The HOPE Center of First Baptist Pelham
Intake Form

Patient Name ____Date ______________________________
First Middle Last

Address ____
Street City State Zip code

Phone____
Home Cell Work

Date of Birth ______________________Social Security# ___________________________Sex _______ Race ______

Marital Status______________________ Years Married ___________________ Years a Couple __________________

Employer/ School ____ Job Title _________________________

Spousal Information: ____
Name Employer Phone

Nearest Relative/Friend ____ Phone___________________
Name Relationship

Address ____
Street City State Zip code

Insured's Name ____ Phone _________________________________
Home Cell Work

Insured's Address ____
Street City State Zip code

Insurance Plan/Program Name _____________________________ Employer's/School Name ____________________

Insured's Insurance ID Number ___________________________________ Group# ____________________________

Insured's Date of Birth ________________________________ Insured's Social Security# ________________________

Authorization # ____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

_________ **I authorize payment of medical benefits to the undersigned physician or supplier for services rendered.**
Initials

Printed Name ____

SIGNED ____ **DATE** ________________

Office Use Only:

Billing Provider: **First Baptist Church Pelham for The HOPE Center**

Rendering Provider: ____

The HOPE Center of First Baptist Pelham
Consent To Use and Disclose Your Health Information

This form is an agreement between you, _____________________________ and me/us _______________.
When we use the word "you" below, it can mean you, your child, a relative, or other person if you have written his or her name here ___________________ .

When we examine, test, diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide any treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from our privacy officer.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to do as you asked.

After you have signed this consent, you have the right to revoke it (by writing a letter to our Privacy Officer telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

____ _________________________
Signature of client or his or her personal representative Date

____
Printed name of client or personal representative Relationship to the client

____
Description of personal representative's authority

____
Signature of authorized representative of this office or practice

Date of NPP __________ ☐ Copy give to the client/parent/personal representative.

The HOPE Center of First Baptist Pelham
Informed Consent and Consent to Treatment

Patient Name ____ Date __________________

INFORMED CONSENT

CONFIDENTIALITY: Privileged Communication is any communication between a client and counselor given in confidence and not intended to be disclosed to a third party other than those to whom disclosure is made in the furtherance of providing professional services to the client. Confidentiality is limited by the following.

- Child abuse of any kind, examples are physical or sexual abuse.
- A present and clear danger to yourself.
- A present and clear danger to another person.
- A court order to release records (or be held in contempt of court).
- During the course of marital counseling, information from individual sessions, appointments, telephone conversations are not maintained as confidential from the other spouse.

FEES: Services are rendered on a "PAY AS YOU GO" basis. If you have a question about the fee, please feel free to discuss this with your counselor.

CANCELLATION: Appointments are contracted time. The full fee will be charged for appointments which are not canceled 24 hours in advance. Emergencies are considered on an individual basis.

I have read and understand the above information. By accepting services, I accept the fee charged as a lawful debt and promise to pay the fee as outlined and to include the cost of collection, attorney fees, and court costs if such is necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama or any other state. I also understand that failure to pay the fee may result in a fee collection process and the release of my name and other information included on this intake form.

Client Signature____ Date___________________

CONSENT TO TREATMENT

I acknowledge that I have received, have read (or have had read to me), and understand the "Practice Policies & Service Information" and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment. I understand that developing a treatment plan and regularly reviewing our work is part of the process toward meeting my goals. I agree to play an active role in the therapy treatment.

No promises have been made to me as to the results of treatment or of any procedures provided by the therapist.

I understand that counseling sessions may be recorded.

I may stop my treatment at any time. The only thing I will be responsible for is paying for the services received.

If any insurance claims are filed for me, I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers *of any* services or treatments I receive. I understand that if payment for the services I receive here is not made, my treatment may be stopped.

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

Client/Guardian ____ Date _____________

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

Therapist ____ Date ___________________________

The HOPE Center of First Baptist Pelham
Assessment Form

Patient's Name: ____ Date _______________________

I. History:

- Chief Complaint: (Reason you presented for treatment.)____

____

- History of present illness:
  - Current symptoms____
  - Duration of symptoms, frequency of symptoms____
  - How have symptoms interfered with functioning____
  - Why presenting for treatment now compared to some other time_____________________________________

    ____
  - Past /present suicidal/homicidal ideation____
  - Previous suicide attempts ____
  - History of violence ____
  - History of psychotic symptoms ____

II. Psychiatric History

A. Psychiatric History:

- Previous outpatient treatment and reason with approximate dates________________________________
- Previous inpatient treatment and reason with approximate dates_________________________________
- Previous medication trials____
- In women: Past problems in the post-partum period, or pre-menstrually___________________________
- Any history of Eating Disorder behaviors____
- Any episodic changes of mood or behavior ____

B. Substance Use History

- Current and past use of ETOH/drugs - specifically regarding ETOH, marijuana, cocaine, opiates, others - include tobacco - include age of first use and age first identified it as a problem___________________________
- Frequency of use, amount & duration ____
- When did you last use ETOH/drugs ____
- What happens when you try to stop on your own ____
- History of withdrawal symptoms, blackouts, DT's _______________________________________
- History of drug-related legal charges (DUI, possession, etc) _______________________________

C. Social History:

- Marital status, number of children and ages, previous marriages, if currently married, how long ____________________

  ____

  ____
- Education level ____
- Employer (s) - how long, position/occupation, any work stressors, working hours (shift work?) ____________________

  ____

  Legal issues - history of arrests, any pending legal issues, attorney or P.O. involvement, upcoming court dates, custody issues, restraining orders ____

  ____
- Military service history with type of discharge ____
- Financial concerns ____
- Caregiver (elderly, disabled, children) ____
- Relationship history or patterns ____

  ____

  ____

The HOPE Center of First Baptist Pelham
Assessment Form

Patient's Name: ____Date: ___________________________

- Victim of abuse/neglect ____
- Psychosocial stressors ____
- Religious affiliation/Cultural issues: ____

D. Family History

- Any family history of mental illness, substance abuse, suicide attempts or actual suicides - identify what relation.

  ____

  ____

  ____

- Family history of medical conditions, i.e. hypertension, diabetes, cancer, etc. identify what relation ________________________

  ____

  ____

E. Medical/Surgical History:

- Any past surgeries, if so dates or age____
  ____
- Any medical conditions, past and present ____
  ____
- Other hospitalizations ____
  ____
- Physical symptoms associated with current problems ____
  ____
- History of thyroid problems or hormone dysregulation ____
  ____
- Any problems with sleep, appetite, weight, energy ____
  ____
- Method of birth control in women patients____

F. Allergies

____

____

The HOPE Center of First Baptist Pelham
Assessment Form

Patient's Name: ____Date: _______________________

G. Current Medications List current medications, vitamins and herbal treatments:

Medication	Dose	Route	Frequency	Prescribed by	Reason

H. List any side effects you attribute to medications:

____

____

____

____

____

I. Disposition

Referred by: ____

Physician Name ______________________________ Therapist Name ______________________________

____ Individual Therapy ____ Group Therapy
____ Couple/ Marital Therapy ____ Psycho-educational
____ Family Therapy ____ Other