OLIVE

COUNSELING

CENTER

WELCOME TO THE OLIVE COUNSELING CENTER!

Thank you for choosing our counseling center to help you with your counseling needs. We want to take this opportunity to explain our policies and procedures.

APPOINTMENTS:

We consider our appointments very important. Counseling is a commitment to work together. We hope you will also share in this commitment. Please do not miss sessions if possible. Therapy sessions are 50 minutes.

LIMITS OF CONFIDENTIALITY:

Information discussion in the counseling setting is held confidential and will not be shared without the written permission of the client except under the following conditions.

- The client threatens to harm self or another person.
- The client reports the abuse of a child, a person who is elderly, or a person who is disabled.
- The client reports sexual exploitation by a counselor, therapist or other mental health professional.
- Your counseling records by a state or federal court of law if legal action is taken against you.

RECORD MAINTENANCE AND EMERGENCY SITUATIONS:

Psychotherapy records must be maintained in our possession according to state laws. Copies of your records or a summary of such records will be provided upon written request. Reasonable cost of reproduction and time to prepare such records will be charged. If you should experience an emotional or behavioral crisis and we cannot be reached immediately by telephone, you and your family members are instructed to contact the "HELP" Line at 438-1617, dial 911, or present yourself at the nearest hospital emergency room. Our contact number is 850-473-4461.

FINANCIAL RESPONSIBILITY:

You are responsible for full payment of all services regardless of insurance coverage. At the

completion of each session you will receive a receipt of service that is appropriate to file with your insurance for reimbursement. Please make checks payable to Olive Baptist Church. Fees are as follows:

Initial Intake Session: $100.00 (50 minutes)
Individual Session: $90.00 (50 minutes)
Family/Couple Initial Session: $120.00 (50 minutes)
Family/Couple Session: $120.00 (50 minutes)

(We offer a sliding fee scale based on household income. Please let us know if you need this service. We do not want money to be the reason you do not receive help.)

We accept the following major credit cards: Visa, MasterCard, Discover and American Express. No fees will be charged for appointments canceled 24 hours or more prior to appointment date and time. *If you cancel your appointment less than 24 hours before it is scheduled, you will be subject to a charge of half your session fee.* You will not be seen again until the cancellation charge is paid. To avoid a cancellation fee, please provide cancellation notice at least 24 hours prior to your appointment. Voice mail is available 24 hours a day and messages are checked each business day. You may call 850-473-4461.

SOCIAL MEDIA AND TELECOMMUNICATION

Due to the importance of your confidentiality and the importance of minimizing dual relationships, we do not accept friend or contact requests from current or former clients on any social networking site (Facebook, Instagram, LinkedIn, etc.) We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about this matter.

I have read the Financial and Confidential Policies outlined in this document and agree to comply with these policies. I agree to the limits of confidentiality.

_____

Client's Signature Date

_____

Parent or Guardian's Signature Date

_____

Counselor's Signature Date

_____I have your permission to leave a message at the contact number if I need to reach you or as a courtesy call for an appointment reminder. I cannot ensure confidentiality through a text message.

Olive Counseling Center
1830 E Olive Road
Pensacola, Florida 32514
850-473-4461

FACE SHEET

1. Patient Name: _____
(Last) (First) (MI) (Nickname)

2. Address:_____
Street City State Zip Code

3. Email: _____

4. Home Phone: ( )_____ Cell: ( )_____

5. Work Phone: ( )_____ 6. DOB: _____ Age: _____

7. Sex: M F 8. Marital Status: Single Married Divorced Widowed

9. Employer: _____ 10. Occupation: _____

11. Student/School: _____

12. If dependent child, are custodial parents: ____ Married ____ Separated _____ Divorced ____ Other __

13. Religion: _____ 14. REFERRED BY: _____

15. IN CASE OF EMERGENCY NOTIFY:

Name:_____ Relationship: _____ Phone( )_____

****

FINANCIALLY RESPONSIBLE PARTY

Guarantor's Name: _____Birth Date: _____

Guarantor's Address:_____

Guarantor's Relationship to Patient: _____

Guarantor's Employer: _____ Phone:( ) _____ ___--__

****

I understand I am financially responsible for all service rendered to me or the client and agree to pay charges at the time services are provided.

Client Signature_____ Date:_____

Consent to Treatment

I do hereby seek and consent to take part in treatment with _____.
I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or any procedures provided by this therapist. I acknowledge that I have been informed counseling can be a painful process. I have had all my questions answered fully.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court system.)

I know I must call to cancel an appointment at least 24 hours before the time of the appointment to avoid late cancellation charges. Cancellations less than 24 hours before your appointment is scheduled, will be subject to a charge of half your session fee. I am aware that an agent of my insurance company or third-party payer may be given information about the type(s), cost(s) and providers of any service or treatments I receive. I understand payment for service is due at the end of each session, and I am responsible for full payment regardless of insurance coverage.

My signature below shows I understand and agree with all these statements.

_____

Signature of client (parent, guardian, or other representative) Date

_____

Relationship to Client

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian or other representative.) My observations of this person's behavior and responses give me no reason to believe this person is not fully competent to give informed consent and willing consent.

_____

Therapist Date

This questionnaire will help me get to know a little more about your situation and how I may be of help to you. If you feel uncomfortable with any question you may leave it blank and we can discuss it when we meet.

ADOLESCENT INTAKE FORM (ages 12-17)
(To be completed by the adolescent)

CLIENT INFORMATION

Name:_____
Date of Birth: _____ Age: _____ ❒ Male ❒ Female
Physical Address: _____
Mailing Address: _____
Phone (Cell): _____ Messages okay? _____
Phone (Home): _____ Messages okay? _____
School: _____Grade: _____
Race/Ethnic Origin: _____
Religious Preference: _____

PERSONAL STRENGTHS

What activities do you enjoy and feel you are successful when you try?

_____
_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe)

_____
_____

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem for which you are seeking counseling.

_____
_____

What would you like to see happen as a result of counseling?

_____

COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor? ❒Yes ❒No
If yes, what did you find most helpful in therapy?

_____
_____

If yes, what did you find least helpful in therapy?

_____
_____

CHEMICAL USE AND HISTORY

Do you currently use alcohol? _____Yes _____No
If yes, how often do you drink? _____Daily _____Weekly _____Occasionally _____Rarely
If yes, how much do you drink? _____ (#) per time.
Do you currently use tobacco? _____Yes _____No
If yes, how much do you smoke/chew? _____
Do you currently use any other drugs? _____Yes _____No
If yes, what drugs do you use? _____
If yes, how often do you use? _____Daily _____Weekly _____Occasionally _____Rarely
Have you received any previous treatment for chemical use? Y/N _____
If so, where did you go? _____
____Inpatient ____Outpatient

ADOLESCENTS (please answer the following with Y/N)

Have you ever used more than 1 chemical at the same time to get high? _____
Do you avoid family activities so you can use? _____
Do you have a group of friends who also use? _____
Do you use to improve your emotions such as when you feel sad or depressed? ____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family at present or have had a significant effect upon you in the past. _____

FAMILY HISTORY

Are your parents married or divorced? _____
Do you think their relationship is good? Y/N /Unsure)_____
If your parents are divorced, whom do you primarily live with? _____
How often do you see each parent? Mom_____% Dad _____%.
Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable.

_____

FAMILY CONCERNS (Please check any family concerns that your family is currently experiencing.)

____Fighting
____Feeling distant
____Loss of fun
____Lack of honesty
____Medical Concerns
____Education problems
____Financial problems
____Death of a family member
____Inadequate health insurance
____Inadequate housing/feeling unsafe Other
____Disagreeing about relatives
____Disagreeing about friends
____Alcohol or Drug use
____Trauma
____Infidelity (couple)
____Divorce/separation
____Issues regarding remarriage
____Birth of a child
____Job change or job dissatisfaction

Other concerns not listed:

_____

PEER RELATIONS

How do you consider yourself socially: __outgoing ___shy ___depends on the situation
Are you happy with the number of friends you have? (Y/N) _____
Have you ever been bullied? (Y/N) _____
Are your parents happy with your friends? (Y/N) _____
Are involved in any organized social activities (e.g. sports, scouts, music)?

_____

SCHOOL HISTORY

Do you like school? (Y/N) _____
Do you attend regularly? (Y/N) _____
What are your current grades? _____
Do you feel you are doing the best you can at school? (Y/N) _____
Is there anything else you would like me to know:

_____
_____
_____

Please note that the information is important for your child's care. Please fill out forms as completely as possible and have them ready before your first counseling session.

ADOLESCENT INTAKE FORM (ages 12-17)
(To Be Filled Out by the Parent(s)

Adolescent's Name: _____DOB: _____
Mother's/Guardian's Name: _____
Phone Contact: Home: ( )_____ Cell: ( )_____
Mother's/Guardian's Physical Address:
_____
Mother's/Guardian's Mailing Address:
_____

Father's/Guardian's Name: _____
Phone Contact: Home: ( ) _____ Cell: ( )_____
Father's/Guardian's Physical Address:
_____
Father's/Guardian's Mailing Address:
_____

CURRENT HOUSEHOLD AND FAMILY INFORMATION
Name: _____Age:____Sex:____Living with you? Y/N_____
Relationship (parent, sibling, etc): _____ Type (bio, step, etc): _____

Name: _____Age:____Sex:____Living with you? Y/N_____
Relationship (parent, sibling, etc): _____ Type (bio, step, etc): _____

Name: _____Age:____Sex:____Living with you? Y/N_____
Relationship (parent, sibling, etc): _____ Type (bio, step, etc): _____

Name: _____Age:____Sex:____Living with you? Y/N_____
Relationship (parent, sibling, etc): _____ Type (bio, step, etc): _____

Name: _____Age:____Sex:____Living with you? Y/N_____
Relationship (parent, sibling, etc): _____ Type (bio, step, etc): _____

Name: _____Age:____Sex:____Living with you? Y/N_____
Relationship (parent, sibling, etc): _____ Type (bio, step, etc): _____
Name: _____Age:____Sex:____Living with you? Y/N_____
Relationship (parent, sibling, etc): _____ Type (bio, step, etc): _____

Name: _____Age:____Sex:____Living with you? Y/N_____
Relationship (parent, sibling, etc): _____ Type (bio, step, etc): _____

(If additional space is need please list on the back of page)

Current Reason for Seeking Counseling for Your Adolescent:
Briefly describe the problem for which your adolescent is seeking counseling?

_____
_____
What would you like to see happen as a result of counseling?

_____
_____
What is most concerning right now?

_____
_____

COUNSELING HISTORY
Have your son or daughter previously seen a counselor? ❒Yes ❒No If Yes, where:

_____

Approximate Dates of Counseling:

_____
For what reason did your son or daughter go to counseling?

_____
_____
Does your son or daughter have a previous mental health diagnosis?

_____
What did you find most helpful in therapy?

_____
_____
What did you find least helpful in therapy?

_____
_____

Has your son or daughter used psychiatric services? Yes____ No____ If yes, who did they see?
_____
If yes, was it helpful? N/A____ Yes____ No_____

Has your son or daughter taken medication for a mental health concern? Yes ____ No _____
Does your son or daughter have other medical concerns or previous hospitalizations? Y/N ___
If so, please describe: _____
_____

CHILD'S DEVELOPMENT
Were there any complications with the pregnancy or delivery of your child?
Yes ___ No ___ If yes, describe:
_____
_____
Did your child have health problems at birth? Yes _____ No _____ If yes, describe:
_____
_____
Did your child experience any developmental delays (e.g. toilet training, walking, talking)?
Yes ___ No ___ Not sure_____ If yes, describe:
_____
_____
Did your child have any unusual behaviors or problems prior to age 3?
Yes ___ No ___ Not sure_____ If yes, describe:
_____
_____
Has your child experienced emotional, physical, or sexual abuse?
Yes ____ No ____ Not sure _____ If yes, describe:
_____
_____

CHEMICAL USE
Do you have any concerns with your son or daughter using alcohol or drugs? (Y/N) _____
If yes, please explain your concern:
_____
_____

INTERNET/ELECTRONIC COMMUNICATIONS USAGE
Do you have any concerns with your son or daughter using the internet or electronic communication such as Facebook, Snapchat, Twitter, texting etc? (Y/N) _____

If yes, please explain your concern:

_____

_____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family, son or daughter, at present, or have had a significant effect upon you or your son or daughter in the past.

_____

_____

FAMILY HISTORY

(Please answer the following as best as you can, we understand that you may not be able to answer some of the questions pertaining to the other parent.)

Father's Name: _____DOB:_____ Age: _____
Ethnic Origin: _____
Total years of education completed: _____ Occupation: _____
Place of Employment: _____
Military experience? Y/N _____ Combat experience? Y/N _____
Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____

Mother's Name: _____DOB:_____ Age: _____
Ethnic Origin: _____
Total years of education completed: _____ Occupation: _____
Place of Employment: _____
Military experience? Y/N _____ Combat experience? Y/N _____
Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____

PARENT'S MARITAL STATUS

❒Single ❒Married (legally) ❒Divorced ❒Cohabitating ❒Divorce in process ❒Separated ❒Widowed ❒Other _____
Length of marriage/relationship:_____
If divorced, how old was your child at time of divorce? _____
If divorced, how much time does your child spend with each parent?
Mother_____%, Father _____%

FAMILY CONCERNS Please check any family concerns that your family is currently experiencing:

___Alcohol or drug use
___Birth of a child
___Death of a family member
___Disagreeing about friends
___Disagreeing about relatives
___Divorce
___Education problems
___Feeling distant
___Fighting
___Financial problems
___Inadequate health insurance
___Inadequate housing/feeling safe
___Infidelity (couple)
___Issues regarding remarriage
___Job change or dissatisfaction
___Lack of honesty
___Loss of fun
___Medical concerns
___Trauma
___Other (Describe:)_____
_____

Have you or anyone in your family experienced any abuse (physical, verbal, emotional, or sexual) inside or outside of your home? Please describe as much as you feel comfortable.

_____
_____
_____

Have you or anyone in your family been treated for issues relating to depression, anxiety, suicide or other mental health disorders? If so, please describe:

_____
_____

YOUR ADOLESCENT'S STRENGTHS

What activities do you feel your son or daughter is successful when they try?

_____
_____

What personal qualities would you say your son or daughter has?

_____
_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your son or daughter's life? (Please describe):

_____
_____
_____

Is there anything else you would like me to know?

_____