Assessment

Confidentiality

All sessions are completely in accordance with law and recognized professional standards. If I, as your counselor, need to communicate to another about your case, you must give me written permission to do so. The only exception to this is if in accordance with law and reasonable professional judgment, such communication appears needed to protect you or others from harm, or in response to legal process, or in other proper circumstances, the privileged nature of your communication will be ceased. Possible exceptions include, but are not limited to, the following situations: child abuse, abuse of the elderly or disabled, threats of suicide, and threats of homicide. Insurance companies are entitled to diagnosis, date, and type of service.

Informed Consent

Therapy is an interactive process between client and therapist. It is meant to promote change and understanding. Sometimes this process can be emotionally painful, and at other times, very fulfilling. You will be expected to contribute to all decisions regarding therapeutic interventions devised for you, including out of session assignments. You have the right to refuse or alter any service and intervention. While I will use my best effort to assist you, the nature of psychological services is that there can be no assurances or results, and no promises can be made regarding the outcome of any services provided. You should question the rationale of any services, interventions, and discussion if these seem unclear to you.

Fee Rate

The basic fee is $30 per group session.

Payment Method

Payment is expected at the time services are rendered, by cash, check or credit. Psychological reports or court reports will not be issued until full payment for services are received.

Missed Appointments

If you are unable to keep an appointment, please notify me immediately. If an appointment is canceled or missed without 24 hours prior notice, you will be billed for the missed session at the rate of $35. Third and subsequent late cancellations will be billed the full fee.

Consent

I, voluntarily, agree to receive mental health assessment, care, treatment or services and authorize the undersigned therapist to provide such. I understand and agree that I will participate in the planning of these services and that I may stop such care at any time. By signing this consent form, I acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification on anything unclear to me.

_____ _____

Client Date

_____ _____

Allison Spencer, LCSW Date

Consent for Treatment of Minors under the age of 18

I, _____ am the parent or legal guardian with legal custody of _____
(Parent/Guardian Signature)

and give permission to provide counseling services to my child(ren) identified above.

Client Information

Client Name _____ Date of Birth _____ Age _____

Partner Name _____

Parent(s) Name (for minor child only) _____

Address _____

City _____State _____ Zip Code _____

Employer _____ Occupation _____

School _____ Grade _____

Email _____

Cell Phone _____ Home _____ Other _____

Financial Responsibility

Name _____ Relationship _____

Address _____

City _____State _____ Zip Code _____

Email _____

Cell Phone _____ Home _____ Other _____

I accept full responsibility for all fees due to professional services. I realize that any third party billing is out of courtesy to me and does not transfer any financial responsibilities for unpaid services.

I understand that 24 hour notice is required to cancel or change an appointment, and that if 24 hours notice is not given, I am responsible to pay a cancellation charge of $15.

Signature of Responsible Party: _____ Date _____

Relational Difficulties
___ Marital/Partner problems
___ Communication problems
___ Remarried family problems
___ In-laws
___ Problems with your parents
___ Brother/ Sister problems
___ Sexual relationship problems
___ Separation
___ Divorce
___ Premarital issues
___Parenting

Physical Health Problems
___ Headaches
___ Back ache and neck pain
___ Lack of energy
___ Difficulty concentrating
___ Memory disturbances
___ Difficulty Sleeping
___ Decreased sexual drive
___ Loss/ Increase of appetite
___ Other _____

Emotional Difficulties
___ Depression
___ Anxiety
___ Panic attacks
___ Suicidal thoughts
___Suicide attempts
___Self harming
___Anger
___Aggressive (Verbal/Physical)
___ Sadness/Crying
___OCD
___ Loneliness
___ Low self esteem
___ Guilt/Shame
___ Career choices
___ Learning disability
___ Difficulty concentrating
___ Paranoia/Hallucinations
___ Impulsivity
___Hyperactivity
___Defiance
___Running away
___Withdrawing/Isolating
___Eating Disorder
___Nightmares
___PTSD

Current use or behavior problems with:
___ Alcohol
___ Drugs
___ Gambling
___ Sex/ Pornography
___ Eating
___ Shopping
___ Work
___ Other _____

Past use or behavior problems with:
___ Alcohol
___ Drugs
___ Gambling
___ Sex/ Pornography
___ Eating
___ Shopping
___ Work
___ Other _____

Situational Difficulties
___ Death of a loved one
___ Physical abuse (past or current)
___ Sexual abuse (past or current)
___Emotional abuse (past or current)
___Finances
___Few or no friends
___Problems at school
___Problems at work
___Sexual Identity(coming out)
___Legal problems
___Recent move
___Unemployment
___Bullying
___Drop in grades
___Job dissatisfaction
___Major change in your life

Please list the three items that are causing you the most difficulty:
1. _____
2. _____
3. _____

Have you ever seen a counselor before? ___ Yes ___ No If yes, When, where, how often and was it effective?

_____
_____
_____

Does anybody in your family have a history of mental health or substance abuse issues?
___ Yes ___ No If yes, please explain:

_____
_____
_____

What is your current living situation (who do you live with, where do you live, describe relationships)

_____
_____
_____
_____
_____
_____

Are you presently taking any medications? ___ Yes ___ No
If yes, please explain:

_____
_____
_____
_____
_____
_____

Are you involved in any legal proceedings? ___ Yes ___ No
If yes, please explain:

_____
_____
_____

Are there any financial issues that I need to be aware of? ___ Yes ___ No
If yes, please explain:

_____
_____
_____

What is your religious preference? _____
Do you want your faith to be a part of your treatment? ___ Yes ___ No
If yes, please explain:
_____
_____
_____

List family, friends, support groups or others who are helpful to you:
_____
_____
_____

What are your hobbies and recreational activities?
_____
_____
_____

Any other information that would be helpful for your treatment:
_____
_____
_____

TREATMENT PLAN

Presenting problem bringing you into treatment:

_____

_____

_____

_____

My goals for treatment are:

1. _____

2. _____

3. _____

Therapist Signature:_____ Date:_____

Client Signature:_____ Date:_____

Parent/Guardian Signature:_____
Date:_____