Doctor	Phone	Purpose of Visit

Are you taking any medication (Prescription, over-the-counter or herbal remedy)? Yes No

Medication	Purpose	Dosage	Start Date	Prescribed By

SUBSTANCE USE HISTORY

Have you every used tobacco in any form? Yes No

(Please describe the history and current pattern of your tobacco use)

Have you ever used alcohol? Yes No

(Please describe the history and current pattern of your alcohol use)

Have you ever used caffeine (any form, including cola drinks)? Yes No

(Please describe the history and current pattern of your caffeine use.)

Have you ever used illegal drugs of any kind? Yes No

(Please describe the history and current pattern of your drug use including which drugs)