



Client Information Sheet

Client's name: _____ Date: _____

Address: _____

City, State: _____ Zip: _____

Phone numbers *with area code* Home: () _____

Work: () _____ Cell: () _____

Birth date: _____ Age: ____ Social Security Number: _____

Employer: _____

Position: _____ For how long? _____

Education: _____

Marital/relationship status: _____ Significant other's name: _____

Significant other's age and sex: _____ How long together? _____

Names and ages of all children in the home: _____

How did you hear about Lexington Counseling Center?

Who shall we contact in case of emergency?

Name: _____ Phone () _____

In this box, please indicate the address and telephone number you want us to use to when sending bills or when we need to contact you. If this box is left blank, we will use the address and any of the telephone numbers you have provided above.

If you do *not* want us to leave a message on your answering machine, please tell us how you want us to reach you by phone:

I hereby consent for Lexington Counseling Center to provide evaluation and treatment to me.

Signature

Date



Medical and Health History

Name: _____ Date: _____

List any allergies you have: _____ None _____

Primary Care Physician: _____ Address: _____

City: _____ State: _____ ZIP: _____

Primary Care Physician's phone number: (____) _____

Date of your most recent physical examination: _____

Please list all current medications and dosages:

Name of Medication	Dosage	Name of Prescribing Doctor	When did you start taking it?

Please list all current or past health problems, and any major operations:

Current	Past

List all therapists you have seen, and dates you saw them: _____

List any substance abuse treatment or inpatient psychiatric treatment you have had, and the dates: _____

Please indicate which of these substances you currently use:

Substance	Amount used	How often?
Cigarettes		
Alcohol		
Pills not prescribed for me		
Marijuana		



Cocaine or crack		
LSD		
Heroin		
Other (please list):		

What kind of problem brings you to Lexington Counseling Center ?

Please indicate if you are having any of the following problems, or if you had them in the past:

	I have this now	I had it in the past
Difficulty falling asleep or staying asleep	_____	_____
Sleeping too much	_____	_____
Change in appetite, weight loss, or weight gain	_____	_____
Frequent crying	_____	_____
Panic attacks or anxiety attacks	_____	_____
Thoughts of killing or hurting myself	_____	_____
Attempts to kill or hurt myself	_____	_____
Problems concentrating	_____	_____
Problems remembering things	_____	_____
Periods of daily sadness lasting more than two weeks	_____	_____
I startle easily	_____	_____
Can't stop remembering upsetting past events	_____	_____
Difficulty controlling my temper	_____	_____
I physically hurt other people	_____	_____
I break things sometimes	_____	_____
I worry a lot	_____	_____
Little or no interest in sex	_____	_____
I feel tired almost every day	_____	_____
Feelings of unreality	_____	_____
Made myself throw up in order to lose weight	_____	_____
Used laxatives or exercised excessively to lose weight	_____	_____
I often feel like I am an outsider	_____	_____
Sexual problems	_____	_____
Worry that something is wrong with my body	_____	_____
Frequent arguments with the people I live with	_____	_____
I hear voices inside my head	_____	_____
Other (please list):	_____	_____

Signature

Date



Psychotherapist-Client Services Agreement

This form has three purposes. First, it tells you about my procedures and policies concerning important aspects of your psychotherapy. Please let me know if you have concerns about any of these policies. Your first visit will help me get a general understanding of your situation in order to determine how I might best help you. Because I want you to participate actively in planning your counseling, don't hesitate to ask questions.

Psychotherapy is a way of talking through your problems in order to begin resolving them. You will need to take an active part in psychotherapy by working on and thinking about the things you talk about with your therapist. Psychotherapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and feeling much less distressed. However, there are no guarantees of what you will experience, and at times a psychotherapy session may leave you with unhappy feelings.

Second, this form is an Agreement between you and Lexington Counseling Center. You may revoke (cancel) this Agreement in writing at any time. That revocation will be binding on Lexington Counseling Center unless I have already relied on this Agreement to take action *or* if you have not paid your bill in full.

Finally, this form also contains information about a federal law that affects your privacy rights. This law, called HIPAA (Health Insurance Portability and Accountability Act), regulates the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. HIPAA requires that we give you a Notice of Privacy Practices (the Notice). The Notice, which is attached to this Agreement, explains HIPAA's application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Please take home the Notice and read it before your next session; you and your therapist can discuss any questions you may have about it next time.

APPOINTMENTS, HOURS AND LOCATION

Individual appointments last approximately 50 minutes and can be scheduled by calling **(781) 274-7777** or emailing randy@lexingtoncounselingcenter.com. Please leave a message. *If you need to cancel an appointment, notify me at least 24 hours before the session, or you will be charged \$100 for the time you reserved for the appointment.* However, if you call in advance to cancel an appointment because you are ill, there will be no charge.

Lexington Counseling Center schedules appointments on Monday through Friday from 9AM to 8PM and Saturday from 9AM to 3PM.

TELEPHONE CALLS AND EMERGENCIES

If you receive my voice mail, please leave a message and I will get back to you as soon as is feasible. Lengthy telephone consultations may be prorated and billed at my standard hourly rate for professional service.

In emergencies, please call 911 or go to a hospital emergency room. An emergency is generally a situation in which you are in danger of harm or have hurt yourself or someone else.



CONFIDENTIALITY AND FILES

The laws governing confidentiality can be quite complex. The attached Notice explains some specific Patient Rights that you have under the HIPAA law. We will maintain a Clinical Record file on your case, which is the property of Lexington Counseling Center. You may examine and/or receive a copy of your file *if* you request it in writing *and* the request is signed by you *and* dated not more than 60 days from the date it is submitted. There may be a charge for writing reports or for copying materials. In most situations, Lexington Counseling Center can release information about your treatment to others *only* if you sign a written authorization form for each release. However, I am a mandated reporter and there are a few situations where I am required to disclose information to authorities. These situations are listed at the bottom of page 7.

Your signature on this agreement is written, advance consent for the following releases of information:

- Your therapist may occasionally find it helpful to consult other health and mental health professionals about a case. During consultations, your therapist makes every effort to avoid revealing the identity of patients. The other professionals are also legally bound to keep the information confidential. The therapist will note all consultations in your Clinical Record.
- Your therapist may find it helpful to receive or exchange information with your primary care physician or other health and mental health professionals who are currently treating you. Your signature on this Agreement is written, advance consent for me to release information to these professionals. A record of any disclosures will be kept in your Clinical Record.

 Check here if do NOT wish us to release any information to other mental health and health professionals who are currently treating you.

There are some situations where Lexington Counseling Center is required to disclose information *without* your consent or authorization:

- If a client is clearly likely to seriously harm him/herself, we may be required to take action to prevent self-destruction.
- If there is a clear risk that a client plans to seriously harm another person, we may have a duty to warn the potential victim; or disclose the risk to appropriate public authorities.
- If a therapist suspects that abuse of a child or senior citizen may have taken place, the therapist is required to report the suspected abuse to the Department of Social and Health Services.
- If the client is a minor younger than age 13, both parents have access to the minor client's complete Clinical Record, including Psychotherapy Notes, unless there is a court order prohibiting one of the parents from access.
- If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis or treatment, such information is protected by the counselor-client privilege law. Lexington Counseling Center cannot provide any



information without your (or your personal or legal representative's) written authorization. However, if a court **orders or subpoenas** Lexington Counseling Center to disclose information, we are required by law to provide it. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.

- If a client files a complaint or lawsuit against Lexington Counseling Center or any of its staff, Lexington Counseling Center may disclose relevant information regarding that patient in order to defend itself.
- If a client files a worker's compensation claim, the client must sign an authorization so that Lexington Counseling Center may release the information, records or reports relevant to the claim.
- Lexington Counseling Center may present disguised case material in seminars, classes, or scientific writings. In this situation, all identifying information and Protected Health Information is removed, and client confidentiality and anonymity is maintained.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS, AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE OF PRIVACY PRACTICES DESCRIBED ABOVE.

Client or responsible party

Date



Fees for Counseling and Financial Agreement

The standard fee for psychotherapy is \$150 per session.

A session is generally 50 minutes in length with 10 minutes for record keeping. Longer sessions are charged as a prorated fee.

Fee Agreement (to be filled out by counselor)

_____ Fee for one session _____
Prepaid 3-Session Package - (Discount of 5%) _____
Prepaid 6-Session Package - (Discount of 10%) _____
Prepaid 10-Session Package - (Discount of 15%) _____

1. FEE INCREASES

Occasionally, Lexington Counseling Center may increase its standard fee. If you are in therapy when an increase is to occur, you will be notified in advance. At that time, your fee will be adjusted to the new fee, this fee agreement will be terminated, and you will be asked to sign a new agreement which reflects the new fee. Any prepaid sessions will continue to be honored at the original rate until they are used.

2. PAYMENT ARRANGEMENT:

All fees are payable in full at the time of service. Established clients may be offered an account arrangement at the discretion of Lexington Counseling Center. Overdue accounts may be charged interest at the rate of 10% per year. Payment may be made in cash, by check, or by money order.

_____ STANDARD PAYMENT ARRANGEMENT: Payment in full at the time of service.

_____ ALTERNATIVE PAYMENT ARRANGEMENT:

3. COLLECTIONS PROCEDURES:

Lexington Counseling Center reserves the right to collect any unpaid balance due to it. If a client is not making regular monthly payments on the account balance, Lexington Counseling Center may use a collection agency or take legal action to secure payment, as authorized by state or federal law, and the collections action will become a part of your credit record. Clients will be notified in writing before Lexington Counseling Center takes action to collect.

4. LIMIT ON UNPAID BALANCE: Lexington Counseling Center may terminate treatment and refer the client elsewhere for continued care if any unpaid balance exceeds **\$300.00**.

I have read and understood the above fee agreement, and I agree to abide by its terms.

Client or Responsible Party

Date