ELBOW TREE

Clinical Intake and Personal Data

Name(s):_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell:_____ Other:_____

Email:_____ Website:_____

Please CIRCLE any addresses, phone numbers or e-mails that you DO NOT want me using to reach you OR leaving a message. I do not want to compromise your confidentiality or create an uncomfortable situation.

Are you Married? _____ For How Long?_____

Previous Marriages? (Him)_____ How Many?_____ (Her)_____ How Many?_____

Are your parents divorced? (Him):_____ How old were you?_____ (Her):_____ How old were you_____

Please give the following info for each person that currently lives in your home, including yourself:

Name	Age	Relationship to Self

Are you currently taking any prescription psychiatric medications? _____

Dr./Drug	Reason	How Long

Do you have any current or expected legal involvement?_____ If yes, please explain:_____

_____

Are you currently under an order of protection?_____ If yes, please explain:_____

_____

Who may we contact in the event of an emergency? Please mark your initials to give us permission to do this._____

Name:_____ Relationship:_____

Address:_____ Phone:_____

Do you currently attend any church? Which one?_____

What is your occupation? (Him):_____ (Her):_____

Have you ever been to see a therapist before? _____

Was it helpful? _____

How did you hear about Elbow Tree Christian Counseling? _____

May we thank them for referring you? _____

What brings you to therapy today?_____

_____

_____

Do you have any other special circumstances or information that would be helpful for me to know?_____

_____

_____

***Are you allergic to dogs or do you have an aversion to them?_____

From time to time, Elbow Tree staff will bring their dogs to the office with them.

Credit Card Information:

Card Type _____ Card Number _____

Expiration _____ /_____ CV Code _____ Billing Zip Code _____

I authorize Hayne Steen, LMHC to bill my credit card after each client session.

Signature _____ Printed Name _____

ELBOW TREE

Professional Disclosure Statement and Counseling Agreement

Hayne Steen, M.A., LMHC

Elbow Tree was established in 2006 on the Southside of Chattanooga, TN at the foot of Lookout Mountain by some dear friends and colleagues, Greg and April Seymour. I planted my own independent counseling practice right here in Saint Augustine, Florida. While our practices share a name, some familiar branding, a similar ethos and language, they are two very distinct counseling practices, each independently owned and operated. _____ (initial)

NATURE OF COUNSELING

My goal for you in counseling is to help identify your childhood wounds, faulty thinking, and unhealthy behavioral and relational patterns and to walk beside you in the healing process. Unfortunately there are no "quick fixes" in counseling only hard work in the form of sessions, homework assignments, writing, reading, learning tools and techniques, and attending workshops when appropriate. As a Christian counseling practice we are committed to help your spiritual life develop and enable you to understand Biblical truth and apply it to your life.

CONFIDENTIALITY

We respect the information you share with us and how difficult it can be to open up. I may review "un-identifying details" of your case with other counseling professionals whom I consult with in order to help you in the best way possible. Our conversations and our written/taped records will be kept confidential and are protected by law, with a few exceptions, which are for your own protection: (1) when we believe that you intend to harm yourself or another person (2) when we believe a child or elderly person has been - or will be - abused or neglected and (3) when there is domestic violence in the home. In rare circumstances, Professional Counselors can be ordered by a judge to release information. Otherwise, we will not tell anyone else about your treatment, diagnosis, history, or even that you are a client without your full knowledge, and usually with a signed Release of Information Form. A copy of the HIPAA (Health Insurance Portability and Accountability Act) Patient Notification of Privacy Rights will be made available to you. Signing at the end of this disclosure will indicate that you have had an opportunity to review and understand this (HIPAA) document. _____ (initial)

We are committed to staying on the leading edge with regard protecting your confidentiality and Private Health Information (PHI). Therefore, we will deliver all PHI securely to our clients. I understand that utilizing a communication stream like email or text messaging could jeopardize the confidentiality of my PHI. _____ (initial)

COUNSELING RELATIONSHIP

During the time of your treatment we will meet regularly for 50-minute sessions. Ours is a professional relationship and must be respected by both sides. There may be opportunity for us to run into each other in a social context i.e. church, the grocery store or school etc. Let's both keep our professional relationship in mind at this time. To protect you, I'll tend to avoid initiating with you in public. However, you always have the freedom to initiate with me. Please feel free to discuss this with me at any time when this happens. My goal is to make you comfortable with our professional relationship and best meet your needs as a client. _____ (initial)

SCHEDULING AND LENGTH OF SESSIONS

Sessions are 50 minutes long. I will schedule our sessions per mutual agreement, as time is available. If you call the main ETCC phone number, you will usually have to leave a message, but my desire is to call you back as soon as possible. Because, I operate on an appointment basis only, I may not be able to handle urgent emergencies that may arise with clients. If your situation is out of control and can not wait on an appointment, it is important that you contact 911 or your local emergency services. If you are unable to keep an appointment, please call/email/text me no less than 24 hours prior to your appointment. You may leave me a message if you need to. Cancellations made inside that 24 hour window will result in you being responsible for paying the full cost of the session that you missed. Of course, this policy does not apply to emergencies. Because of my participation in two different networks of providers who participate in disaster response (one local and one international), from time to time, I may ask you to consider rescheduling a standing appointment(s). I would appreciate your sensitivity, flexibility and grace in this area. _____ (initial)

FEES/METHODS OF PAYMENT

The fee is $100.00 per 50 minute session. I ask for payment at the time of service, and do not engage in billing for clients. Cash, personal checks and most credit/debit/HSA cards are acceptable for payment. For credit/debit/HSA cards, there will be a $3 convenience fee. I will provide you with a receipt upon request, for fees paid if you desire. There will be a $25 fee for returned checks. I am also willing to help you seek financial support from your local church and your family to help with the cost of counseling. If you are involved in litigation and I am required to be involved in your case (travel time, preparation, attendance at court, letters) I will charge you a fee of $200/hour (pre-paid). _____ (initial)

BILLING/INSURANCE REIMBURSEMENT

I am a board certified "Licensed Mental Health Counselor" (#MH16012) in the state of Florida which will allow me to provide you with viable insurance receipts and clinical diagnosis. I am currently not listed on any insurance panels. _____ (initial)

COMPLAINT PROCEDURES

If you are dissatisfied with any aspect of our work, please inform me, Hayne Steen, owner of ETCC in Saint Augustine, immediately. This will make our work together more efficient and effective. If a problem arises requiring a legal remedy to solve, the client agrees to solve all problems through the means above or independent mediation and not pursue formal litigation. Complaints should also be registered with the Florida Board of Health at Department of Health,
4052 Bald Cypress Way, Bin C75 Tallahassee, Florida 32399-3260 or 850-245-4339.

_____ (initial)

APPROPRIATE REFERRALS

I am qualified to meet the needs of the vast majority of the people who come to see me. If I cannot help you, I will try my best to refer you to another appropriate professional in the community to meet your needs.

If you have any questions, please feel free to ask me. Once you have read and understood this statement, please sign and date. Thank you for choosing this practice to meet your needs.

Counselor Signature :_____

Date :_____

Client Signature :_____

Date :_____

Parent – or - Legal Charge, if Client is a Minor:_____

Date:_____