THE RANCH COUNSELING SERVICES
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ADULT PAPERWORK

Client's Legal Name Last: _____ First: _____ Middle Initial: _____

Client's Nickname (If Applicable): _____ Date of Birth: _____ Female: _____ Male: _____

Address: _____

Emergency Contact} Name: _____ Relation: _____ Phone#: _____

Name of Person Responsible for the Bill: _____

Address of the Person Responsible for the Bill: _____

Home#: _____ Work#: _____

Cell#: _____ Cell#: _____

Email Address: _____ Email Address: _____

Appointment Reminders

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a computer generated voice message) the day before your scheduled appointments.

Where would you like to receive appointment reminders? (CHECK ONLY 1 OPTION)

____ Email

____ Text Message ***(normal text message rates will apply)***

____ Phone call ***(automated call to your phone)***

____ None of the above. I'll remember my own appointments. ***(Missed appointment fees will be $25)***

CLIENT INFORMATION FORM

First Name_____ Middle Initial _____ Last Name_____ Date _____

Social Security #_____ Drivers License. #_____

Home Phone_____ Can we use this number for reminder calls/ changes? __ Y __N leave messages? __Y __N

Work Phone_____ Can we use this number for reminder calls/ changes? __ Y __N leave messages? __Y __N

Cell Phone_____ Can we use this number for reminder calls/ changes? __ Y __N leave messages? __Y __N

Marital Status: single___ married___ separated___ divorced___ widowed___

Occupation/Place of Employment _____

Highest educational level completed _____ Students: name of school & current grade level _____

Who else lives with you (the client) in the home? (List below; continue on back of page, if needed)

Name	Date of birth/age	Relationship

Marital History (Describe the current marital relationship.

_____
_____
_____

1st marriage: # of years____ # of children & ages_____comments_____
2nd marriage: # of years____ # of children & ages_____comments_____
3rd marriage: # of years____ # of children & ages_____comments_____

Family of Origin: briefly describe your relationship with the family that you grew up with: parent figures, siblings. Relatives

_____
_____
_____
_____

Who referred you here or how did you hear about us? _____

Briefly describe your reasons for seeking help

_____

_____

_____

_____

SYMPTOM CHECKLIST: PLEASE PUT AN [X] BY ALL OF THE ITEMS THAT APPLY TO YOU

Situations

____Parenting
____Children
____Marriage
____Divorce
____Separation
____Dating
____Premarital counseling
____Sexual problems
____Stress
____School/education
____Career choices/goals
____Finances
____Legal concerns
____Religion
____My past

Relationship Issues

____Relationship with parents
____Relationship with friends
____Relationship with In-laws
____Feeling lonely or isolated
____Feeling inferior to others
____Feeling a lot of conflict
____Feeling too submissive
____Feeling too controlling/dominant
____Feeling out of control
____Feeling threatened or endangered
____Difficulty trusting others

Feelings

___Nervous
___Angry
___Irritable
___Guilty
___Shamed
___Depressed
___Sad
___Fearful
___Shy
___Anxious
___Worried
___Hopeless
___Worthless
___Numb/no feelings
___Mood swings
___Happy/elated

Thinking

___Blaming others
___Difficulty acknowledging problems
___Poor concentration
___Attention span problems
___Short-term memory problems
___Long-term memory problems
___Confusion
___Racing thoughts
___Trouble making decisions
___Problems with day to day functions

Thinking (continued)

____Nightmares
____Flashbacks
____Hearing voices
____Seeing strange things
____Obsessive/Repetitive thoughts
____Suicidal thinking

Physical Complaints

____Insomnia
____Sleeping too much
____Weight gain
____Weight loss
____Low energy/fatigue
____Lower sexual interest
____Less interest in pleasure/fun
____Alcohol use
____Drug use
____Headaches
____Upset stomach
____ Ulcers
____Allergies
____Asthma
____Body aches
____Bedwetting/Soiling
____Other:
_____
_____
_____

Counseling History

Previous Counseling: __Y __N With whom?/dates_____

_____

_____

Previous Inpatient hospitalization: __Y __N With whom?/dates_____

What was your outcome and response?_____

Medical History

Name of Physician_____ Ph #_____ Permission to Contact? __Y __N

Current medical conditions_____

Past medical conditions:

_____

Hospitalizations? _____

Current medications you are taking (we can make a copy if you have a list with you):

Name	Dosage	Frequency	How long have you taken it?	Response

Confidentiality

- What you and your counselor discuss is private.
- Your right to privacy is protected by federal regulations and the rules governing your counselor's specific professional licensing board.
- Your counselor is not authorized to share information about you unless you sign an Authorization to Release Information stating in writing the specific information you want shared and the specific person that you want to receive the information.
- **There are exceptions to this policy. Confidentiality may be broken and the appropriate individuals or authorities notified if any of the following occur:**

    1. I learn that you are threatening to harm yourself or others.
    2. I suspect that a child or an elderly adult or a person not competent to care for himself, may have been abused in the past, is presently being abused, or might be abused in the future. State law requires me to report this.
    3. A court of law orders that I release specific information about you in a judicial proceeding.

I have read this section and understand my rights to privacy and my exceptions to confidentiality

Signature_____ Date_____

Fee Policy and Procedures

FEES

1. 1st session = **$130.00**.
2. 2nd and subsequent sessions = **$130.** *for sessions 50 minutes in length, longer or shorter sessions prorated from this fee.
3. **Court Appearances = $200.00***
   ***Whether you request it, or your attorney, or if I am subpoenaed, you will be responsible for all my time, including driving to court, waiting to testify, giving testimony, and preparation and research time that is required. Four (4) hour minimum due to the need to cancel other clients.
   Payment is required in advance. Insurance does not cover this.
4. **Payment Method-** Payment is required at the time services are rendered. You may pay in cash, check, Venmo @Rosieholl or Cashapp $Rosieholl72.
5. **Missed Appointments & Late Cancellations-** Any appointment that is missed without 24 hours notice will result in your being billed $25.00 directly.
   Insurance will not cover missed appointments.
   PLEASE NOTIFY US IMMEDIATELY IF YOU ARE UNABLE TO KEEP AN APPOINTMENT!

Responsibility

1. You, the client, are responsible for payment of services.
2. We reserve the right to employ a collection agency and furnish them with your information to collect payment in the event that you fail to pay an outstanding balance.
3. When a third party fails to make timely payments, payments will be expected from the client.
4. Third party payors include divorced or separated spouses, insurance companies.

Insurance

1. We will file claims directly to your insurance company **if** you provide us with all information requested. We will accept your deductibles/copays at the time of service.
2. We will verify benefits and review with you what you will be required to pay for each session.
3. If we cannot verify benefits, you will be required to pay full fee until we receive payment from the insurance company. **You are responsible for the balance of your account regardless of the insurance status.**

Signature

You are encouraged to ask any questions you may have at any time including before you sign this form. Your signature below indicates that you understand and will comply with the above policy and procedures.

Your signature_____date_____

I am paying today by: ____Cash ____Check ____Credit/Debit Card

CLIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION
For

Rosemary Hollingsworth, M.A., LPC

I_____
Name of Client

hereby give my consent for Rosemary Hollingsworth, LPC, to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). By signing this form I agree to let you use and disclose my information to carry out my treatment and/or arrange for payment of treatment and/or consult with other providers about my treatment.

The Notice of Privacy Practices explains in more detail how you can use and disclose my information. I have the right to review the NPP prior to signing this document. Please read it before you sign below.

I may request that you restrict how you use and disclose my PHI to carry out my TPO, however Rosemary Hollingsworth, LPC is not required to agree to my request, but if she does, she is bound by this agreement. I may revoke my consent (in writing) except to the extent that disclosures have already been made in reliance on my prior consent.

If I do not sign this consent form or later revoke it Rosemary Hollingsworth, LPC may decline to provide treatment to me.

Rosemary Hollingsworth, LPC reserves the right to revise his Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Rosemary Hollingsworth, LPC.

_____ _____

Signature of Client Date

_____ _____

Print Name of Client Client's Date of Birth

No Show/Late Cancellation Policy

We are pleased that you have chosen CC Counseling Services and are grateful for the relationship we will develop with you. This counseling practice desires to serve many clients. In order to do so, we need your help. Each client who is seen in counseling has a reserved time to be seen. That time has been agreed upon by the client and the counselor together. Clients who cancel and call the office more than 24 hours in advance provide a way for the counseling office to schedule other clients. However, when a client does not show up for an appointment or cancels an appointment less than 24 hours in advance, other clients may be deprived an opportunity to be seen. Counselors lose time and money from cancellations because without advance notification, scheduled appointment times cannot be filled with other clients. If a client does not show up at the appointed time, the counselor waits to see whether the client is coming or not before moving on to other tasks.

For these reasons, the practice is hereby notifying you that, **clients who do not show up for a scheduled appointment (NS) or who cancel an appointment but fail to contact the office more than 24 hours before the scheduled appointment time (LC) will be charged a $25.00 fee. (This fee is not covered by insurance and will be the client's responsibility to pay it.) This $25.00 fee must be paid before any future appointments may be scheduled. Additionally, until the fee is paid, all standing appointments previously scheduled will be canceled and client privileges to schedule appointments online will be denied. (Clients who choose not to return for counseling will still be billed the $25.00 fee.) Each time a client "no shows (NS)" or "late cancels (LC)", the $25.00 fee will be charged. Repeated no shows or late cancellations may result in the counselor choosing to terminate the counseling with the client.**

Remember that you have multiple communication options for canceling your appointment, including calling, emailing, and leaving a voice message at any time of day. Overall, we believe that this new cancellation policy will benefit our clients by allowing each client to have more options in scheduling.

_____Please PRINT Client Name _____Today's Date

_____Signature (of client) indicates I have read and understand this policy.