# The Hope Center for Healing - Melinda Rader, MS, LPC-S

****** Please carefully read the following information******

The purpose of the consent form is to inform you about the counseling service that Melinda Rader will be providing. This is to help you understand the therapeutic process, as well as, legal standards that apply. You must read and sign all documents before your first counseling appointment.

## Counseling Services

Mental health treatment varies depending on the personalities of the therapist and client. There are many different methods Melinda Rader will utilize to address what you may bring forward. For therapy to be successful, you will have to work on things during session and outside of session. Mental health treatment can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. Therapy may lead to improved mental health. However, there is no guarantee of what you may experience, and it is different for everyone.

## Policies

Counseling sessions will last 50-55 minutes. If you need to cancel or change your appointment, please let Melinda Rader know at least 24-hours in advance. If you give notice during the 24-hours leading up to your scheduled appointment, you will be charged the full rate of $175.00. If you are more than 15-20 minutes late for your appointment, you will still be charged for the full session. If you are needing emergency mental health assistance and/or having suicidal thoughts and will harm yourself, please call 911.

## Confidentiality

Counseling services assures its clients that confidentiality will always be maintained. All interactions with Melinda Rader are confidential. No information is provided to anyone unless you request a release of information form that would enable Melinda Rader to disclose any information with the person of your choosing. A court order may require an exception to lawful protection of your legal right to privileged communication with Melinda Rader. However, if it becomes clear that there is a real danger to your physical safety or the safety of others, Melinda Rader is legally allowed to break confidentiality to ensure your safety. Also, if you describe abuse of children or others unable to protect themselves, action may be necessary. Your counseling records can include private information. The records are locked in a secure location with only Melinda Rader having access to them.

## Consent to Services

By signing your name below, you acknowledge that you have read and understood the information on this form. If you have any questions about the information in this document, please ask Melinda Rader about it today. You may stop counseling services at any time should you decide that you are no longer interested in receiving therapy by giving notice to Melinda Rader.

_____ _____

Signature Date

# CONFIDENTIALITY AGREEMENT & LIMITS

All interactions which take place in the setting of therapy are considered confidential. This includes requests by telephone, all interactions with this counselor, any scheduling or appointment notes, all session content records and any progress notes that I take during your sessions. I will not even verify that you are a client. You may choose to give me permission in writing to release any or specific information about you to any person or agency that you designate**.**

Noted exceptions are as follows:

1. In some legal proceedings a judge may issue a court order. This would require this counselor to testify in court.
2. If I learn of or believe that there is physical or sexual abuse or neglect of any person under 18 years of age, I must report this information to county child protection services.
3. If I learn of or believe that an elderly person, or disabled person is being abused or neglected, I must file a report with the appropriate state agency that handles elder abuse.
4. If I learn of or believe that you are threatening serious harm to another person, I am obligated to report this. This can be in the form of telling the person who you have threatened, contacting the police or placing you into hospitalization.
5. If there is evidence that you are a danger to yourself and I believe that you are likely to kill yourself unless protective measure are taken, I may be obligated to seek hospitalization for you or to contact family members or others who can help provide protection
6. There may be times when I consult with outside sources about cases. In these cases, no personally identifiable information will be used to discuss this case. However, discussion topics will be used in order to ensure that I am getting and giving the best assistance possible. The persons with whom I discuss cases are legally bound to keep information confidential.

*I agree to the above limits of confidentially and understand their meanings and ramifications.*

_____ _____

Client Signature (Parent Guardian if under 18) Today's Date

# CANCELLATION POLICY

1. If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the **entire** cost of your missed appointment.

2. A full session fee is charged for missed appointments or cancellations with less than a 24- hour notice unless it is due to an illness or an emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment.

3. I understand that I am responsible for knowing the amount per session. It is **$175.00**.

4. I understand that these charges are an out of pocket expense and that my insurance carrier will not cover these charges.

5. I understand that the therapy session will last 50-55 minutes. I understand that if I am late to the appointment, I will still have to end the session at the allotted time. By signing this, I am agreeing to the above stated terms and stipulations regarding the services I receive from this therapist.

   Thank you for your consideration regarding this important matter.

_____

Signature of Responsible Party

_____

Date

# CLIENT INTAKE FORM

***Please provide the following information. Please Note: Information you provide here is held to the same standards of confidentiality as our therapy.***

Name: _____
(Last) (First) (Middle)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle)

Birth Date: ___/___/____ Age: _____

Gender: □ Male □ Female

Emergency Contact name and number: _____

Sexual Orientation: _____

Marital Status:

□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Please list any children/age:

_____

Address: _____
(Street name and number)

_____
(City, State, and Zip Code)

Home Phone: _____ May I leave a message: □ Yes □ No

Cell Phone: _____ May I leave a message: □ Yes □ No

Email: _____ May I Email you: □ Yes □ No
**Please note: Email/Text Messages correspondence is not considered to be a confidential medium of communication**

Referred by (if any): _____

## TREATMENT HISTORY

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? □ YES □ NO

Have you had previous psychotherapy?
□ YES □ NO If yes, previous therapist's name _____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?
□ YES □ NO

If yes, please list: _____

Prescribed by: _____

## HEALTH AND SOCIAL INFORMATION

Do you currently have a primary physician? □ YES □ NO

If yes, who is it? _____

Are you currently seeing more than one medical health specialist? □ YES □ NO

If yes, please list: _____

When was your last physical? _____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.: _____

Are you currently on medication to manage a physical health concern? □ YES □ NO
If yes list: _____
_____

Are you having any problems with your sleep habits? □ YES □ NO

If yes, check where applicable:
□ Sleeping too little □ Sleeping too much □ Poor quality sleep
□ Disturbing dreams □ other _____

How many times per week do you exercise? _____

Approximately how long each time? _____

Are you having any difficulty with appetite or eating habits? □ YES □ NO

If yes, check where applicable: □ Eating less □ Eating more □ Bingeing □ Restricting

Have you experienced significant weight change in the last 2 months? □ YES □ NO

Do you regularly use alcohol? □ YES □ NO

In a typical month, how often do you have 4 or more drinks in a 24-hour period?

_____

How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly
□ Rarely □ Never

Do you smoke cigarettes or use other tobacco products? □ YES □ NO

Have you had suicidal thoughts recently? □ Frequently □ Sometimes □ Rarely □ Never

Have you had them in the past? □ Frequently □ Sometimes □ Rarely □ Never

Are you currently in a romantic relationship? □ YES □ NO

If yes, how long have you been in this relationship? _____

On a scale of 1-10 (10 being the highest quality), how would you rate your current relationship? _____

In the last year, have you experienced any significant life changes or stressors?
If yes, please explain: _____

_____

Have you ever experienced any of the following?

| | |
|---|---|
| Extreme depressed mood | Yes / No |
| Dramatic mood swings | Yes / No |
| Rapid speech | Yes / No |
| Extreme anxiety | Yes / No |
| Panic attacks | Yes / No |
| Phobias | Yes / No |
| Sleep disturbances | Yes / No |
| Hallucinations | Yes / No |
| Unexplained losses of time | Yes / No |
| Unexplained memory lapses | Yes / No |

| | |
|---|---|
| Alcohol/substance abuse | Yes / No |
| Frequent body complaints | Yes / No |
| Eating disorder | Yes / No |
| Body image problems | Yes / No |
| Repetitive thoughts (e.g. obsessions) | Yes / No |
| Repetitive behaviors (e.g. frequent checking, hand washing | Yes / No |
| Homicidal thoughts | Yes / No |
| Suicidal attempts | Yes / No If yes, when? |

## OCCUPATIONAL INFORMATION

Are you currently employed? □ YES □ NO

If yes, who is your currently employer/position? _____

If yes, are you happy with your current position? _____

Please list any work-related stressors, if any _____

_____

_____

## RELIGIOUS/SPIRITUAL INFORMATION

Do you consider yourself to be religious? □ YES □ NO

If yes, what is your faith? _____

If no, do you consider yourself to be spiritual? □ YES □ NO

## FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

| **Difficulty** | **Yes / No** | **Family member** |
|---|---|---|
| Depression | Yes / No | |
| Bipolar disorder | Yes / No | |
| Anxiety disorder | Yes / No | |
| Panic attacks | Yes / No | |
| Schizophrenia | Yes / No | |
| Alcohol/substance abuse | Yes / No | |

| | | |
|---|---|---|
| Eating disorders | Yes / No | |
| Learning disabilities | Yes / No | |
| Trauma history | Yes / No | |
| Suicide attempts | Yes / No | |
| Chronic illness | Yes / No | |

**OTHER INFORMATION**

What do you consider to be your strengths? _____

_____

_____

What do you like most about yourself? _____

_____

What are effective coping strategies that you have learned? _____

_____

_____

What are your goals for therapy?

_____

_____

_____

_____