



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 to take place, 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. 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

Adult Psychosocial Form

Client's Name: _____ Date: _____

Address: _____

Street City State Zip Code

Home Phone: () _____ Cell: () _____

Date of Birth: _____ Age: _____

Email: _____

Emergency Contact: _____ Relationship: _____

Phone: () _____

Reason for seeking services today:

Please check behaviors and symptoms that occur more often than you would like them to:

- | | | |
|---|--|--|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Panic Attacks |
| <input type="checkbox"/> Alcohol dependence | <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Phobias/Fears |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Grief | <input type="checkbox"/> Poor judgment |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Self-Esteem Problems |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Sexual Difficulties |
| <input type="checkbox"/> Compulsive behavior | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Concentration Problems | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Social Withdrawal |
| <input type="checkbox"/> Cyber addiction | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Thoughts disorganized |
| <input type="checkbox"/> Disorientation | <input type="checkbox"/> Irritability | <input type="checkbox"/> Trembling |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Unresolved Trauma |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Memory impairment | <input type="checkbox"/> Worrying |
| <input type="checkbox"/> Drug dependence | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Other (specify): |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Obsessive Thoughts | _____ |

Employment

Please check employment status:

employed full-time employed part-time unemployed disabled retired

If currently employed, please list job information below:

Employer	Job Title	How long there?
_____	_____	_____

Family/Living Situation

Single Partnered Married Separated Divorced Widowed

Name of Spouse or Partner: _____ Age: _____

How long together? _____

Children:

_____	Age: _____	Living with you? <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Age: _____	Living with you? <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Age: _____	Living with you? <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Age: _____	Living with you? <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	Age: _____	Living with you? <input type="checkbox"/> Yes <input type="checkbox"/> No

Counseling/Prior Treatment History

Have you had any prior professional counseling or psychiatric treatment? Yes No

If yes, please list most recent treatment episodes, who treated you, and outcome below:

Approximate Treatment Dates:	Treatment Provider/Facility:	Outcome:
_____	_____	_____
_____	_____	_____

Medication and Chemical Use History

Have you ever been treated for alcohol or drug dependence/abuse? Yes No

Have you ever felt like you should cut down on alcohol or other drug use? Yes No

Has a friend or relative ever discussed concerns about your drug use? Yes No

Have you ever felt guilty about your drinking or drug use? Yes No

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? Yes No

Is there a history of problems with alcohol or drug use in your family? Yes No

Medical/ Physical Health

List any current health Concerns:

Primary Care Physician:

Name: _____ Phone: () _____

Current Prescribed Medications:	Dosage:	Frequency:	Purpose:	Side Effects:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Family History/Development

List any pertinent family history of medical, mental health, or substance abuse problems:

Have you ever been a victim of sexual, physical, emotional, or verbal abuse? __ Yes __ No

Are there other unusual/traumatic circumstances that affected your development? __ Yes __ No

If Yes, please describe: _____

Spiritual History

Religious upbringing: _____ Present Affiliation: _____

Is this an important part of your life? _____ Why/why not? _____

Where are you at spiritually right now? _____

Family of Origin Information

Parents:

Father alive? _____ Where residing? _____ Relationship: _____

Mother alive? _____ Where residing? _____ Relationship: _____

Siblings:

Circle your place in the family. If a sibling is deceased, put an X through the placement number.

- #1 M F Age: _____
- #2 M F Age: _____
- #3 M F Age: _____
- #4 M F Age: _____
- #5 M F Age: _____
- #6 M F Age: _____

Family alcoholism or domestic violence? _____
Sexual Addictions or Abuse? _____

Parents divorced? _____ If yes, what year? _____ Your age at the time: _____
If deceased, what year? _____ Your age at the time _____ Cause of death _____
Any step-parents? _____ If yes, describe when and your relationship with them:

If raised by someone other than your birth parents, describe the situation in some detail:

Tell anything else in the space below that you think would be helpful for me, as your therapist, to know:

Please state what you would like to work on in therapy:

Therapist's Signature

Date