Journey Counseling Center, PLLC
2801 E Memorial Rd, Edmond, Oklahoma 73013
Office: (405) 425-5250 Fax: (405) 425-5451

Client Information

Client: ______________________________ ____________ ________
Last Name First Name MI Date of Birth Age

Home Address Street Apt. No. City State Zip

______________ May we leave ☐ Yes ______________ May we leave ☐ Yes
Home Phone Number a message? ☐ No Work Phone Number a message? ☐ No

Female __ Male __ ______________ ______________ ______________
Social Security Number Occupation/School Length of Employment/Grade

______________________________ ______________________________
Name of Employer/School Employer Address

☐ **Spouse** ____________________ __________ ________________ May we leave ☐ Yes
☐ **Parent** Name Date of Birth Work Phone Number a message? ☐ No

Social Security Number Occupation Length of Employment

Name of Employer Employer Address

Emergency ____________________ __________ ________________ May we leave ☐ Yes
Contact Name Relationship Phone Number a message? ☐ No

What concerns brought you to the office? ____
Referral Source: ____
Married? ____yes___no
Children? ___yes___no Name(s)________________,________________________________, _____________
Previous mental health/substance abuse treatment? ___yes___no
If yes When and Where?____
____
Religious Affiliation:_________________________________
Military Service? ___yes___no If yes are you currently active duty? Reserves? National Guard?________________

Payment for each visit is expected at the time of the visit. Payment may be made by check or cash. Your signature indicates you accept responsibility to pay for all services rendered and that you will be charged $50.00 for a missed appointment not cancelled 24 hours in advance.

X Client's or authorized person's signature: ______________________________ ________________
Date

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Insurance Information (Complete If Applicable)

Patient Name:______________________________

Patient DOB:______________________________

Insurance Company Name:____

Insurance Company Phone Number____

Member Name (If Different from Patient):____

Member DOB:_____________________________

Member Address (If Different):____

Patient Insurance ID #:____________________________________

Member Insurance ID # (If different):________________________

Insurance Group #:____

INFORMED CONSENT FOR TREATMENT

I hereby voluntarily consent to utilizing the services provided by my counselor/therapist. Possible services include: individual counseling/psychotherapy, family therapy, psychological consultation and psychological testing. I understand my counselor/therapist is not warranting a cure or offering any guarantee of results or improvement of any condition.

ASSUMPTION OF RISKS:
As a client utilizing the services of a mental health professional, I understand that I have the right to ask any questions I may have about the process, methods, duration, and goals of therapy; the right to discuss any concerns I may have about my progress in therapy; the right to discuss any concerns I may have about any progress in therapy; and the right to terminate therapy if I believe I am not making progress or if I find myself too uncomfortable, I understand that the potential benefits of undergoing psychological services may include obtaining a professional opinion, an increased understanding of my self and a relief of symptoms. Then too, I understand potential risks include: that in treatment, material may be discussed which is "difficult and Painful" and that this may be necessary to help contend with difficulties; that symptoms may not go away as quickly or as easily I would like. Because I have the right to refuse services at any time, I understand and agree that my continued participation in therapy implies voluntary informed consent. I understand that alternative procedures include services provided by another psychologist, psychiatrist or mental health professional.

LIMITS OF CONFIDENTIALITY:
All communication and records, which involve mental health treatment, are confidential. No one from this office may release any information except under the following special circumstances:

(1) upon express written consent of the client or legal guardian of a minor client; (2) if release is ordered by a court, or the client introduces their mental status into issue in a lawsuit; (3) if there is sufficient reason to suspect that abuse or neglect of a child, an elderly, disabled or incompetent individual is occurring; (4) upon the need to disclose information to protect the rights and safety of self or others if a client indicates he/she may present a danger to self or others. In such circumstances, possible actions could include notification of a family member, notification of law enforcement authorities, notification of individual(s) at risk of harm, arrangement for voluntary or involuntary hospitalization of the client; (5) if necessary to collect fees owed for professional services rendered, provided that only information relevant to the financial resolution may be disclosed; (6) if legal proceedings or complaints with a licensing board of regulatory body are initiated against the mental health professional. In that unlikely event, information necessary for response to such a claim or action may be disclosed.

RELEASE OF INFORMATION:
Under ordinary circumstances, the Psychological Record of your sessions will not be released to you congruent with present Oklahoma State Statutes. If you foresee this to be a difficulty, please discuss your concern with your therapist immediately.

STATEMENT OF UNDERSTANDING:
My signature below indicates I have read this form or it has been read and explained to me and that I fully understand the above information and that I consent for either myself or for a minor child for whom I am legally responsible to receive services.

X ______________________________ ______________________________

Client or Legal Guardian Date

____

Relationship to Minor Child

Consent to the Use and Disclosure of Behavioral Health Information
For Treatment, Payment, or Healthcare Operations

I understand that as part of my behavioral health care, **Journey Counseling Center, PLLC** originates and maintains behavioral health records describing my personal history, symptoms, assessment results, diagnoses, treatment, and any plans for future care or treatment. I further understand that this information serves as:
- a basis for planning my care and treatment
- a means of communication among the health professional who contribute to my care
- a source of information for applying my diagnosis and treatment information to my bill
- a means for a third-party payer to verify that services were billed as actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing.

I understand and have been provided with a patient privacy notice that provides a more complete description of information uses and disclosures. I understand I have the right to review the patient privacy notice prior to signing this consent. I understand that **Journey Counseling Center, PLLC** reserves the right to change the notices and practices, but that prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that **Journey Counseling Center, PLLC** is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent he has already taken action in reliance thereon.

By Oklahoma law I am required to notify you… that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as acquired Immune Deficiency Syndrome (AIDS).

In addition to the releases outlined above, information may be released to the following individuals/organizations for the indicated purpose:______________________________
____
I request the following restrictions to the use and/or disclosure of my health information:
____

You ___may ___ may not leave (appointment reminders) (counseling information) by phone
You___may____may not leave (appointment reminders) (counseling information) by text message
You ___ may ___ may not fax information to me. My fax number is: _______________
You ___ may ___ may not contact me by e-mail. My e-mail address is _____________________@_____________

X________________________________ ________________
Signature of Patient or Legal Representative Date Notice Effective

Journey Counseling Center, PLLC ___ accepts _____denies ____accepts conditionally the restrictions imposed on release of information as stated above.

____ ________________
Signature/Title Date

CURRENT SIGNS AND SYMPTOMS: (Self-Report)

	None	Mild	Moderate	Severe
Marital Conflict	____	____	____	____
Depressed Mood	____	____	____	____
Hopelessness	____	____	____	____
Suicidal Thinking	____	____	____	____
Disturbed Sleep	____	____	____	____
Appetite Changes	____	____	____	____
Significant Changes	____	____	____	____
Poor Concentration	____	____	____	____
Agitation	____	____	____	____
Mood Swings	____	____	____	____
Tension/Anxiety	____	____	____	____
Fearfulness	____	____	____	____
Hostility	____	____	____	____
Violent Behavior	____	____	____	____
Lawbreaking	____	____	____	____
Authority Conflict	____	____	____	____
Social Isolation	____	____	____	____
Alcohol Use	____	____	____	____
Drug Use	____	____	____	____

Current Medical Conditions: ____

Current Medications (and dosage if applicable): _________________________

____

Primary Care Physician: ____