



CLIENT INFORMATION FORM

This form should be completed by the adult who will be responsible for the primary person receiving services. All information will be handled confidentially.

Client Name: _____ Date _____
Please Print

Date of birth: _____ Gender: _____ Marital Status: _____

Email Address: _____

(Optional) Race/Ethnicity: Asian _____ Black/African American _____ Hispanic _____
White _____ Other _____

(Optional) Religious Preference _____

RESPONSIBLE PARTY *(If client is a minor please provide parent or legal guardian information)*

Name: _____ Phone Number: _____

Date of birth: _____ Gender: _____ Marital Status: _____

Relationship to Client: _____

IN THE CASE OF AN EMERGENCY: Please contact: _____

Relationship to Client: _____ Phone _____

IF YOU ARE USING INSURANCE: Please give the receptionist your insurance card, if you haven't already, so we can make a copy for your file. Also, please remember that if at any point your insurance changes while you are a client here, you need to let us know.

EAP COMPANY: (if applicable) _____

EAP AUTHORIZATION #: _____ NUMBER OF SESSIONS: _____

AGAPE Client History

Please complete the following regarding the *individual who will be receiving counseling*. Use the back of the form if more space is needed.

Name of **person receiving counseling**: _____ Date: _____

Medical history (list major illnesses, hospitalizations, surgeries, etc.; include dates)

1. _____
2. _____
3. _____

History of counseling or psychiatric care:

	<u>Provider (counselor or facility)</u>	<u>Approx. Dates</u>	<u>Nature of problem</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Family history of emotional, behavioral, psychological, or alcohol/drug problems:

	<u>Family member (relationship to person seeking services at AGAPE)</u>	<u>Nature of problem</u>
1.	_____	_____
2.	_____	_____
3.	_____	_____

Employment history (list major jobs beginning with most recent; include approximate dates)

1. _____
2. _____
3. _____

Counselor's Notes:

AGAPE Client Symptom Rating Scale

Rate all symptoms below based on **the past month**. Rate each symptom 0 - 5 according to symptom severity = symptom absent, 5 = symptom is extreme. Your counselor will review and discuss your responses with during the intake interview. (Parents should complete form for child clients.)

Client Name: _____ Date: _____

Emotional Symptoms (Rate each symptom; circle 0 - 5)

Anger	0 1 2 3 4 5	Anxiety	0 1 2 3 4 5	Extreme mood shifts	0 1 2 3 4 5
Irritability	0 1 2 3 4 5	Frustration	0 1 2 3 4 5	Helplessness	0 1 2 3 4 5
Hopelessness	0 1 2 3 4 5	Fear	0 1 2 3 4 5	Apathy	0 1 2 3 4 5
Lack of emotions	0 1 2 3 4 5	Guilt feelings	0 1 2 3 4 5	Depression	0 1 2 3 4 5
Worry	0 1 2 3 4 5	Other (specify) _____			0 1 2 3 4 5

Mental Symptoms: (Rate each symptom; circle 0 - 5)

Problems with concentration	0 1 2 3 4 5	Inattention	0 1 2 3 4 5	Memory problems	0 1 2 3 4 5
Difficulty making decisions	0 1 2 3 4 5	Distractibility	0 1 2 3 4 5	Racing thoughts	0 1 2 3 4 5
Repeated unwanted thoughts	0 1 2 3 4 5	Other (specify) _____			0 1 2 3 4 5

Physical Symptoms: (Rate each symptom; circle 0 - 5)

Increase or decrease in appetite	0 1 2 3 4 5	Sleep difficulties		0 1 2 3 4 5
Tearfulness/crying spells	0 1 2 3 4 5	Increased heart rate/pounding heart		0 1 2 3 4 5
Sweating/chills	0 1 2 3 4 5	Stomach or intestinal distress		0 1 2 3 4 5
Frequent or severe headaches	0 1 2 3 4 5	Body pain/numbness		0 1 2 3 4 5
Muscle tension	0 1 2 3 4 5	Other (specify): _____		0 1 2 3 4 5

Behavioral Symptoms: (Rate each symptom; circle 0 - 5)

Hyperactivity	0 1 2 3 4 5	Impulsivity	0 1 2 3 4 5	Withdrawal	0 1 2 3 4 5
Arguing	0 1 2 3 4 5	Disorganized	0 1 2 3 4 5	Self-injury	0 1 2 3 4 5
Binge eating/ over eating	0 1 2 3 4 5	Suicidal Gesture/attempt	0 1 2 3 4 5	Induced Vomiting	0 1 2 3 4 5
Increased alcohol use	0 1 2 3 4 5	Fighting/ Aggression	0 1 2 3 4 5	Oppositional Defiant	0 1 2 3 4 5
Lying/ deceitfulness	0 1 2 3 4 5	Avoidance of school or job		0 1 2 3 4 5	
Other (specify) _____					0 1 2 3 4 5

Notes (for counselor's use):



Acknowledgement of Agreement for Services and HIPAA Notice

Your signature below indicates that you have received the **THERAPIST - CLIENT AGREEMENT** and agree to become an AGAPE client under the terms therein. This includes but is not limited to the points noted below. Please refer back to the **AGREEMENT** for more details or ask your counselor about anything that is unclear. By signing this form you:

- 1) acknowledge that you have been provided access to the HIPAA NOTICE form (a copy of the NOTICE is available at the check-in desk and is also posted in the waiting area)
- 2) permit AGAPE to disclose information about you and the services you were provided as necessary to process insurance claims or to collect overdue fees / payments from you
- 3) acknowledge your responsibility to inform AGAPE promptly of any changes in your insurance status or financial status that affects your coverage, benefits, co-payments, or fees. You acknowledge your responsibility for any fees/costs not covered by your insurance
- 4) acknowledge and understand that AGAPE staff must take action to protect serious threats to the life or safety of others. This will include reporting suspected abuse of a child or vulnerable adult, taking every reasonable step to prevent threats of violence against others from being carried out. You furthermore acknowledge that AGAPE will disclose information about you as necessary to comply with other legal requirements, such as responding to court -ordered releases of treatment records.

Print name of **patient/client** here: _____

Signature of patient / client (or parent / guardian)

(Date)

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Revised 02/2021



AGAPE

Love Works

Financial Agreement

- I understand that AGAPE requires payment before the counseling session begins. I will make sure I have the ability to pay before arriving.
- I understand that AGAPE has a **24-hour** Late Cancellation Policy. If I cancel an appointment after the 24-hour time frame, except in cases of sudden illness or an emergency, **I will be charged \$40.**
- If I **do not show up** for a scheduled appointment, **I will be charged a \$40 No-Show fee.**
- If my credit card is on file with AGAPE, it will **automatically** be charged the Late Cancellation or No-Show fee.
- **If I choose to participate in virtual or telephone sessions,** my credit card must be on file and is subject to the automatic charge of the Late Cancellation or No-Show fee.

I have read and understand the policy and agree.

Printed Name

Signature

Date

AGAPE

Informed Consent for Teletherapy

Confidentiality – AGAPE only uses digital forms of communication that are HIPAA compliant. Even though we do all we can to ensure your privacy, we cannot guarantee the same degree of confidentiality as we do with office visits. AGAPE uses electronic medical records that are secure and HIPAA compliant. Information stored on the client’s local computer, such as browser history, is one of the biggest threats to confidentiality. The client is responsible for the environment set-up on their end. It is best to be in a private room with minimal distractions during a session. Examples of situations to avoid would include being at a coffee shop or library, having kids running around in the background, or having a TV on. Therapists will also set up a distraction-free environment on their end, as well. Sessions will not be recorded by either party, unless agreed upon in advance.

Technology – Depending on the type of teletherapy offered, the client may require the use of a webcam, smartphone, or similar device with access to private (NOT public or free) wi-fi. If a smart phone is expected to be used it is advised to ensure that the device is fully-charged or plugged in prior to the scheduled appointment. Your teletherapy may also require the use of a video-conferencing platform (PatientClick). Your therapist will provide you with instructions regarding its use.

Technology Failures – There are many points of potential failure in electronic communication (e.g. computer components, local Internet connection on both sides, server-side issues, storms, power outages, etc.). If a technology failure occurs, you and your therapist should have a plan for how to reconnect, such as a phone call, and decide whether to continue the session or reschedule. Generally, it is best for the therapist to have a reachable phone number for the client and have the therapist call the client, instead of both trying to call each other at the same time.

Emergency Situation/Duty to Warn – AGAPE cannot guarantee the safety of a client, particularly when the client is not at our office for a face-to-face session. It is important for your therapist to have client location information in order to alert emergency services, if the need arises. Each time a new session starts; the therapist needs to be informed of the client’s whereabouts and cannot assume they are at home. The client needs to be ready with this information. Your therapist will ensure that you have a safety plan that includes at least one emergency contact and the closest emergency room to your location, in the event of a crisis situation.

E-mail or Text Messaging – E-mail is not used as a form of distance therapy by AGAPE. It is intended more for administrative issues. Generally speaking, scheduling issues should be handled by calling the main office. Therapists try to respond to emails within 24 hours on business days, but it is not guaranteed.

Payment/Billing/Reimbursement – You should confirm with your insurance company that teletherapy (“video sessions,” or “telephone sessions”) will be reimbursed since not all insurance companies cover teletherapy sessions. Also, just as with regular office visits, not all therapeutic issues are covered under the "medical necessity" criteria of all insurance policies. Whether out of pocket payment or a co-pay, the payment will be collected automatically with a credit card either before or after the session, similar to our standard practice for face-to-face sessions. If your insurance company does not reimburse for teletherapy, you may be responsible for the full payment.

If you need to reschedule your appointment, we request that you notify our office with more than 24-hour advanced notice. If you attempt to reschedule with less than 24-hour notice, or if you fail to attend the appointment at the designated time, you may be subject to a no-show fee of up to \$40.

Limits of Teletherapy – Face-to-face therapy is the preferred method of delivery. Any version of distance-based therapy is qualitatively different than an in-person meeting. Body language, non-verbals and the like are hindered or absent with teletherapy. Even with the slight delay from real-time interaction, pauses and accidentally talking over each other can cause distraction. We elect to offer teletherapy as a temporary alternative to the absence of therapy since our goal is to provide needed therapy to the greater middle Tennessee area. It can still be a helpful and powerful experience, just be aware that it does not equate to face-to-face therapy.

Please Be Prepared and On Time – With the option of teletherapy, the client and therapist may not be in the same time zone. It is important to be aware of time zone differences and make sure to clarify the actual time of the session for each party. As a policy, we do not conduct therapy across state lines. Also, sessions typically last about 45 minutes. Please plan accordingly and make sure to get logged into the session on time and a few minutes early if possible. If you need to cancel or change your appointment time, please contact our main office at 615-781-3000.

If You Are Not an Adult – Please be aware that children under the age of 16 will require the permission of a parent or legal guardian (and their contact information) before you may participate in teletherapy sessions.

Ending Teletherapy – The counselor is required to monitor the effectiveness of teletherapy. If it is determined by the counselor that teletherapy is no longer appropriate, the counselor will encourage the client to participate in face-to-face sessions.

Client Signature _____ Date _____

Clinician Signature _____ Date _____