

Briefly indicate your reasons for seeking services at this time:

What led you to choose to call our clinic?

How long do you think therapy should last? _____

Check all the words that describe how you are feeling about beginning the therapy experience:

- | | |
|---|---|
| <input type="checkbox"/> Nervous | <input type="checkbox"/> Pressured by someone |
| <input type="checkbox"/> Hopeful | <input type="checkbox"/> Open |
| <input type="checkbox"/> Skeptical | <input type="checkbox"/> Angry |
| <input type="checkbox"/> Very committed | <input type="checkbox"/> Excited |

What questions do you have about any aspects of the therapy experience?

How do you hope things will be different for you after counseling? (Be as specific as possible.)

Description of your household:

Name (List Yourself)	Age	Sex	Relationship	Employment
			Self	

Have you been in therapy before, or have you received any prior professional assistance? If so, please give the following information about the professional(s) who have helped you.

- **Name & Professional Title** _____
Organization & Address _____
Approximate dates of treatment _____
Problems for which you sought treatment, and results _____

- **Name & Professional Title** _____
Organization & Address _____
Approximate dates of treatment _____
Problems for which you sought treatment, and results _____

FEES AGREEMENT
THE HOPE CENTER
206 South 28th Avenue
Hattiesburg, MS 39402
601-264-0890

1. I, _____, understand that fees for services are as follows:

Dr. Smallwood:

Krystal Draughn, LCSW
Thomas Pough, MS, LPC:

\$160.00	1 diagnostic hour	\$140.00	1 diagnostic hour
\$145.00	1 hour	\$120.00	1 hour
\$131.00	¾ hour	\$108.00	¾ hour
\$ 87.00	½ hour	\$ 72.00	½ hour
\$ 44.00	¼ hour	\$ 36.00	¼ hour

2. I understand that a therapeutic hour is 50 minutes. This allows your therapist time to complete documentation and schedule your next appointment. This is standard practice in the mental health profession.
3. These fees apply to therapy sessions, telephone consultations, records review, consultations with lawyers and other professionals, and letter/report preparation.
4. I also understand that payment for outpatient services is **DUE AT THE TIME SERVICES ARE RENDERED**. I further understand that insurance is a method of reimbursement to me for my payment to the clinic and is not considered a substitute for payment. Should I wish to file insurance, I understand that I will be given the proper forms so that I may collect for covered services.
5. I hereby give my consent to release pertinent information (i.e., diagnosis codes, procedure codes, summary of treatment, etc.) to my insurance company or managed care company, should they request it.
6. I further understand that I will be charged full fee for any missed appointment should I fail to cancel my appointment at least one business day in advance (i.e., I must cancel Monday appointments by 5 p.m. the preceding Friday; and Tuesday through Friday appointments must be canceled 24 hours in advance). I also understand that I will be charged for any portion of time spent in therapy over my scheduled session length. In addition, any phone calls in excess of 15 minutes will be charged accordingly, at quarter-hour increments.
7. I am aware that some psychological testing may be necessary for treatment, and that fees for such testing are available upon request and will be discussed with me by my therapist.
8. I further understand that if my account should become delinquent, legal action for collection may be undertaken. I hereby give my consent to release necessary information, that is, name, address, account number, phone numbers, amount due, action taken to date, place of employment, for taking such action.

Signature of client or legal guardian _____

Signature of witness _____

Date _____

Checklist of Current Problems

The following section is designed to help you describe your current problems in greater detail and to identify problems that might otherwise go unnoticed. This will help us design your treatment experience and to tailor it to your specific needs. Please check the behaviors/symptoms/feelings that you have experienced in the past three months. Please write in any details which may be helpful.

Name _____ Date _____

- Depression
- Appetite disturbance (Up or down?)
- Weight gain or loss (Circle one, then, write in number of pounds)
- Sleep disturbance (Too much or too little? Describe hours/times of sleep)
- Low energy level/fatigue
- Feelings of inadequacy/low self-esteem
- Decreased effectiveness/productivity
- Difficulty concentrating
- Withdrawal from people
- Loss of interest and pleasure in things you usually enjoy
- Irritability/anger (Toward whom?)
- Difficulty responding positively to praise or reward
- Less active than usual
- Less talkative than usual
- Pessimistic attitude about the future
- Brooding about the past

- Feeling sorry for yourself**
- Crying/tearfulness**
- Excessive guilt**
- Recurrent thoughts of death or suicide**
- Plan for suicide**
- Recurrent thoughts of hurting someone else**
- Plan for hurting someone else**
- Fears/phobias (describe)**
- Panic attacks or anxiety**
- Problems with breathing**
- Heart racing or unusual heartbeat**
- Chest pain or discomfort**
- Dizziness or unsteady feelings**
- Feeling as if things around you aren't real**
- Tingling in hands**
- Tingling in feet**
- Hot flashes**
- Cold flashes**
- Fear of dying**
- Fear of going crazy**
- Fear of doing something uncontrollable**
- Excessive worrying**
- Thoughts that go over and over in your mind**
- Behaviors you do over and over, like a "ritual"**

The following questions relate to past trauma. Please respond accordingly if you have experienced a past trauma in your life.

Past trauma (describe and give approximate dates):

When past trauma has been experienced, respond to the following:

- Recurrent distressing memories of the event**
- Recurrent distressing dreams of the event or about some aspect or feeling of the experience**
- Acting or feeling as if the event were actually recurring**
- Intense distress when something “brings back the event”—either a situation that you encounter or your own thoughts**
- Physical stress reactions (e.g., perspiration, increased heart rate, change in breathing) when you are exposed to something that reminds you of the traumatic event**
- Efforts to avoid thinking about, feeling, or talking about the trauma**
- Efforts to avoid places, activities, or people that bring back memories of the trauma**
- Inability to remember an important part of the trauma**
- Decreased interest or participation in significant activities**
- Feeling detached, different from, far removed from others**
- Restricted feelings (e.g., unable to have loving feelings)**
- Difficulty seeing a good future ahead (e.g., not expecting to have a career, marriage, children, normal life span)**

- Difficulty falling/staying asleep**
- Irritability/outbursts of anger**
- Concentration problems**
- Heightened caution; “looking over your shoulder”**
- Easily startled**
- Seeing things others don’t see**
- Hearing things others don’t hear**
- Strong feelings of being controlled by others**
- Difficulty standing up for yourself**
- Difficulty saying no**
- Difficulty expressing negative feelings**
- Concerns over body/weight**
- Overeating/binging**
- Vomiting**
- Regular use or overuse of laxatives**
- Drinking too much (Please describe your drinking patterns, how much, how often, in what situations?):** _____

- Use of non-prescription mood-altering drugs (Please describe what drugs, how often, in what situations?)** _____

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- Working too hard**
 - Procrastination**
 - Loss of control (Describe.)**
 - Difficulty keeping a job**
 - Aggressive behavior**

CLIENT'S RIGHTS AND RESPONSIBILITIES

IMPORTANT-PLEASE READ!

The Hope Center
206 South 28th Avenue
Hattiesburg, MS 39402
Phone (601) 264-0890

To be an effective consumer of psychological services, it is important that you know about your rights and responsibilities and about our obligations to you. Please read this statement carefully before signing the "Client Information Form," and discuss any questions with your therapist.

OUR COMMITMENT TO YOU:

We are dedicated to providing quality counseling, testing, and consulting services. We work hard to assure that each client receives competent, considerate, prompt, and respectful services regardless of race, ethnic background, religion, sex, age, sexual or affectional preference, or disability. When necessary, and with your written permission, we consult with other specialists, and we may refer you to additional sources of help.

We welcome you, your questions, and your concerns. Our administrative policies are set up to allow us to work smoothly and efficiently. We welcome your feedback as to how they work for you.

RIGHTS

When you become our client, you have the rights to:

1. **Confidentiality:** It is our policy to respect your privacy and to protect the confidentiality of your relationship with us. It is also our policy to inform you of the limits we have in protecting this right to confidential care. Some limitations are imposed by state statute and others come from the ethical standards for therapists. They are:
 - A. Ethical standards encourage therapists to confer with other professionals when helpful and appropriate, provided you have signed a written release of information.
 - B. We are obligated by law to inform relevant parties when there is a clear and imminent danger to an individual or to society. We also must report to appropriate authorities when there is evidence of child abuse or abuse of vulnerable adult.
 - C. By law we must comply when ordered by court to supply records.
 - D. Parents (including non-custodial parents) have the legal right to information concerning a minor child. However, from a therapeutic standpoint, it is important for the child or adolescent to develop a trusting relationship with the therapist. Therefore, we request that parents grant the child's confidentiality subject to the above limitations. We will, of course, consult with the parents regarding their involvement in the treatment process.
 - E. Except in the circumstances outlined in A, B, and C above, we will not release to others any information regarding you and/or our services to you unless you request and authorize its release with your signature. We encourage you to discuss any questions you may have about confidentiality or release of information with your therapist.

- 2. ***Cost of Services Information:*** You have the right to be informed of the cost of professional services before receiving the services. This is described in the Fees Agreement.
- 3. ***Informed Consent:*** As our client, you have the right to know the nature of our services you are receiving. In the first session, you and your therapist will discuss goals and design a plan to meet your needs. We encourage you to be active in those discussions.

YOUR RESPONSIBILITIES

- 1. You are responsible for supplying accurate and complete information about yourself: your problems and their history, your past illnesses, previous counseling, medication, and family and work history when appropriate.
- 2. You are responsible for honoring your financial agreement with us. Fees for groups, workshops, and organizational consultation are negotiated on a situation-by-situation basis. Our clinic operates on a *cash check, or credit card basis*. You must make payment each time you receive services.
Psychological services are covered under many health insurance plans. We advise that you check your insurance policy or the benefits department at your place of employment to confirm that you do, indeed, have such coverage. Your service ticket, given to you upon each visit, will provide all of the information you will need so that you can process your claims. Insurance is considered a method of reimbursing the fees paid to the therapist, not as a substitute for payment.
- 3. You are responsible for keeping appointments. *Missed appointments, except in emergencies, will be billed at the normal rate.* To avoid billing, you must cancel one business day prior to your appointment; that is, you must cancel Monday appointments before 5 p.m. the preceding Friday, and Tuesday through Friday appointments must be canceled at least 24 hours in advance. You may cancel by calling (601) 264-0890. We are also available at this number to answer your questions.

If any of these rights and responsibilities seem unclear to you, please feel free to ask your therapist for clarification. We look forward to working with you!

Date

Signature of Client