Turning Point Counseling Center

New Client Profile

Client Name: ____
First Middle Last

Physical Address: ____

City: _____________________________ State: _____________ Zip Code: ______________

Mailing Address if different from physical address: ____

City: _____________________________ State: _____________ Zip Code: ______________

Date of Birth: _____________ ☐ Male ☐ Female ☐ Other/Identify as: ____________________

Sexual Orientation/Preference: ___________________

Race (Optional): ☐ White ☐ African American ☐ Latino ☐ Other: ________________________

Married: __ Partner ___ Separated: ___ Divorced: ___ (# of times ___) Widowed: ___ Single: ___

Contact Information:

Cell Phone: _________________________ May we contact your cell: ☐ Yes ☐ No

Would you like appointment reminders sent via text to your cell phone: ☐ Yes ☐ No

Home Phone: __________________________ May we contact your home phone: ☐ Yes ☐ No

Email: ____ May we email you: ☐ Yes ☐ No
(Please note email correspondence is not considered to be a confidential medium of communication)

School: (if a student) ____ Grade: ________

Highest grade or degree completed: _____________

Employer Name (if applicable): _____________________________ Phone: __________________

Were you referred to us? ☐ Yes ☐ No Referral Source: _____________________________

Do you have a church affiliation or spiritual influence? ☐ Yes ___________________________ ☐ No

Spouse/Partner Information:

Spouse/Partner Name: ___________________________ Date of Birth: _______________

Cell Phone: ____________________________ Home Phone: _____________________

Employer Name: _________________________ Phone: ___________________________

In the event of an emergency may we contact your spouse/partner? ☐ Yes ☐ No

Emergency Contact if other than spouse/partner:

Name: ___________________________ Phone Number: _________________ Relationship: ___________

Members of Immediate Household:

Name	Relationship	Age

Family History:

Is there a family history of mental health/behavioral related disorders? ☐Yes ☐No

If yes, please specify family member (parent, sibling etc.) and disorder (depression, substance abuse, etc.)

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Insurance

If you are using insurance and are not the primary policyholder, please leave the primary cardholder information below to ensure your benefits can be obtained. (If self, please skip this section)

Name: ____ Date of Birth: ___________________

Address: ____

City: ______________________ State: _________ Zip Code: _______________

Phone: ____________________________________

We will obtain a copy of your insurance card for our records to determine eligibility and benefits.

Do you have a secondary Insurance? ☐Yes ☐No

Please note: We do not submit to secondary insurance currently. We will give you a superbill so that you are able to submit to your secondary insurance.

Presenting Problem: Please give a brief description of why you are attending today?

____
____
____

On a scale of 1 to 10 what is your level of distress today: (1 very little / 10 – very distressed) __________
Are you currently experiencing any suicidal thoughts? ☐Yes ☐No
Have you experienced any suicidal ideations in the past? ☐Yes ☐No
If yes, did you have a plan? ☐Yes ☐No

Have you received mental health treatment or therapy in the past? ☐Yes ☐No

If yes, what was the reason for seeking therapy at that time? ___________________________________

Medical/Health Screen: Coordination of Care

Are you currently receiving medical treatment for any conditions ☐Yes ☐No

If yes, please specify: ____

Would you like Turning Point to Coordinate Care with your Primary Care Physician?
Please **check** one of the below:

☐No – I decline to have any information released to my PCP at this time.
☐No – I do not currently have a Primary Care Physician.
☐Yes- I authorize, Turning Point Inc. to release or exchange the following information from my behavioral health record in order to coordinate care.
☐Yes-Diagnosis & Therapist Summary
☐Other: ____

Name of PCP: ____

Address: ____

Phone: _____________________________ **Fax: _______________________________**

Note: You have the right to revoke the Coordination of Care authorization at any time in writing, except to the extent that action has already been taken based on the authorization chosen.

Are you currently taking any prescription medications ☐Yes ☐No (If yes, please specify)

Medication	Dose	Frequency	Prescribing Physician

Abuse History:

Do you have a history of physical, sexual, emotional abuse, domestic violence, or neglect? ☐Yes ☐No

Other: ____

Addictions History: (if none please skip)

Are you currently, or have you ever abused any of the substances listed below? ☐Yes ☐No

Does client have family history of addictions or substance abuse? ☐Yes ☐No

Are there other forms of addiction present (internet, pornography, gambling, sexual)? ☐Yes ☐No

List Here: ____

Substance Use History (if applicable):

Substance	Currently Using	Date of first use	Frequency of use	Amount used	Date of last use	Family History
Alcohol						
Nicotine						
Opiates						
Amphetamines						
Marijuana						
Other:						

Criminal History:

Have you ever been incarcerated? ☐Yes ☐No (If yes, specify below)

Jail/Prison (Location)	Conviction	Duration of Incarceration (Dates)	Probation(Duration)

Please check any of the following below that apply to you today:

☐ Stress ☐Anxiety ☐Depression ☐Substance Abuse ☐Physical Pain

☐Financial Worries ☐Physical Abuse ☐Emotional Abuse ☐Grief

☐Marriage/Partner ☐Anger ☐Hopelessness ☐Trauma ☐Family

☐ Other: Please explain: ____

<u>CHILD/Adolescent Information</u> (if applicable)

Custodial Information (<u>if client is a minor</u>):

Please list below names of those with legal parental rights to this minor:

Are parents of child divorced? ☐Yes ☐No If yes, is custody shared? ☐Yes ☐No

Have all custody arrangements been resolved/finalized? ☐Yes ☐No

Note: <u>copy Legal Guardianship paperwork or copy of final divorce decree may be requested</u>

<u>Biological Father</u>: ____________________________________ Legal Guardian: ☐Yes ☐No

Address if different from above: ____

Phone if different from above: ___________________

<u>Biological Mother:</u> ___________________________________ Legal Guardian: ☐Yes ☐No

Address if different from above: ____

Phone if different from above: ___________________

<u>Other Legal Guardian(s):</u> ____ Phone: _____________________

Address if different from above: ____

Phone if different from above: ___________________ Relation to client: _______________________

<u>Is there anything you would like to share with us regarding your child? (Please use space below).</u>

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HIPAA / Informed Consent for Treatment

* I understand that I am consenting only to mental health treatment that my counselor is qualified to provide within the scope of the professional (or his/her supervisor's) license, certification, and training he/she has obtained. I understand that if I am seeing an unlicensed master's level therapist who is obtaining clinical hours for licensure that my case may be discussed with their licensed clinical supervisor.

* I understand my treatment will be kept confidential and is protected by Federal Law and regulations (see 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal Laws and 42 CRF part 2 for Federal regulations).

* Release of information will only occur by my signed and witnessed consent. In compliance with the Laws of the State of Indiana, the exceptions to this rule would include suspected child abuse/neglect, disabled or elder abuse/neglect, danger to self or others, a court order, and in the treatment of minors to biological parents or legal guardians (except those minors seeking treatment for substance abuse.)

* I agree that I am fully responsible for payment at the time of service unless prior arrangements have been made. I agree to adhere to the fees, scheduling, and cancellation policies of Turning Point Inc. I understand the following fees:

a) No show - $**40 fee**
b) Less than 24 hours cancellation notice - $**40 fee**
c) Court Testimony (including travel, preparation, waiting) - **$100 per hour**
d) Phone/In Person Consultation – sliding fee scale per household income
3) Records Request – **No Charge**

* I understand that Turning Point Counseling will be using a HIPAA compliant program for any video sessions. Confidentiality will be as secure as the HIPAA program and Turning Point Counseling can enforce. I agree to accept possible risk.

* I understand my clinical information/treatment plan/diagnosis may be shared with my insurance company should said company request further information needed for payment of services.

* If you have authorized such, a confidential voicemail/text message may be left 24 hours a day, 7 days a week. Our therapist's will try to return all messages within 24-48 hours. If there is an emergency, please call 911 or go to the closest emergency room.

* If the client is a minor, I certify I have the legal right to authorize treatment for the minor.

* Electronic Communication – cell phones, email, etc may be used within the scope of treatment by mutual choice between you and your therapist. While Turning Point takes every precaution for security and privacy, if you choose to use electronic devices you waive your right to confidentiality within them

* I affirm that Turning Point Inc. has offered me a copy of the privacy practices (signed in your intake packet) and that I am aware of my HIPAA rights. I also acknowledge that a copy of the privacy practices will be placed in my file should I request a copy at a later time.

Turning Point Inc. accepts the following forms of payment:
Cash * Check * Visa/Mastercard/Discover/American Express * Website Payment * Phone Payment

Note: Acknowledgement by signature located on final page

Acknowledgement and Consent

My signature below indicates that I have read, understood, and consented to the above items and the provisions set forth by HIPAA regulations:

Client(s) Signature:

____ **Date:** _________________

____ **Date:** __________________

Custodial Parent/Guardian (if client is a minor):

____ **Date:** __________________

Counselor Signature: ____ **Date:** __________________