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:_____

Parental Consent to Treat a Minor

I, _____
(name of Parent or Guardian of child),
give my permission for my child,

_____
(full name of Minor),

_____
(birth date AND age of Minor),
to be treated by _____ in psychotherapy.

I also understand that for therapy to be successful with any individual, their confidentiality needs to be respected, even in the case of a minor child, **with exceptions of if the minor is a danger to himself/herself or to others.**

I understand that this permission to treat with respect for my child's confidentiality is given with my full consent. This consent will be valid throughout the duration of therapy, or until the following date: _____ (date consent expires).

_____
Parent or Guardian's Signature Relationship to Minor Today's Date

_____
Print name of Parent or Guardian

_____
Address of Parent or Guardian (Street, City, State, Zip code)

_____
Other Parent or Guardian's Signature Relationship to Minor Today's Date

_____
Print name of Other Parent or Guardian

_____
Address of Parent or Guardian (Street, City, State, Zip code)

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

Child Intake Form

(11 yrs old and under)

Child's Name: _____ DOB: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Parent Cell Phone: ( ) _____

Email: _____

School: _____ Phone:_____ Teacher:_____ Grade: _____

How does your child do in school academically?

_____

How does your child do in school behaviorally?

_____

Does your child have a learning or physical disability? _____Yes _____No _____Maybe

Specify: _____

Does your child have a mental health diagnosis? _____Yes _____No

Specify: _____

Does your family have specific spiritual beliefs?

_____

Medical History

During pregnancy, did mother use: _____ Cigarettes _____ Alcohol _____ Drugs

_____ Experience Extreme Stress?

Specify frequency, amounts, and duration: _____

_____

List any birth complications (Ex: premature, jaundice, C-section, etc.)

_____

List any medical conditions or history (Ex: surgeries, broken bones, allergies, etc.)

_____

Does child use: _____ Cigarettes _____ Alcohol _____ Drugs

Specify amount and frequency:

_____

Primary Care Physician:

Name: _____ Phone: ( ) _____

Last seen on: _____

Current Prescribed Medications	Dosage	Frequency	Purpose	Side Effects

Medication Allergies:

_____

Other Allergies:

_____

In the first two years, did your child experience:

_____ Separation from mother _____Out of home care _____Disruption in bonding

_____ Depression of mother _____ Abuse _____ Neglect _____Chronic pain

_____Chronic Illness _____Parental Stress

If yes, please specify:

_____

Reached developmental milestones: _____On time _____ Early _____Late

How many times has the child moved homes? _____

What are five adjectives that describe:

Mother:

_____

Father:

_____

Child:

_____

Parental Relationship:

_____

Family History

Biological Dad: _____ DOB: _____

Biological Mom: _____ DOB: _____

____/____/____ Married ____/____/____ Separated ____/____/____ Divorced

Siblings (1st to last):

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Custodial Adults (If not biological parents):

Name: _____ DOB: _____

Date became caretaker: _____

Name: _____ DOB: _____

Date became caretaker: _____

People in household, if different from above:

_____

Does father work outside of the home? ___Yes ____No
Occupation: _____ Hours:_____

Father's highest level of education: _____

Does mother work outside of the home? ___Yes ___No
Occupation: _____ Hours:_____

Mother's highest level of education:

_____

If separated or divorced, visitation schedule:

_____
_____

Has the child experienced any significant loss? _____If yes explain:

_____
_____

What do you view as your child's major strengths and positive traits?

_____

_____

What are your child's hobbies?

_____

_____

Where do you believe your child is spiritually?

_____
_____

How does your child handle anger?

_____

_____

How does your child handle anger?

_____

_____

Does either parent have legal issues?

_____

List any history of mental illness or addiction in immediate or extended family (Ex: depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.):

_____
_____
_____

Has child witnessed domestic violence? ____Yes ____No Specify:

_____

_____

How is your child disciplined? Please list each method and frequency of use:

Trauma History

Has your child been verbally abused? __Y, __N, __Suspected. Specify:

_____
_____

Has your child been physically abused? __Y, __N, __Suspected. Specify:

_____

_____

Has your child been sexually abused? __Y, __N, __Suspected. Specify:

_____

_____

Other stressors or traumas?

_____

_____

Check the symptoms your child displays and list the number of times per week symptom is displayed:

__Anger
__Anxiety
__Acts out sexually
__Bed wetting
__Conduct problems
__Controlling day defecation
__Day wetting
__Defiance
__Depression
__Disassociates
__Drug or alcohol use
__Has unusual sexual knowledge
__Homicidal thoughts
__Hyperactivity
__Hyper vigilance
__Impaired conscience
__Isolation
__Lack of empathy
__Lack of motivation
__Lethargy
__Low impulse control
__Low self-esteem
__Lying
__Masturbates excessively
__Nightmares
__Obsesses
__Over/under eating
__Peer problems
__Phobias
__Plays out sexual themes
__Plays out violent themes
__Running away
__Shy
__Sleeplessness
__Somatic symptoms: (headaches, stomach aches, etc)
__Stealing
__Tantrums
__Other (specify):

Briefly describe your goals for your child's therapy:

_____

_____

Please list any information you deem to be important for the therapist to know:

_____

_____

_____

_____

Therapist Signature Date