REFINE
COUNSELING
REFINE THE MIND~ TRANSFORM THE LIFE

refinecounseling.org

ADULT CLIENT INFORMATION FORM

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law without prior written consent.
**If you have been a client before, please fill in only the information that has been changed.*

Date: _____

First Name: _____ Last Name: _____

Your nicknames or aliases: _____

Date of birth: _____ Age: _____

Home street address: _____Apt #:_____

City: _____ State: _____ Zip: _____

Cell phone: _____ Alternate Phone: _____

Email: _____

Calls will be discreet, but please indicate any restrictions: _____

Emergency Contact Name: _____ Cell Phone: _____

Referral: How did you hear about us? *Counselor / Therapist / Pastor / Friend / Brochure / Website / Other*

May I have your permission to thank this person for the referral? □ Yes □ No **Initia**l _____

How did this person explain how I might be of help to you?

_____

ALCOHOL AND DRUG USE HISTORY

Drugs of choice: *Alcohol Opioid Sedative Cocaine Cannabis Stimulants Hallucinogens*

Substances of choice: _____

Age of beginning use: _____How quickly did your use escalate? _____

Most recent method of use: _____ Amount: _____

Frequency: _____

Current pattern of use has occurred for how long: _____

Date last used: _____ Amount used: _____

What have been the **consequences** of your using? _____

_____

Has your **tolerance** of your drug of choice: *Increased* *Stayed the same* *Decreased*

What is you **perception of your problem** with your drug of choice?

Not a problem *Mild problem* *Moderate problem* *Serious problem* *Severe problem*

What efforts have you made to **control** your use of this substance?

None / Very little / Some / Stopped, but went back / Unable to stop for any significant length of time

Is there any other drug use i.e. prescriptive drugs? *No / Yes*

If yes, what? _____ Amount: _____

Frequency of use: _____ Pattern: _____

Have you used alcohol in the past seven (7) days? *No* *Yes*

Number of times have previously been to inpatient treatment: _____

Facility: _____ Date: _____

Facility: _____ Date: _____

Facility: _____ Date: _____

At this time are you: *Clean/Sober* *Withdrawing* *Impaired*

Marital History:

Are you currently: single ____ engaged ____ married ____ divorced ____ separated ____ widowed ____

Number of times married: _____ Number of children _____

If married, current spouse's name: _____ months/years married _____

ADULT CHECKLIST OF CONCERNS

Please mark all the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

___ Abuse—physical, sexual, emotional, neglect (of children or elderly), cruelty to animals
___ Aggression, violence
___ Alcohol use
___ Anger, hostility, arguing, irritability
___ Anxiety, nervousness
___ Attention, concentration, distractibility
___ Career concerns, goals, and choices
___ Childhood issues (your own childhood)
___ Children, child management, child care, parenting
___ Codependence
___ Confusion
___ Compulsions
___ Custody of children
___ Decision making, indecision, mixed feelings, putting off decisions
___ Delusions (false ideas)
___ Dependence
___ Depression, low mood, sadness, crying
___ Divorce, separation
___ Drug use—prescription medications, over-the-counter medications, street drugs
___ Eating problems/Weight Issues: overeating, under eating, appetite, vomiting
___ Emptiness
___ Failure
___ Fatigue, tiredness, low energy
___ Fears, phobias
___ Financial or money troubles, debt, impulsive spending, low income
___ Friendships
___ Gambling
___ Grieving, mourning, deaths, losses, divorce
___ Guilt
___ Headaches, other kinds of pains
___ Health, illness, medical concerns, physical problems
___ Inferiority feelings
___ Interpersonal conflicts
___ Impulsiveness, loss of control, outbursts
___ Irresponsibility
___ Judgment problems, risk taking
___ Legal matters, charges, suits
___ Loneliness
___ Marital conflict, distance/coldness, infidelity/affairs, remarriage
___ Memory problems
___ Menstrual problems, PMS, menopause
___ Mood swings
___ Motivation, laziness
___ Nervousness, tension
___ Obsessions, compulsions (thoughts or actions that repeat themselves)
___ Oversensitivity to rejection

___ Panic or anxiety attacks
___ Perfectionism
___ Pessimism
___ Procrastination, work inhibitions, laziness
___ Relationship problems
___ School problems
___ Self-centeredness
___ Self-esteem
___ Self-neglect, poor self-care
___ Sexual issues, dysfunctions, conflicts, desire differences
___ Shyness, oversensitivity to criticism
___ Sleep problems—too much, too little, insomnia, nightmares
___ Smoking and tobacco use
___ Spiritual or religious concerns
___ Stress, relaxation, stress management, stress disorders, tension
___ Suspiciousness
___ Suicidal thoughts
___ Temper problems, self-control, low frustration tolerance
___ Thought disorganization and confusion
___ Threats, violence
___ Withdrawal, isolating
___ Work problems, employment, workaholism/overworking, can't keep a job

Any other concerns or issues:

Looking over the concerns you have checked, with which one do you most desire help?

Check condition and relationship of any blood relative who has or has had any of the conditions listed below:	Mother	Father	Paternal grandfather	Paternal grandmother	Maternal grandfather	Maternal grandmother	Siblings	Other ____
Alcoholism/Substance Abuse								
Depression								
Mental Illness								
Learning/Attention Problems								
Suicide/Suicide Attempt								
Long Term Illness (cancer et.)								
Other (specify)								

Spiritual Life

Would you like to incorporate spiritual or religious beliefs in your treatment? ☐ Yes ☐ No

Would you like for prayer to be part of your counseling? ☐ Yes ☐ No

Please give any other information you feel is important about your spiritual life:

_____

_____

_____

_____

Sexual History:

Parental attitudes toward sex (Was there sex instruction or discussion at home?)

_____

_____

When and how did you derive your first knowledge of sex?

_____

_____

Do you partake in pornography?

Do you partake in any extramarital or other sexually illicit behavior?

If so, in what activities do you indulge?

Have you ever experienced anxiety or guilt related to masturbation or sex? If yes, please explain:

Self-Description:

CIRCLE each of the following words that you might use to describe yourself:

Intelligent	Confident	Worthwhile	Ambitious	Sensitive	Loyal	Victim
Trustworthy	Full of regret	Worthless	A Nobody	Useless	Evil	Unfaithful

Crazy Conflicted Considerate A Deviant Unattractive Naïve Shameful

Unlovable Inadequate Confused Ugly Stupid Incompetent Failure

Attractive Suicidal Persevering Hard working Perfectionist Deceptive

Horrible thoughts Morally degenerate Concentration difficulties

Memory problems Can't make decisions Good sense of humor

What do you consider to be your most irrational thought or idea?

Are you bothered by thoughts that occur over and over again?

On each of the following items, please circle the number that most accurately reflects your opinions

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I should not make any mistakes	1	2	3	4	5
I should be good at everything I do	1	2	3	4	5
When I don't know, I should pretend I do	1	2	3	4	5
I should not disclose personal information	1	2	3	4	5
I am a victim of circumstances	1	2	3	4	5
My life is controlled by outside forces	1	2	3	4	5
Other people are happier than I am	1	2	3	4	5
It is very important to please other people	1	2	3	4	5
Play it safe, don't take any risks	1	2	3	4	5
I don't deserve to be happy	1	2	3	4	5
It is my responsibility to make others happy	1	2	3	4	5
I should strive for perfection	1	2	3	4	5
Basically, there are 2 ways of doing things - the right way and the wrong way	1	2	3	4	5

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AGREEMENT TO PAY FOR PROFESSIONS SERVICES

I, the client (or guardian/legal representative), request that the therapist named below provide professional services to me or to _____, who is my_____, and I agree to pay this therapist's fee of $ _____ per 45/50-minute session. This same fee will be applied per each hour of consultation, assessment, or other therapeutic activity unless otherwise negotiated in writing.

I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform him or her, in person or by certified mail, that I wish to end it. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me (or this client) up until the time I end the relationship.

I understand that if I do not pay for services that the services provided may be terminated by the therapist. Continued non-payment of fees may result in further consequences such as my case being referred to a collection agency.

I agree that I am responsible for the charges for services provided by this therapist to me (or this client), although other persons or insurance companies may make payments on my (or this client's) account. If my any part of my fees is being paid by an insurance company or other third party payer, I understand that this may result in limitations to my confidentiality.

_____ _____
Signature of client (or person acting for client) Date

_____
Printed Name

I, the therapist, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Signature of Therapist Date

_____ Copy accepted by client

_____ Copy kept by Counselor/ Therapist

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APPOINTMENT AND CANCELLATION POLICY

REFINE COUNSELING is dedicated to providing you with the best care and service possible.

The time scheduled for your appointment is specifically reserved for you on our schedule to the exclusion of others. Please notify your counselor or **REFINE COUNSELING'S** Schedule Administrator ***within 24 hours*** of your appointment if you are not able to meet at your scheduled time. Please be sure and leave us **your name and counselor's name** if you send a cancellation notice via text or voicemail.

When sufficient notice is not given to cancel, or change a reserved appointment, the following policy will be administered:

A "No-Show" is defined as missing a scheduled counseling appointment with NO PRIOR

notification directly to the counselor or **REFINE COUNSELING'S** Schedule Administrator via phone or text within 24 hours except in cases of extreme emergency.

REFINE COUNSELING'S late cancellation (outside of a 24-hour notice) and no-show fee up to the cost of a full counseling session.

All late/ no show fees must be paid in full before scheduling or confirming your next appointment.

I have read and fully understand **REFINE COUNSELING'S** Appointment and Cancellation Policy.

_____ _____

Client Signature Date

To Cancel or Reschedule an Appointment
You may call or text us at

405-641-0686

***Please Be Sure To Let Us Know Your Name And The Name Of Your Counselor**

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AUTHORIZATION FOR RELEASE OF INFORMATION

Please carefully read the following information before signing this form. If you do not understand the nature of the information to be released, ask your counselor. This form should be completed in full before adding your signature.

- I understand that the release of information is in my best interest and is not a required condition of treatment.
- I understand that the release of information is limited to the party named below and that it will not be passed on to anyone else or used for any other purpose other than that specified below.
- I understand that I may cancel this authorization at any time by signing and dating the original of this authorization where indicated. I understand that cancellation does not affect prior action taken under this authorization.
- I understand that a photocopy of this authorization is as authentic as the original signed authorization for release of information.

I, _____, authorize
(Printed Name)

REFINE COUNSELING and my counselor _____ to release
(Printed Name of Counselor)
information to:

Name: _____

Agency: _____

Address: _____

For purposes of _____

With the following restrictions: _____

For the period: _____ to _____

Signed: _____ **Date:** _____

Witnessed: _____ **Date:** _____

I, (print name) _____ have decided to cancel the above authorization

As of Date: _____

Witnessed: _____ *Date:* _____

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CONSENT FOR TREATMENT SIGNATURE PAGE FOR ADULTS

1. All clinic files are confidential and my written consent is required for any release of information by the clinic to any other persons outside Refine Counseling except in the following circumstances: (a) court orders and subpoenas, (b) to defend legal action against Refine Counseling, (c) need to prevent clients from harming him/herself or others, and (d) suspected child abuse/neglect. If I request that the Refine Counseling submit reimbursement forms for your insurance, complete confidentiality cannot be agreed. If I file a lawsuit related to mental health issues, Refine Counseling's records may also be accessed by the court. _____**Initial Here**

2. While I have the right to access my file, I understand that doing so may jeopardize the therapeutic process. I agree to consult with my therapist about any questions I have concerning the content of my file or sessions. _____**Initial Here**

3. I may be asked to sign consent forms for the release of social, medical, and/or psychological information from other agencies or individuals for the use by the staff of this clinic in my assessment or treatment. I may request restrictions on the use/disclosure of information in my file for treatment, payment and health care operations purposes, but the therapist is not bound to agree with my request. _____**Initial Here**

4. I understand that it is impossible to assure privacy of any communication by electronic means (email, faxes). Email should never be used to communicate any urgent matter to Refine Counseling. _____**Initial Here**

5. Information from clients' files may be compiled to study various issues such as treatment outcomes and client satisfaction. My name or any identifying information will not be used in such research. _____**Initial Here**

6. Refine Counseling does not provide after-hours services. My therapist and I will set appointments. For after-hours emergencies, I should call 911. _____**Initial Here**

7. The practice of psychology and related disciplines is not an exact science, and I acknowledge that no guarantees have been made to me regarding the results of treatments, assessments, and consultations. I understand that I am responsible for working with my therapist to help ensure better treatment outcomes. _____**Initial Here**

8. Refine Counseling is not a medical doctor; therefore, she cannot prescribe medications and is not authorized to practice medicine. If my therapist thinks that I should consider medication as a part of treatment, and I want to try this, my therapist will refer me to a physician with whom they would work to provide coordinated services. I understand that psychological problems can have medical or biological origins and I should have regular physical exams and speak with the doctor about all my symptoms. _____**Initial Here**

9. I consent to undergo all testing and treatment procedures necessary to address the problems for which I am seeking help. I understand that I have the right to be informed of the nature and purpose of any procedure and that I can refuse or discontinue testing or treatment at any time. _____**Initial Here**

10. I understand I am responsible for any fees for services to which I consent, and that failing to pay such fees may result in the termination of any further services to me. Payment is due at the beginning of my appointment. I must cancel at least 24 hours before my session, unless my therapist and I both agree my cancellation was due to an emergency, or I am responsible for the session fee before I can schedule a new session. Continued non-payment of fees may result in action including being referred to a collection agency. _____**Initial Here**

11. I understand special arrangements may need to be made regarding payment and reporting of assessment and treatment results in cases of divorce and court-mandated services. _____**Initial Here**

12. I acknowledge that my therapist has reviewed the General Consent for Treatment form with me and I have been given a copy to keep for my own records. _____**Initial Here**

Signature of Therapist /Witness Date

Signature of Client/Guardian Date

Printed Name of Client

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NOTICE OF PRIVACY PRACTICES

This notice talks about **privacy information**. This is nothing new. We've always taken great care to safeguard your privacy. What is new is a government regulation requiring us to explain your rights.

This notice describes how medical and mental health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. In the event the notice is changed; a new notice will be sent to you by mail or at the time of your next appointment. You may request a copy of our Notice at any time.

This notice takes effect immediately and will remain in effect until we replace it.

Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked to sign a consent form. Once you have consented to the use and disclosure of your protected health information for treatment by signing the consent form, this agency will use or disclose your protected health information as described below.

Treatment: We may use and disclose, as needed, your protected health information to provide, coordinate, or manage your health care and any related services.

Health Operation: We may use and disclose, as needed, your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of mental healthcare professionals, evaluating practitioner and provider performance, employee review activities, conducting training programs, accreditation, certification, licensing or credentialing activities, and conducting or arranging for other business activities.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization, at any time, in writing. Your revocation will not affect any use or disclosures permitted by our authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the notice.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Other permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Require by Law: We may use or disclose your protected health information to the ex ten t that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

Health Oversight: We may disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

Abuse or Neglect: We may disclose your protected health information to the Department of Human Services which is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse or neglect to the Department of Human Services. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Legal Proceedings: We may disclose your protected health information in the course of any judicial, or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: Consistent with applicable federal and state laws, we may disclose you r protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages or letters).

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et.seq.

Client Rights

Access: You have the right to inspect and copy your protected health information. We will use the format your request unless we cannot practicably do so. You must submit your request in writing to obtain access to you r health information. You may obtain a form to request access by using the contact information at the end of this notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If your request copies, we will charge you $1.00 for the first page, and $.25 each page thereafter to locate and copy your health information plus postage if you want the copies mailed to you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

Restriction: You have the right to request a restriction of your protected health information. You may also request that any part of your protected health information not be disclosed by family members or friends who may be involved in your care or notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. If we agree to the additional restrictions, we will be able to abide by our agreement (except in an emergency).

We are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your protected health information, your protected information will not be restricted.

Alternative Communication: You have the right to request to receive confidential communications from us by alternative

means or at an alternative location. You must make your request in writing.

Amendment Request: You have the right to request that we amend your protected health information. Your request must be in writing and explain why the information should be amended. In certain cases, we may deny your request for an amendment. If we deny your request for your amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Disclosure Accounting: You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment or healthcare operations as described in this Notice of Privacy Practices.

Notice: You have the right to obtain a paper copy of this notice from us upon request.

Questions and Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We support your right to the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

You may contact our Privacy Officer below for further information about the complaint process.

ATTN: REFINE COUNSELING
1401 NW 150th Ste. B
Edmond, OK 73013
www.refinecounseling.org

_____ _____

Client's Signature Date