Counseling is a cooperative venture with responsibility resting on both the counselor and the client. In order to enable you and your counselor to work most effectively together, we ask that you carefully read the information below. If you have any questions, your counselor will be happy to discuss them with you.

East-West Psychotherapy exists to provide counseling from a Christian perspective for individuals, couples, families, and groups. The Center’s services are available to residents of the community regardless of religious affiliation.

_______ (initial) **CONFIDENTIALITY:**
The Health Insurance Portability and Accountability Act (HIPPA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the “medical records privacy law,” HIPPA provides patient protections related to the electronic transmission of data, the keeping and use of patient records, and storage and access to health care records. HIPPA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. An explanation of those rights is attached to this document.

Communications between client and counselor are confidential and will not be revealed unless required by law such as in situations of child abuse or threats of physical harm to self or others or subpoena of a court. If your clinician is unlicensed, communications with your counselor are not protected by privilege which means that they may be subject to subpoena by the courts should litigation be brought against you. If you believe that you may need the testimony of a counselor in a court of law, a licensed mental health professional would be an appropriate choice.

Your counselor will be discreet if it is necessary to contact you at home or at work. If you have a specific number that is best for contact please let your counselor know.

_______ (initial) **COUNSELING FEES:**
The nominal fee for counseling sessions will be determined by your individual counselor. We ask that your account be kept current and that payment be made prior to beginning each session. Should the fee not be paid for two sessions, no further sessions will be scheduled until the balance is paid. A charge of $25.00 will be made for returned checks plus the amount of the unpaid session.

_______ (initial) **INSURANCE:**
Our individual counselors participate in a variety of payment forms. Please discuss your method of payment with your counselor.

_______ (initial) **CANCELLATION OF APPOINTMENTS:**
Your appointment time is important to you, to your therapist, and to others who are in need of therapy. If you must cancel your appointment, please phone your counselor and leave a message on their voicemail at least 24 hours in advance of your scheduled appointment. A charge of $75.00 will be made for the time reserved when cancellations are received less than 24 hours in advance, except in case of illness or emergency. You are personally responsible for this charge and all future appointments may be cancelled until this fee is paid.

_______ (initial) **TELEPHONE CALLS:**
Should you need to contact your counselor, you may leave a message on their provided phone number. All calls that are over 15 minutes in length, your counselor may ask if you would like to schedule a session or continue the telephone call for your nominal fee for a 50-minute session.

_______ (initial) **EMERGENCY PROCEDURES:**
If you have an emergency, you will need to contact either a hospital emergency room or the police depending on the situation. If you feel your life or someone else’s is in danger call 911.

I have read the above information and voluntarily request counseling services at East-West Psychotherapy Associates, and I agree with these terms and conditions*

Signature_______________________________________________ Date_________________________

*The signature of the custodial parent or guardian is required for clients under 18 years of age.
The Health Insurance Portability and Accountability Act (HIPPA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the “medical records privacy law,” HIPAA provides patient protections related to the electronic transmission of data (“the transaction rules”), the keeping and use of patient records (“privacy rules”), and storage and access to health care records (“security rules”). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPPA law and regulations are extremely detailed and difficult to grasp if you don’t have formal legal training. This Patient Notification of Privacy Rights is our attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document, as it is important you know what patient protections HIPPA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship, and as such, you will find we make every effort to do all we can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask for further clarification.

By law, East-West Psychotherapy is required to secure your signature indicating you have received a copy of the Patient Notification of Privacy Rights document.

East-West Psychotherapy Associates
HIPAA Compliance Officer

Patient Name (print) ______________________________________________________________________

I have received a copy of the East-West Psychotherapy Associates Patient Notification of Privacy Rights document, which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand that I have the right to review this document and that I may at any time now or later, ask any questions about or seek clarification of the matters discussed in this document. Signing below indicates only that I have received a copy.

___________________________________________
Patient Signature

____________________________
Date

___________________________________________
Patient Signature if patient is a Minor

____________________________
Date

___________________________________________
Guardian Signature if patient is Legal Charge

____________________________
Date
The following form, which will become a part of your confidential record, will enable us to gain a quicker understanding of you. Please answer each question as completely and carefully as you can. You may use the back of any page for additional comments.

Name: _________________________________ Date of Birth: ____________________________ Age: ___________ Sex: _________

Present Address: _____________________________________________________________________________________________
___________________________________________________________________________________________________________
Street
___________________________________________________________________________________________________________
City / State                                                                                                                         Zip

Phone: _________________________________ Email: _________________________________ Ethnicity: _____________________

Years of Education: _______ Referred by: ________________________________________________________________________

Marital Status: Single _______ Married _______ (# of Years _______ ) Divorced _______ Separated _______

Presently Living With: Parents _____ Spouse _____ Roommate _____ Alone _____ Other _________________________________

Occupation: ____________________________________________________________ Total Hours/Week ______________________

Employed by: ____________________________________________ Phone: _______________________________

Religious Affiliation: _______________________________________ Church: _______________________________

Are you a member? Yes _______ No _______ Active _______ Inactive _______

Family member to notify in case of emergency: Name: _________________________________________________

Address: ________________________________________________ Phone: _____________________________

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<table>
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<tr>
<th>Relationship</th>
<th>Name</th>
<th>Age</th>
<th>Grade in School Last Completed</th>
<th>Occupation if Out of School</th>
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<tbody>
<tr>
<td>Spouse</td>
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<tr>
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<tr>
<td>Children</td>
<td></td>
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</table>

Describe any physical problems you have that require medication or physical care: __________________________________________________________

__________________________________________________________________________________________________________________________________________

Are you currently receiving medical treatment? Yes_______ No ________

When did you last consult with your primary care physician? __________________________________________________________

Are you currently taking any prescription medications? Yes ________ No ________ If yes, please list by name and dosage:

__________________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________________

Previous Counseling/Therapy Yes ________ No ________ If yes, when?

With whom? Name __________________________ Address: __________________________
Briefly describe the problem which prompted you to seek counseling at this time:

_________________________________________________________________________________________________________
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________

Have there been times when the problem got better or disappeared? Yes_______ No ________

If yes, when? ____________________________________________________________

What do you think helped? _________________________________________________
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________

Were there times when the problems were especially bad? Yes ________ No ________

If yes, when? ____________________________________________________________

What made it bad? _________________________________________________________
_________________________________________________________________________________________________________

Are there other people who play a major role in causing your problems or in helping you cope with your problems?
Yes ________ No ________

Explain briefly: ___________________________________________________________
_________________________________________________________________________________________________________

Is there anything else that you believe might be important for your counselor to know at this time? ______________________________
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________

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Using the scale below, please choose a number that reflects the extent of your concern about each of the issues listed below. Please rate every item.

<table>
<thead>
<tr>
<th>No Concern</th>
<th>Moderate Concern</th>
<th>Extreme Concern</th>
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<tr>
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<td>8</td>
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<tr>
<td>9</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

- _____ Anger
- _____ Depression
- _____ Education
- _____ Eating Difficulties
- _____ Fearfulness
- _____ Nervousness
- _____ Financial Problems
- _____ Marital Problems
- _____ Physical Problems
- _____ Problems with social relationships
- _____ Problems with children
- _____ Problems with parents
- _____ Religious/Spiritual Concerns
- _____ Sexual Concerns
- _____ Thoughts of Suicide
- _____ Trouble Making Decisions
- _____ Unhappy Most of the Time
- _____ Use of Alcohol
- _____ Use of Alcohol by Family Member
- _____ Use of Other Drugs
- _____ Work
- _____ Worry
- _____ Other (specify) ____________________

I have read the East-West Psychotherapy Associates information sheet and voluntarily request counseling services at East-West Psychotherapy in accord with the terms described on the information sheet.

___________________________________________  __________________
Patient Signature                      Date

For clients age 17 and under, the signature of his/her guardian or custodial parent is required.

___________________________________________  __________________
Guardian Signature if patient is Legal Charge  Date

PLEASE SUBMIT PAYMENT WITH THIS FORM PRIOR TO FIRST SESSION
PLEASE COMPLETE THE FOLLOWING:

1. The most important thing to me is

2. I worry about

3. What I do best is

4. I have sometimes felt guilty about

5. What makes me angry is

6. My biggest mistakes were

7. My job

8. My personality would be better if

9. I often felt that mother

10. My temper

11. My childhood

12. My biggest disappointment

13. To me, sex is

14. I would be better liked if

15. I often felt that father

16. My children (child) (brothers and sisters)

17. Women are

18. What hurts me most is

19. My biggest problem in life is

20. Men are