Background Information

Date of First Appointment: ________________

Last Name: _________________________ First Name: ________________________ MI: ____

SSN: _____-____-_____ DOB: ___/___/___ Age: ____ Sex: ☐ M ☐ F Ethnicity _________

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Address: _________________________ City: __________________ State: ____ Zip: _______

Home Phone:________________ Work Phone:________________ Cell Phone:_____________

E-mail_____________________________

Check if we can leave a message on your: ☐ Home phone ☐ Work Phone ☐ Cell Phone

EMERGENCY CONTACT (If client is under 18 or under legal guardianship, list Parent/Guardian)

Last Name: _________________________ First Name: _________________________ MI: ___

Address: _________________________ City: ____________________ State: ____ Zip: ______

Home Phone: _____________ Work/Other Phone: _____________ Relationship: ____________

HEALTH CARE RESOURCES

☐ Private Insurance ☐ Public Insurance (Medicaid) ☐ None

Insurance Provider: ____

Policy/ID #: ________________________________ Group #:__________________________

Policy Holder (name as it appears on the insurance card): _____________________________

Policy Holder Date of Birth: ___________________________

Policy Holder Employer:____

____

CURRENT LIVING SITUATION & FAMILY HISTORY

I live (check one): ☐ Alone ☐ w/Significant Other ☐ in Community Based Shelter

☐ Other: ____________________ Number of Persons in Home: _____

CHILDREN LIVING IN HOME (use back if needed)

Last Name: _________________, First ________________, MI ___ Age __ ☐ Male ☐ Female

Last Name: __________________, First _______________, MI ___ Age __ ☐ Male ☐ Female

Last Name: _________________, First _______________, MI ___ Age __ ☐ Male ☐ Female

OTHERS LIVING IN HOME (use back if needed)

Name: _______________________________ Relationship to Client: ______________________

Name: _______________________________ Relationship to Client: ______________________

Office use only: **Client Record #**______________ ☐ Check if shared file. Shared record #______________

CHILDREN LIVING OUTSIDE OF HOME (use back if needed)

Last Name: _________________, First _______________, MI ___ Age __ ☐ Male ☐ Female

City & State ______________________ If minor, with whom ___________________________

Last Name: _________________, First _______________, MI ___ Age __ ☐ Male ☐ Female

City & State ______________________ If minor, with whom ___________________________

PRESENTING PROBLEM/HISTORY OF PRESENTING PROBLEM

Who referred you? ____

Please write a couple of sentences concerning the reason for your request of services.

____

____

____

Please check your employment status ☐ Full-time ☐Part-Time ☐Unemployed ☐Not in Labor Force

If employed, who is your employer?

____

What is the highest level of education you have received?________________________________

In the past 60 days, how many days have you or the minor been absent from school and/or daycare?

____

Have you served in the military? ____ If so what is your current status? _____________________

Are you currently receiving any government assistance? ____ If so, what programs? ___________

Please check all that apply ☐ Medicaid ☐ Medicare ☐ SSI ☐ SSDI

Are you currently using tobacco products? ___ If so, please describe your use. _______________

How many days have you used tobacco in the past 30 days?______________________________

Are you currently using alcohol? ___ If so, please describe your use. ________________________

Are you currently using other substances? ___ If so, please describe your use. ________________

How many times have you been in jail in the past 30 days?__________ 12 months?___________

Have you ever experienced (check all that apply): ☐ Physical Abuse, ☐ Emotional / Verbal Abuse, ☐ Sexual Abuse / Molestation / Sexual Misconduct, ☐ Neglect, ☐ I would rather not answer these

Have you ever attempted suicide? YES or NO

If “yes,” identify month & year of attempt(s) ____

Have you ever had thoughts of suicide? YES or NO

If “yes,” identify month & year of latest thought(s) _____________________________________

Office use only: **Client Record #**_____________ ☐ Check if shared file. Shared record #_____________

MEDICAL

Are you currently under the care of a physician for medical problems/medication? ☐ Yes ☐ No

If yes, describe: ____

____

Physician Name: ____________________________ Phone: ____________________

Address: _____________________ City, State, Zip: ________________________

Are you currently taking medications? ☐ Yes ☐ No

If yes, list those you are currently taking (use back if needed):

	Medication	Strength & Dosage	Length Taken	Purpose & Side Effects
☐	______________	__________	______	______________
☐	______________	__________	______	______________
☐	______________	__________	______	______________

Please list any allergies:____

Are you currently receiving behavioral/mental health services elsewhere? ☐ Yes ☐ No

If yes, provide the following:

Date	Type*	Where	Purpose/Diagnosis
________	_____	____________	________________

* out-patient, in-patient, crisis intervention, day treatment, group, etc.

Have you received behavioral/mental health services in the past? ☐ Yes ☐ No

If yes, provide the following (use back if needed):

Date	Type*	Where	Purpose/Diagnosis
________	_____	____________	________________
________	_____	____________	________________
________	_____	____________	________________

How many self-help meetings have you attended in the past 30 days? ____________________

Please include any other information you feel is important for therapist to know.

____

____

____

Office use only: **Client Record #**__________ ☐ Check if shared file. Shared record #__________

Background Information

Date of First Appointment: ________________

Last Name: _________________________ First Name: ________________________ MI: ____

SSN: _____-____-_____ DOB: ___/___/___ Age: ____ Sex: ☐ M ☐ F Ethnicity _________

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Address: _________________________ City: __________________ State: ____ Zip: _______

Home Phone:________________ Work Phone:________________ Cell Phone:_____________

E-mail_____________________________

Check if we can leave a message on your: ☐ Home phone ☐ Work Phone ☐ Cell Phone

EMERGENCY CONTACT (If client is under 18 or under legal guardianship, list Parent/Guardian)

Last Name: _________________________ First Name: _________________________ MI: ___

Address: _________________________ City: ____________________ State: ____ Zip: ______

Home Phone: _____________ Work/Other Phone: _____________ Relationship: ____________

HEALTH CARE RESOURCES

☐ Private Insurance ☐ Public Insurance (Medicaid) ☐ None

Insurance Provider: ____

Policy/ID #: ________________________________ Group #:__________________________

Policy Holder (name as it appears on the insurance card): _____________________________

Policy Holder Date of Birth: ___________________________

Policy Holder Employer:____
____

CURRENT LIVING SITUATION & FAMILY HISTORY

I live (check one): ☐ Alone ☐ w/Significant Other ☐ in Community Based Shelter

☐ Other: ____________________ Number of Persons in Home: _____

CHILDREN LIVING IN HOME (use back if needed)

Last Name: _________________, First _______________, MI ___ Age __ ☐ Male ☐ Female

Last Name: _________________, First _______________, MI ___ Age __ ☐ Male ☐ Female

Last Name: _________________, First _______________, MI ___ Age __ ☐ Male ☐ Female

OTHERS LIVING IN HOME (use back if needed)

Name: _______________________________ Relationship to Client: ______________________

Name: _______________________________ Relationship to Client: ______________________

Office use only: **Client Record #**_____________ ☐ Check if shared file. Shared record #____________

CHILDREN LIVING OUTSIDE OF HOME (use back if needed)

Last Name: _________________, First ______________, MI ___ Age __ ☐ Male ☐ Female

City & State ____________________ If minor, with whom _________________________

Last Name: _________________, First ______________, MI ___ Age __ ☐ Male ☐ Female

City & State ____________________ If minor, with whom _________________________

PRESENTING PROBLEM/HISTORY OF PRESENTING PROBLEM

Who referred you? ____

Please write a couple of sentences concerning the reason for your request of services.

____

____

____

Please check your employment status ☐ Full-time ☐Part-Time ☐Unemployed ☐Not in Labor Force

If employed, who is your employer?

____

What is the highest level of education you have received?______________________________

In the past 60 days, how many days have you or the minor been absent from school and/or daycare?

____

Have you served in the military? ____ If so what is your current status? ____________________

Are you currently receiving any government assistance? ____ If so, what programs? ___________

Please check all that apply ☐ Medicaid ☐ Medicare ☐ SSI ☐ SSDI

Are you currently using tobacco products? ___ If so, please describe your use. _______________

How many days have you used tobacco in the past 30 days?______________________________

Are you currently using alcohol? ___ If so, please describe your use. _______________________

Are you currently using other substances? ___ If so, please describe your use. ________________

How many times have you been in jail in the past 30 days?__________ 12 months?___________

Have you ever experienced (check all that apply): ☐ Physical Abuse, ☐ Emotional / Verbal Abuse, ☐ Sexual Abuse / Molestation / Sexual Misconduct, ☐ Neglect, ☐ I would rather not answer these

Have you ever attempted suicide? YES or NO

If "yes," identify month & year of attempt(s) ______________________________________

Have you ever had thoughts of suicide? YES or NO

If "yes," identify month & year of latest thought(s) __________________________________

MEDICAL

Are you currently under the care of a physician for medical problems/medication? ☐ Yes ☐ No

If yes, describe: ____

____

Physician Name: ___________________________________ Phone: ________________________

Address: __________________________ City, State, Zip: ______________________________

Are you currently taking medications? ☐ Yes ☐ No

If yes, list those you are currently taking (use back if needed):

	Medication	Strength & Dosage	Length Taken	Purpose & Side Effects
☐	_____________________	_____________	________	_________________________
☐	_____________________	_____________	________	_________________________
☐	_____________________	_____________	________	_________________________

Please list any allergies:____

Are you currently receiving behavioral/mental health services elsewhere? ☐ Yes ☐ No

If yes, provide the following:

Date	Type*	Where	Purpose/Diagnosis
___________	_______	___________________	_______________________________

* out-patient, in-patient, crisis intervention, day treatment, group, etc.

Have you received behavioral/mental health services in the past? ☐ Yes ☐ No

If yes, provide the following (use back if needed):

Date	Type*	Where	Purpose/Diagnosis
___________	_______	___________________	_______________________________
___________	_______	___________________	_______________________________
___________	_______	___________________	_______________________________

How many self-help meetings have you attended in the past 30 days? _____________________________

Please include any other information you feel is important for therapist to know.

____

____

____

Consent For Treatment

Statement of Professional Disclosure

You may access the laws and regulations which govern said professionals at the following websites:

LMFT, LPC: http://www.ok.gov/health/Protective_Health/Professional_Counselor_Licensing_Division/index.html.
LADC: http://www.okdrugcounselors.org/.

Right as a Client of Family Solutions Counseling

Please make sure you read and understand this and all forms.

Family Solutions Counseling (FSC) is comprised of the following therapists: Rebel Buersmeyer, LMFT, Carrie Kyger, LMFT, and Joshua Nichols, LMFT. Counseling services are voluntary. By signing this form, you acknowledge you are consenting to receive services necessary for yourself, your child and/or family, including diagnosis and treatment. FSC utilizes a team approach to treatment; therefore, as a client of FSC, you understand that our team approach to treatment may include case consultation, assessment, and treatment planning. By signing this form, you are also consenting to the possibility of your record being a “shared file” among multiple therapists at FSC. Whether or not to “share” your record will be determined on a case by case basis. Your consent to receive services does not waive your legal rights as recognized under Oklahoma law. Our conversations and your records are confidential. Information regarding your records or services is not available to anyone unless:

- You give your written permission on a release of information form.
- A court orders me to disclose records.
- A legal guardian gives written permission to release the information of a minor child.
- In an emergency situation when your personal safety or the safety of others may be threatened (Duty to Warn).
- There is a suspicion or report of abuse or neglect of children, elderly or disabled persons.

No Secrets Policy

As systemically trained therapists, we view the client, couple, and/ or family as the unit of treatment. Therefore, we adhere to a “no secrets policy” in our work. This means that your therapist may choose to NOT partake in “keeping secrets” from members of the therapeutic system. Thus, if you are partaking in couple’s or family therapy, any information you disclose to your therapist may openly be discussed with other participating parties as part of treatment. Therefore, if you strongly desire to discuss matters other parties involved in therapy may or may not be aware of, and you desire to keep those matters secret, simply notify your therapist of this desire and s/he will set you up with an individual counselor to discuss the matters of concern.

You have a right to review all written reports about our work before they are sent/released.

It is further understood that your mental health insurance providers may request some records (e.g.) treatment plans or session notes in order to verify services and to assure the quality of services being provided. You will be informed when these circumstances occur. You have a right and responsibility to review these documents. Also be aware that peer consultation may occur between providers to assure services are appropriate and beneficial to you and/or your family.

You may request to have communication between therapist and your Primary Care Provider regarding evaluation and treatment information upon signing a release of information form. Upon request that your records be sent to another professional or agency, your wishes will be fulfilled with promptness upon receipt of your written request for information and provided there is no outstanding balance on your account.

Requested records may be protected under 42 C.F.R. Part 2, governing Alcohol and Drug Abuse patient records, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. pts. 160 & 164, State Confidentiality laws and regulations and cannot be released without your consent unless otherwise provided for by regulations. State and Federal law regulations prohibit any further disclosure of such records without your specific written consent or when otherwise permitted by such regulation.

Note: At least one parent or guardian must consent to the therapy of any minor children.

As a client, you have the right to leave the premises at any time. You are not to be detained against your wishes unless you are a danger to yourself or others

You have the right to refuse any service which you do not want and to discontinue any services you have already started. However, if you choose to discontinue treatment against professional advice, a notation to that effect will be placed in your records. In the event of court-ordered clients, the terms of the court may supersede this right.

It is the policy of Family Solutions to treat all clients and not to discriminate with regard to race, color, religion, national origin, age, sex, sexual orientation, gender identity or expression, or disability.

Records and Emergency Procedures

Licensed Mental Health Professionals hold the confidentiality of records to the highest standards. Therefore, client confidentiality is protected upon his/her incapacitation from death or disability. Records will not be released to a third party unless a waiver is signed by the client. If your therapist becomes incapacitated from death or disability, your records will remain and be maintained by Family Solutions Counseling.

□ I would like to sign a waiver electing to release my records to a third party upon my incapacitation from death or disability.

Confidentiality of Electronic Communications and Social Media

Confidentiality of Electronic Communications includes, but is not limited to, E-mail, Cell Phone Communication, Text, and Social Media Websites. If you choose to e-mail your therapist, it is preferred that you do so by setting up an account via therapyappointment.com, which is encrypted and HIPAA compliant. Please call the office with help setting up your login. If you call your therapist, please be aware that unless you are both on landline phones, the conversation is not confidential. Likewise, text messages are not confidential. The landline number for your therapist is (405) 242-5305. **Please take note that FSC cannot guarantee confidentiality if you choose to email from your personal account or call or text from a cellular phone. The preferred method of communication is by landline phones.** Family Solutions Counseling maintains several social media accounts. You are welcomed to utilize FSC's social media websites for purposes of education and keeping updated of event opportunities; however, confidentiality of friending, fanning, following, and interacting cannot be guaranteed.

Services

Family Solutions Counseling provides family, couples, group and individual therapeutic mental health and relationship services.

Services do *not* include:

- Personality, ability, or vocational interest testing or evaluations.
- Custody evaluations and/or forensic reports
- Prescription of medications or treatment of problems for which medication or hospitalization may be the treatment of choice, such as major depression, suicidal intention, hallucinations, delusions, etc.

Emergency Services:
Family Solutions Counseling is not an emergency service. Therefore, in the event of an emergency, you are advised to contact the Oklahoma County Crisis Line at 405-522-8100, Suicide Prevention Hotline at 1-800-SUICIDE (1-800-784-2433, Reachout National Hotline Crisis and Information Line at 1-800-522-9054 , dial 911, or go to the emergency room of the nearest hospital.

Counseling, Legal Issues, Court Reports and Testimony

As a counselor, I am frequently asked to provide counseling services to a child or family, whose parents or guardians are involved with legal disputes or challenges involving custody, visitation or other court related issues. The regulations and codes of ethics under which I practice my profession specifically describe how I legally may or may not conduct my services in matters involving legal decisions.

If I accept a child, adult or family as a client for counseling services, I cannot be used as an expert witness for any forensic purposes. As your counselor, I would only be able to serve as a "fact" witness in any legal report, deposition or testimony. I could only provide factual information about services you received, and only when the client and/or legal guardian gives her/his written permission to waive confidentiality. Waivers of privilege/ confidentiality must describe what specific information is to be released, to whom, for what purpose and for how long the release is valid. As a factual witness, I may not offer any conclusions, opinions or recommendations. I can report that I provided X number of sessions; that we have developed a counseling plan; what the goals and objectives of the plan are, and other "facts".

I will charge a fee for report writing, telephone consultations with attorneys, depositions, and court appearance and testimony. I will provide clients with a fee schedule that details the amounts charged for these services.

****I have read the "Consent for Treatment" form and agree to the terms of consent. I understand and agree to the limits and conditions of therapy.****

Client Signature ____ Date ____________________

Client Signature ____ Date ____________________

Parent/ Guardian Signature ______________________________________ Date ____________________

Witness ____ Date ____________________

Acknowledgement of Receipt of Notice of Privacy Practices

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices. The notice states how we may use and/or disclose your health information.

Please sign this form to acknowledge receipt of the Notice.

You may refuse to sign this acknowledgment, if you wish

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

____
Please print your name here

____
Signature

____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

- □ The patient refused to sign.
- □ Due to an emergency situation, it was not possible to obtain an acknowledgment.
- □ We weren't able to communicate with the patient.
- □ Other (please provide specific details) ____

____

_______________________________________ ___________________________________
Employee Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices. The notice states how we may use and/or disclose your health information.

Please sign this form to acknowledge receipt of the Notice.

You may refuse to sign this acknowledgment, if you wish

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

____
Please print your name here

____
Signature

____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation, it was not possible to obtain an acknowledgment.
- ☐ We weren't able to communicate with the patient.
- ☐ Other (please provide specific details) ______________________________

____

______________________________ ______________________________
Employee Signature Date

Appointment Reminders Online Appointment Scheduling

Appointment Reminders

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a computer generated voice message) the day before your scheduled appointments. This service is provided as a courtesy. A 3rd party is used to handle these reminders, and although the delivery rate is at 99%, there are circumstances where messages will not be successfully delivered (if users are on the phone, out of service, etc). It is YOUR responsibility to record and keep any appointments that have been made, as we cannot guarantee you will successfully receive a reminder every time.

Online Appointment Scheduling

You can also enjoy the convenience of online scheduling at any time. Provide an email address to set up online scheduling. You will receive an email from TherapyAppointment with a link to create your Client Portal login. Once your account has been established, you simply visit **www.therapyappointment.com** and click on 'Find A Therapist' in the bottom center of the screen, type in your therapists full name (i.e. Joshua P Nichols, Carrie Kyger, Rebel Buersmeyer) to schedule or reschedule your appointments. You may continue to schedule appointments in person or by telephone; however, if you have Internet access, you are sure to enjoy the convenience of this online system.

Your name:____

Your email address: ____

Your cell phone number: ____

Where would you like to receive appointment reminders? (check ONE)

_____ Via a text message on my cell phone (normal text message rates will apply)

_____ Via an email message to the address listed above

_____ None of the above. I'll remember my appointments on my own.

Note: Missed appointment fees will still apply

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private and requesting that it be handled as I have noted above.

Client Signature____ Date_________________________