

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
 \$145.00 1 hour
 \$131.00 ¾ hour
 \$ 87.00 ½ hour
 \$ 44.00 ¼ hour

\$140.00 1 diagnostic hour
 \$120.00 1 hour
 \$108.00 ¾ hour
 \$ 72.00 ½ 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 _____

PARENTAL CONSENT FORM

I (We) hereby give my (our) consent for psychological treatment for my (our) minor child at The Hope Center. I (We) understand that, as an adjunct to my (our) child's treatment at The Hope Center, I (we) may be asked to participate in treatment.

I (We) understand that I (we) retain responsibility for my (our) child while he/she is in treatment at The Hope Center. I (We) understand that in the event of an emergency situation, as determined by the staff of The Hope Center, I (we) am expected to respond promptly to requests for assistance from the staff. I (We) understand and agree that should I (we) be unable, for any reason, to respond to such a request, The Hope Center should and will take whatever steps the staff deems necessary and appropriate to resolve the situation.

I (We) understand that, in situations where relevant, the non-custodial parent has legal access to clinical records of The Hope Center, without the custodial parent's consent. I (We) understand that records previously held by The Hope Center are subject to this release policy.

Name of Minor
Date

Signature of Parent or Guardian
Date

Signature of Parent or Guardian
Date

Witness
Date

CHILD PRE-COUNSELING QUESTIONNAIRE
(To be completed by parent or primary caregiver)

Child's Name _____

Person Completing Form _____

Relationship to child _____

We are looking forward to working in partnership with you to address the problems your child has been experiencing. Your insights and observations are crucial to the therapy process. You will be actively involved in helping to create the kind of home environment that supports positive changes in your child's behaviors and emotions.

Because we like to have as much information as possible to assist us in assessment and treatment planning, we ask you to provide us with a "picture" of what has been happening with your child and the "worlds" in which he/she lives. Though this questionnaire requires time, please keep in mind that this can save therapy time in obtaining the needed comprehensive history.

We appreciate your valuable assistance.

I. GENERAL INFORMATION

Child's complete name _____ Birthdate _____ Age _____

Address _____

Telephone _____ Sex M F

II. PRESENTING PROBLEMS

A. What is currently concerning you about your child or family?

B. When did the problems start?

C. How are these problems affecting the other family members?

D. What else was going on in the family or other aspects of the child's life at that time (whether you know these are related to the current problem)?

E. How do you think you or other significant caregivers may have

contributed to the problems?

- F. Describe your relationship with your child and what you would like to change about your relationship.**

- G. What other strategies have been tried to correct the problems? How did they work?**

- H. What other professionals/agencies have been involved in trying to correct the problem?**

- I. How do you think your child will describe the problem?**

- J. How have you talked with your son or daughter about coming to counseling? What was his/her reaction?**

III. FAMILY

A. Father's Name _____ **Age** _____
Address _____
Occupation (Job title, company, location) _____

B. Mother's Name _____ **Age** _____
Address _____
Occupation (Job title, company, location) _____

C. Are both parents living? If not, give the dates and circumstances of their deaths.

Brothers' Names	Age
_____	_____
_____	_____
_____	_____

Sisters' Names	Age
_____	_____
_____	_____
_____	_____

D. Are biological parents divorced? _____ If so, when? _____
Custody & visitation arrangements?

How did the child handle the divorce?

E. Have there been, or are there, court battles over some aspect of the the divorce or custody? _____ If yes, please describe.

Is there a possibility that the therapist might be called upon for testimony in this case? _____ If yes, explain.

F. Names of step-parents, if applicable _____

Names of step-siblings, if applicable _____

F. Other significant adults in your child's life:

Name	Relationship
_____	_____

G. Please describe the child's relationship/reactions to parents and other significant adults (significant as perceived by the child, e.g. step-parents, grandparents, adult friend, special teachers, etc.)

Father

Mother

Other significant adults

H. Please describe the child's relationship with siblings and step-siblings.

Name

Relationship Description

I. How is this child different from your other children (step-children)?

J. Are there any other significant factors that are stressors in the family, in general, that you could share?

IV. SCHOOL

- A. In what grade is your child? _____ School _____
- B. How long has your child attended this school? _____
- C. What kinds of grades is your son/daughter making in school? _____
- D. Is this a change from his/her typical performance? _____
- E. Do you think he/she is performing at the level of which he/she is capable?
Explain.

- F. Has he/she repeated a grade? _____
Which one(s)? _____
- G. What do your child's teachers tell you about his/her academic performance or conduct?

- H. If there are problems at school, what has been done to correct them?
How did it work?

- | | | |
|---------------------------|-----------------|--|
| I. <u>Teachers' names</u> | <u>Subjects</u> | <u>Amount/type of Parent-Teacher contact</u> |
|---------------------------|-----------------|--|

- J. Are there other important school issues of which we need to be aware?

V. SOCIAL RELATIONSHIPS

A. How would you describe your child's ability to make friends? Keep friends? Describe your child's friendships.

Name

Age

Relationship Description

C. What particular concerns, if any, do you have about your son/daughter's peer relationships?

VI. EXTRACURRICULAR ACTIVITIES

A. Please list your child’s favorite non-school hobbies, interests, activities, and games (other than sports):

B. Please list your child’s favorite sports:

C. In what extracurricular school activities is he/she involved?

VII. MEDICAL (Use additional sheet if necessary)

A. What medical conditions does the child currently experience?

B. What treatment is he/she currently receiving?

<u>Medical problem</u>	<u>Treatment</u>	<u>Provider</u>	<u>Medicines</u>
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C. Who is the child’s “primary doctor”? (family doctor, pediatrician)

D. Past medical problems? When?

VIII. DEVELOPMENTAL

A. Was there anything unusual or significant about his/her early development?

- B. Complications at birth?
- C. Early childhood illnesses?
- D. Motor development?
- E. Language development?

IX. PROBLEM CHECKLIST

You've given us a tremendous amount of valuable information already to help us planning for your child's treatment, and we appreciate it. Will you now take just a few more moments to complete this behavior checklist? Check the item if it has been a problem with your child in the past three months. The only exception to this is if it has been a significant problem in the past. If so, please note that. Feel free to add any explanatory comments for all items on the back of the sheet. Thank you!

- | | |
|---|--|
| <input type="checkbox"/> Behavior that is immature for his/her age | <input type="checkbox"/> Crying |
| <input type="checkbox"/> Allergies (describe) | <input type="checkbox"/> Cruelty to animals |
| <input type="checkbox"/> Talks back/argues | <input type="checkbox"/> Cruelty to others |
| <input type="checkbox"/> Behavior like the opposite sex | <input type="checkbox"/> Day-dreaming |
| <input type="checkbox"/> Excessive boasting | <input type="checkbox"/> Talks about death |
| <input type="checkbox"/> Lack of concentration | <input type="checkbox"/> Deliberately harms self |
| <input type="checkbox"/> Clinging or overly dependent behavior | <input type="checkbox"/> Demanding of attention |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Destroys his/her things |
| <input type="checkbox"/> Loneliness | <input type="checkbox"/> Destroys things belonging to his/her family or other children |
| <input type="checkbox"/> Acts confused, like in a "fog" | <input type="checkbox"/> Picks nose, skin or other parts of body (describe) |
| <input type="checkbox"/> Does not obey parents' rules/wishes | <input type="checkbox"/> Physical problems w/out know medical causes |
| <input type="checkbox"/> Gets into trouble at school | <input type="checkbox"/> Aches or pains |
| <input type="checkbox"/> Eating problems | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Has difficulty getting along w/others | <input type="checkbox"/> Nausea, feels sick |
| <input type="checkbox"/> Gets into fights | <input type="checkbox"/> Problems w/eyes |
| <input type="checkbox"/> Shows little/no guilt after misbehavior | <input type="checkbox"/> Academic problems |
| <input type="checkbox"/> Overly jealous | <input type="checkbox"/> Prefers playing w/older children |
| <input type="checkbox"/> Fears (describe) | <input type="checkbox"/> Prefers playing w/younger children |
| <input type="checkbox"/> Resists going to school | <input type="checkbox"/> Refuses to talk |
| <input type="checkbox"/> Is a perfectionist | <input type="checkbox"/> Repeats certain acts over & over again (describe) |
| <input type="checkbox"/> Feels or complains that no one loves him/her | |
| <input type="checkbox"/> Feels others are "out to get him/her" | |
| <input type="checkbox"/> Feels worthless or inferior | |
| <input type="checkbox"/> Is teased by others | |
| <input type="checkbox"/> Chooses friends who get in trouble | |
| <input type="checkbox"/> Hears sounds/voices that aren't there (describe) | |
| <input type="checkbox"/> Impulsivity, acts w/out thinking | <input type="checkbox"/> Runs away from home |
| <input type="checkbox"/> Chooses to be alone a great deal | <input type="checkbox"/> Screams a lot |

- _____ Lying or cheating
- _____ Bites fingernails
- _____ Nervous or tense
- _____ Nervous movements or twitching (describe)
- _____ Nightmares
- _____ Not popular w/other children
- _____ Has a habit of feeling guilty
- _____ Overeating
- _____ Overweight
- _____ Excessive fatigue
- _____ Physically attacks people
- _____ Shy or timid
- _____ Stares in space for significant periods
- _____ Speech problems (describe)
- _____ Threatens people
- _____ Steals outside the home
- _____ Stores up things he/she doesn't need (describe)

- _____ Strange behavior (describe)

- _____ Strange ideas (describe)

- _____ Stubborn, sullen or irritable
- _____ Sudden changes in mood or feelings
- _____ Sulking
- _____ Swearing or obscene language
- _____ Talks about suicide
- _____ Talks or walks in sleep (describe)

- _____ Talks too much
- _____ Temper tantrums or hot temper
- _____ Thinks about sex too much

- _____ Overly secretive (keeps things to self)
 - _____ Sees things that aren't there (describe)

 - _____ Self-conscious or easily embarrassed
 - _____ Sets fires
 - _____ Sexual problems (describe)

 - _____ Showing off or clowning
 - _____ Sleep problems (too much or too little)
 - _____ Steals at home
 - _____ Overconcerned with neatness or cleanliness
 - _____ Skips school
 - _____ Slow moving, lacks energy

 - _____ Depressed or sad

 - _____ Loud
 - _____ Uses alcohol or drugs for nonmedical purposes (describe)

 - _____ Vandalism
 - _____ Bedwetting
 - _____ Whining
 - _____ Worrying
- Please write in any problems your child has that were not listed above:

Thank you so much for your help in providing this information. We look forward to collaborating with you to help your child get back on track and become all that he or she can be.

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