Phoenix
COUNSELING SERVICES, LLC
717-398-2044

Client Name: _____ DOB: _____

Welcome to Phoenix Counseling Services, LLC. Thank you for taking a few minutes to fill out these forms. The information you provide is confidential and will be helpful for you and your counselor when you meet for the first time. If you have any questions, just ask!

Today's Date: _____

Full Legal Name: _____ Age: _____ Date of Birth: _____

Name You Go By: _____ Pronouns: _____

Gender Identity: _____ Sexual/Affectual Orientation _____

Ethnicity: _____ Where did you grow up? _____

Primary Language Spoken: _____

Address: _____
street city state zip

Social Security Number: _____

Emergency contact person (name, relationship): _____
Phone Number: _____

Client's Primary Insurance: _____ Insurance ID Number: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's address if different from above _____

Policy Holder's Social Security Number: _____ Relationship to policy holder: _____

Policy Holder's employer: _____ Do you have Secondary Insurance? Yes or No

How did you hear about us? : _____

State Law (ref: HB2036) requires that we ask if you have a Mental Health advance directive: (circle one): Yes NO

A mental Health Advanced Directive is a legal document of instruction in the event of mental health incapacitation. If you have one, please provide us with a copy for in your chart.
If No, would you like us to provide you with information on how to fill one out?
(circle one) Yes No N/A

For Mental Health Clients Under 14

Custody status (circle one): N/A Shared Joint Legal Mother Only Father Only
Parent/Guardian's Name: _____ Parent Guardian SSN: _____

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Acknowledgement of HIPAA Privacy Notice

Phoenix Counseling Services, LLC is required by law to keep my information safe.

This information may include:

- Notes from your doctor, teacher or other healthcare provider
- Medical history
- Test results
- Treatment notes
- Insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information might be used and shared. Please initial each line acknowledging below:

_____ I acknowledge that I have received a copy of Phoenix Counseling Services, LLC's HIPAA Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.

_____ I have had the opportunity to read the notice and to have any questions regarding the notice answered to my satisfaction.

_____ I understand Phoenix Counseling Services, LLC cannot disclose my health information other than as specified in the notice.

_____ I understand that Phoenix Counseling Services, LLC reserves the right to change the notice and the practices detailed therein if it sends a copy of the revised notice to the address I have provided.

_____ _____
printed name date

_____ _____
signature relationship to client

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Client Name: _____ DOB: _____

Informed Consent for Treatment

Welcome to Phoenix Counseling Services, LLC. Whether you are just starting your recovery journey or looking for a fresh perspective on counseling, it is an honor and privilege that you choose to be here. This document explains some important rights, legalities, and responsibilities you have as a client to ensure that you get the best care possible. Most importantly, if you have any questions, please don't hesitate to ask.

Background/Education

You have the right to know your therapist's education, training background, and experience. At Phoenix Counseling, we have therapists at different stages of education and professional development including: interns who are currently completing masters level education, masters level pre-licensed clinicians who have completed their masters degree, and licensed clinicians who have a masters degree and have obtained a state license. We also have therapists with doctoral degrees or who are working toward a doctoral degree. Your therapist will discuss their education, experience, and specialties with you and answer any questions at your first appointment. A copy of this information can also be provided to you at your request.

Services

Admission to treatment will consist of an initial evaluation appointment. After your first evaluation appointment, your therapist will discuss the services that are the best fit for you. Recommended treatment types may include: individual, group, couple, and family treatment options. Phoenix Counseling Services, offers a variety of modalities and therapy techniques and we will do our best to match each client with the best fitting services. Medication management is not provided by Phoenix Counseling Services, but if your therapist believes this may be a benefit for you, they will assist you with a referral.

Consent to Treatment

By consenting to treatment, you agree to the treatment procedures of this program and will abide by all the rules, regulations, and guidelines as described by your treatment provider. However, this consent does not waive your civil rights and you reserve the right to decline any treatment that you believe is not in your best interest. You have the right to seek therapeutic services elsewhere at any time and we can assist you in the referral process. Sometimes, a higher level or different kind of therapeutic care is needed in order to meet a client's needs. If this situation occurs there will be a discussion with the client and we work with our clients to refer them to an appropriate provider or level of care to meet their needs. You have the continuing right to an explanation of any recommended treatment and the right to view your treatment plan.

Benefits and Risks of Counseling

There are many benefits from counseling including: improvement in personal functioning, relationships, self-image, mood, and the attainment of personal goals. However, be aware that in some cases clients report feeling worse after starting counseling. Clients should understand that the healing process is often difficult and non-linear. Some discomfort will likely be a part of the growth/therapy process. Please let us know if you have any specific needs or concerns about any negative outcomes or feelings that arise during the treatment process.

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Confidentiality

Understand that information obtained during the course of treatment is confidential to the extent of the law. All treatment information is confidential unless a client signs a consent form to release information. Understand that to either release or obtain information from a specific individual or agency, a signed release of information is needed. There are exceptions to this guideline. Under the following circumstances, information may be released without prior authorization from the client:

1. When treatment information becomes part of a legal proceeding where specific Pennsylvania law mandates that a court order and a subpoena require release of information.
2. In the event of medical emergency
3. To authorized persons within the practice or for program audit/evaluation
4. To acquire payment for services or billing purposes
5. There is a reasonable suspicion of abuse against a minor, elderly person, or dependent adult.
6. The client expresses serious intent to harm self or someone else.

**(pertaining to (1, 5, and 6 – for drug and alcohol treatment procedures, the Commonwealth has no case law which recognizes the duty to warn. A Federal law requires a court order to release information in a duty to warn situation for drug and alcohol clients.)*

**To protect your privacy to the greatest extent of the law, it is our policy to assert either, (a) privileged communication in the event of #1 or (b) the right to consult with clients, if at all possible, before mandated disclosure in the event of #5 or #6.*

Clients are expected to keep information of other clients in the building confidential. This is especially important for group sessions. Disclosure of confidential information including names of other clients may be damaging and could result in discharge from treatment. Recording or filming devices of any kind are not permitted in treatment sessions unless all parties are aware and consent to their use. Sometimes a therapist will request to film sessions for supervision purposes. A separate consent form will be signed in this case.

Electronic Communication and Confidentiality

Electronic communication by telephone, text messaging, and internet (including e-mail), are not secure methods of communication, and there are some risks that one's confidentiality that could be compromised with their use. If you wish to communicate with your therapist via this medium, please sign the electronic communication release form acknowledging discussion of this. For more information regarding use of technology, social media, and confidentiality please refer to the "Social Media Policy" document available on our website or by request in our office.

Scheduling and Missed Appointments

Please call 717-398-2044 to schedule or reschedule appointments. If you would like to use email or text messaging to contact about scheduling, please refer to the electronic communication form and discuss with your specific therapist. Once you are an established client you may also schedule appointments on our HIPAA-compliant TherapyNotes portal. Please note that 24 hours is required for any cancelled appointment. If an appointment is cancelled after 24 hours this could result in a $50 fee ($25 for group). Please note that your insurance company will not pay your no show/late cancel fees. As you are aware, in order for therapy to be successful, consistent attendance is crucial, therefore, more than two no show or late cancel appointments could result in discharge from treatment. If attendance is beginning to hinder treatment your therapist will initiate a conversation to discuss how barriers to consistent attendance can be addressed.

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Communication with Therapist Outside of Session

Occasionally you may need to reach your therapist between sessions. Our main office phone is monitored during normal business hours Monday-Friday 9am-5pm, and all calls will be returned by the next business day. Please be advised that your therapist is often in and out of session, and not on call. This means that there will often be a delay in the time it takes for your individual therapist to return your call. Please note that if your therapist is not in the office when you call, they will return your call the next business day they return to the office. Your therapist is not available over the weekend or outside of business hours (except for therapists who work on Saturday). You will be informed via voicemail message or our front desk staff if your therapist is out of office. In the case of an emergency or mental health crisis please contact 911 or local crisis services. Wellspan crisis can be reached at (717) 334-2121.

Fees and Payments

We are aware that payment for therapy can be a stressor for many of our clients and do our best to provide you with transparent information every step of the way. Your cost for therapy will depend on your type of insurance plan or if you are paying independently for services. This fee is due at every session, unless other payment arrangements have been made prior. If you are not using insurance for services your therapist will explain how much each session will cost. If you are using insurance, please see section below. Payment can be made via credit, debit, cash or personal checks made out to Phoenix Counseling Services, LLC. A $40.00 service charge will be levied on all checks returned by the bank for insufficient funds. If more than one check is returned service will be provided on a cash basis only. Please note, failure to pay for treatment could result in discharge.

Insurance

If you are currently covered by an insurance plan, your treatment may be covered by your insurance benefits. If you are using insurance, a claim will be sent to your insurance company and your insurance will determine how much you owe for services. The amount will depend if you have a copay plan, coinsurance plan, or deductible plan. Even though your insurance carrier may pay all or part of the charges at the time of treatment you are responsible for any charges your insurance company denies due to lack of coverage. Contact your insurance carrier or benefit manager to determine your policy's coverage for treatment. Some insurance companies cover only medically necessary or crisis-oriented treatment, resulting in authorization of sessions in small segments. Your insurance, its coverage limitations and authorization guidelines should be discussed with your therapist at the start of your treatment. Your therapist will not know all aspects of your plan. It is recommended you contact your insurance company directly to clarify concerns. In some cases, you may want more therapy than your coverage authorizes, or you may choose a therapist outside your network. If this is your choice it must be documented by your therapist as an out of network treatment.

If your insurance changes at any time. Please notify us immediately. It is very important to give your therapist advance notice of these changes. This will ensure that we can provide continuity of care. Failure to give notice of insurance changes could also result in unwanted costs for sessions.

**For state and federally funded clients: My signature below indicates my understanding that my signature on each service superbill or group sheet will certify that I received a service on that date. I further understand payment for any services that will be from the Federal and State funds, and false claims, statements, documents, or concealment of material may be prosecuted under applicable Federal and State law. I acknowledge the right to receive of copy of this agreement.*

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Court

There are often questions regarding a therapist testifying in court. As a rule, Phoenix Counseling Services therapists do not get involved in matters with client court cases as this often impacts the therapeutic relationship and can create a potential conflict of interest. Furthermore, situations such as evaluations and child custody are not within our scope of expertise. If you get involved in a legal proceeding in which your therapist is subpoenaed or a judge court orders them to testify you will be expected to pay for their professional time, including preparation and transportation costs even if the therapist is called to testify by another party. Because of the difficulty of legal involvement and extensive lost client hours, there is a charge $250 per hour for preparation and attendance at any legal proceeding.

Letters/Records

Please note that you have a right to request records at any given time. Please provide any requests to Phoenix Counseling Services in writing. Please understand that we are a small office and in order to keep overhead to a minimum we do charge a $5.00 retrieval fee for record requests under 50 pages and $15.00 dollars for record requests over 50 pages. In addition, requests will be $1.00 per page up to 60 pages and .36 cents a page after 60 pages. There is a short form that provides basic treatment information that we are happy to provide to you for free.

We often get requests from clients to write them letters for various things. Your therapist will discuss the therapeutic benefit of a letter during a session before proceeding to write it. Kindly note that the fee for letter writing is $60/hour. This is broken down to 10-minute increments. Please note that all requests for letters or paperwork to be completed by your therapist can take up to 10 business days to process.

Conflict Resolution

It is very important to us that you have a positive counseling experience. However, if a conflict occurs and you feel comfortable, you have the right to bring it to your therapist's attention. If you do not feel this is possible or are not satisfied with the results, please reach out to our leadership team: Dr. Tish Weikel and Kate Howe, LCSW. If we cannot resolve the issue with our team we can consult a third party, or assist you in finding a counselor who will be a better fit. At the end of the day, your care and overall treatment is what is most important.

Successful Discharge

At some point your therapy journey will come to an end. Here at Phoenix Counseling Services, LLC, we strive to end treatment successfully whenever possible. In order to successfully discharge from treatment a client must meet their treatment goals. As we embark on your recovery journey together, we will continue to talk more about what your goals are and what the end of counseling looks like for you.

By signing below, I am agreeing that I have fully read, understand, and agree to honor this agreement and consent to treatment:

Client printed name: _____ Date: _____

Signature: _____

Therapist printed name: _____ Date: _____

Signature: _____

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Electronic Communication Form

This document is designed to inform you about your options for communicating using technology with your clinician and how this may impact your privacy. This document covers confidentiality related to email, text message, and fax in your communication with your therapist. If you have questions about the use of social media, please view our entire social media policy available on our website at: https://phoenixcounselingservices.net/wp-content/uploads/2019/11/SocialMediaPolicy.pdf

Electronic Communication and Your Privacy: No form of client communication is 100 percent guaranteed to be private. Conversations can be overheard; e-mails can be sent to the wrong recipients and phone conversations can be listened to by others. But in today's age of e-mail, Facebook, Twitter and other social media, psychotherapists have to be more aware than ever of the ethical pitfalls they can fall into by using these types of communication. Although they add convenience and expedite communication, it is very important to be aware that computers and e-mail and cell phone communication can be accessed relatively easily by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Although we have various encryption software programs to protect your privacy, our emails and data on our computers may not be encrypted, it is always a possibility that faxes can be sent erroneously to the wrong address, and computers, including laptops, may be stolen. Our computers are equipped with a firewall, virus protection and passwords, and we also password-protect and back up all confidential information from our computers (stored in a HIPAA secure cloud) on a regular basis.

Communication Options with your Clinician: If you need to cancel or change an appointment time; a telephone call, SMS (text), or email is a convenient and quick way to notify your therapist. Different clinicians use different mediums to communicate with clients. Clients have the option to select which forms of communication they prefer to use. Please indicate below which kinds of communication you authorize us to use for scheduling appointments. If you choose to communicate confidential, private, or clinical information via SMS (text) or email, we will assume that you have made an informed decision, and will view it as your agreement to take the risk that such communication may be intercepted, and we will honor your desire to communicate on such matters via e-mail using our email encryption. We strongly recommend not communicating clinical information via text and if you do, your therapist will offer to respond via call or encrypted email, or discuss in the next session. Please do not use e-mail, faxes, or text messages for emergencies.

If e-mail communication outside of therapy requires more than 5 minutes to read and respond to, your therapist may charge for professional services rendered in 15-minute increments. If you do not wish to pay for these kinds of communications all detailed discussions will be saved for review during your scheduled appointment time. If you choose to communicate with your

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therapist by e-mail, be aware that all e-mails are retained in the logs of your and our Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any e-mails I receive from you and any responses that I send to you become a part of your legal record and may be revealed in cases where your records are summoned by a legal entity.

Please complete the following to indicate which forms of communication you prefer:

I am aware that both e-mail and text messages have the potential to not be secure forms of communication. I'm also aware that sometimes it may be more convenient to contact my counselor through text and/or e-mail.

I am consenting to the following forms of communication:

____ Phone (specify if home or cell): _____ Okay to Leave Voicemail? ____

____ E-mail (provide address): _____

I would like to sign up for e-mail appointment reminders? Y N
I would like to sign up for Phoenix Counseling Services, LLC online portal? Y N

____ Text (Provide cell): _____

By signing below understand the following:

- ☐ My counselor may respond about to me in the above checked areas about scheduling appointments
- ☐ I am aware that anything e-mailed or texted to my counselor may be printed and placed into my chart
- ☐ I am discouraged from e-mailing or texting my counselor any clinical information

Printed name: _____

Client Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

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Informed Consent and Agreement for Telehealth Clinical Services

This Informed Consent for Teletherapy contains essential information concerning engaging in electronic psychotherapy or Teletherapy. Please read this carefully and let your counselor know if you have any questions. This consent shall only apply to clients physically within the State of Pennsylvania seeking counseling treatment within the State of Pennsylvania. Your clinician follows the laws and professional regulations of the state in which the provider is licensed, and the sessions will be considered to take place in the state and country in which the provider is licensed. This Informed Consent shall be signed in conjunction with Phoenix Counseling Services, LLC informed consent.

Telehealth Platforms

Your clinician will provide you with a HIPAA secure, end to end encrypted platform. They will explain the platform of their choice to you and expectations on how to prepare for your first telehealth session. In most cases, you will receive an e-mail before each session that will include login instructions. We recommend that if this is your first time using the telehealth platform that you login 10-15 minutes in advance to test all of your technology.

Treatment Expectations

You will find that telehealth treatment will last the typical therapy hour, and you will collaborate with your clinician to decide how often you will meet. Please make every effort to be on time for your appointment. If you miss your appointment or late cancel (less than 24 hours), your clinician may require you to pay a no show/late cancel fee of 50 dollars, the same as for in-person appointments.

We take your privacy seriously. Therefore, we request that you find a room without other people or distractions for your telehealth appointment. To ensure additional confidentiality, many clients find it helpful to wear headphones during their sessions. Please note that your clinician may also choose to wear headphones, and is operating from a space where they are alone in the room.

Benefits and Limitations of Online Psychotherapy

Telephone, chat, and video sessions have strengths and limitations compared to sessions provided in a shared physical space. Teletherapy refers to the remote provision of counseling services using telecommunications technologies such as video conferencing. One of the benefits of Teletherapy is that the client and counselor can engage in services without being in the same physical location. This can help ensure continuity of care if the client or counselor is unable to make it to the practice location for various reasons. It can also increase the convenience and time efficiency of both parties.

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It is essential to consider if any of the below limitations may impact your therapeutic progress, and if so, you may want to select an in-person provider (if available). In some clinical situations, such as crisis, suicidal, or homicidal thoughts, in-person treatment may be the most appropriate treatment choice. If your clinician feels you may need face to face therapy for any reason, they will discuss these concerns with you directly. Although there are benefits of Teletherapy, there are fundamental differences between in-person counseling and Teletherapy, as well as some inherent risks. For example:

- ☐ Risks to Confidentiality: Because Teletherapy sessions take place outside of the typical office setting, there is potential for third parties to overhear sessions if they are not conducted in a secure environment. Your counselor will take reasonable steps to ensure the privacy and security of your information. Your counselor will be the only person in the room, and we will not be recording our sessions. You will have our undivided attention-we will not be answering e-mails or browsing the web during our sessions. You need to review your security measures and ensure that they are adequate to protect information on your end. You should participate in counseling only while in a room or area where other people are not present and cannot overhear you. We ask clients to try and minimize distractions such as email on their computer as well to get the most out of the session.

- ☐ Issues related to technology: There are risks inherent in the use of technology for therapy and are important to understand, such as: potential for technology to fail during a session, the possibility that transmission of confidential information could be interrupted by unauthorized parties, or potential for electronically stored information to be accessed by unauthorized parties.

- ☐ Crisis management and interventions: As a general rule, your counselor will not engage in Teletherapy with clients who are in a crisis. Before joining Teletherapy, your counselor will develop an emergency response plan to address potential crisis situations that may arise during the course of the Teletherapy work.

- ☐ Efficacy: Most research shows that Teletherapy is about as effective as in-person psychotherapy. However, some counselors believe that something is lost by not being in the same room. For example, there is a debate about a counselor's ability to fully understand non-verbal information when working remotely. If you ever have concerns about misunderstandings between us related to our use of technology, please bring up such concerns immediately, and we will address the potential misunderstanding together.

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Electronic Communication

Please review our Ethics guidance on Distance Counseling (Teletherapy) as well as the Pennsylvania Teletherapy guidance regulations. https://www.counseling.org/knowledge-center/ethics#2014code

Communication between sessions remains the same as it would for face-to-face sessions. We believe sensitive information is best shared during scheduled appointment times. For additional information, please refer to our Consent to Treat, Electronic Communication, and Social Media Policy.

**Appropriateness of Teletherapy and Crisis Situations*

Teletherapy is solely for established clients. Safety management is an on-going process in counseling. Assessing and evaluating potential safety threats is more difficult when conducting Teletherapy than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in Teletherapy. We ask you to identify your location, and we will determine the appropriate crisis intervention services for that area. In addition, be aware that if an emergency should arise, your counselor may reach out to identified emergency contact that you identified during your intake:

Location (Home Work etc): _____

Address (Where you will be during session):

_____

_____

Closest Crisis and Phone Number:

_____

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911 and/or contact Gettysburg Emergency Center by going to the emergency room or calling crisis intervention at (717)851-5320. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session, and I will wait two (2) minutes and then re-contact you via the Teletherapy platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then contact your clinician on the number they provide you.

If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

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Client Name: _____ DOB: _____
Please note that if an emergency should occur during the telehealth counseling session, your counselor will attempt to contact your emergency contact and call emergency personal.

Records

The Teletherapy sessions shall not be recorded in any way unless agreed upon in writing by mutual consent from the clinician and the client. We will maintain the records of our sessions in the same way we maintain records for in-person in accordance with our policies.
Insurance information
Please note that the coverage of telehealth varies by the insurance company and your specific health insurance plan. We recommend that each client call their insurance to determine eligibility and coverage. For those who have telehealth coverage, we often find that your co-pays and deductibles will be the same as seeing your clinician in a shared space. If your insurance plan does not cover Teletherapy sessions, you are solely responsible for the entire fee of the session. All co-payments for telehealth services will be collected via the TherapyNotes platform and charged to your card on file.
If your insurance does not provide telehealth coverage, we recommend talking to your clinician about self-payment options.
If you have any additional questions about telehealth services, please talk to your therapist.

You are responsible for securing proper information regarding coverage of Telehealth services and the requirements needed for the approved platform. By signing below, you accept responsibility for any unpaid sessions by your insurance and/or you agree to pay our self-pay rate for services.

By signing, you acknowledge you have been fully informed of the risks and benefits; the fees associated with Teletherapy; the security measures in place, which include procedures for emergency situations; the technological requirements needed to engage in Teletherapy; and all the other information provided in this informed consent, agree to and understand the procedures and policies outlined in this consent.

Client signature: _____ **Date:** _____

Therapist signature: _____ **Date:** _____

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Informed Consent for In-Person Services During COVID-19 Public Health Crisis

This document contains important information about the decision made by you and your therapist to resume in-person services despite the COVID-19 public health crisis. This document does not replace you previously signed informed consent documents. When you sign this document, it is a confirmation of the agreement between us. The Phoenix team cares about everyone's safety. While we recognize the importance of consistent counseling and value the benefit of having a shared space, we also want to be sure you are fully aware of any public health risks when coming to our office.

Decision to Meet Face-to-Face
By signing below, you consent to meet in-person for some or all of our future sessions. You understand that by coming to the office, you are assuming the risk of exposure to COVID-19 (or other public health risks). This risk may increase if you travel by public transportation, cab, or a ridesharing service. If there is a resurgence of COVID-19 or if other health concerns arise, your therapist may require that you met via telehealth. If you have concerns about meeting through telehealth, please let us know. If you decide at ANY time that you would feel safer, staying with, or returning to telehealth services, we will respect that decision as long as it is feasible and clinically appropriate. Reimbursement for telehealth services is also determined by the insurance companies and applicable law. If requesting telehealth, please check with your insurance company about their current policy.

Responsibility to Minimize your Exposure
To obtain in person services, we ask that you agree to take precautions in order to help keep everyone safe. If you are unable to adhere to these guidelines, we ask that you talk to your counselor about returning to telehealth. Please initial next to each of these requests to verify your understanding. These precautions may change if additional local, state or federal orders or guidelines are published.

___ Only come to the office if you are symptom free. If you have any symptoms of COVID-19 (fever, cough, shortness of breath) you will notify your counselor. If you need to cancel for this reason we will waive the cancelation fee, or you can choose to maintain your appointment via telehealth.
___ Please use the alcohol-based hand sanitizer or wash your hands when you enter our building.
___If you are bringing your child to session, we ask that you ensure they follow all sanitation protocols as well.
___ You have the option of wearing a mask for the duration of your therapy session. If you would like your counselor to wear a mask during your session, they will gladly do this as well. Please talk to your counselor ahead of time.
__ if you test positive for COVID, a resident of your home tests positive, or you believe you have been exposed to COVID in any way you will notify your counselor and discuss the options of returning to telehealth or canceling appointments in the amount of time compliant with current CDC guidelines.

Confidentiality in the Case of Infection
If you test positive and were at our office, we may have to notify the local health authorities that you were at our establishment. If we need to do this, please note that no names will be provided and your confidentiality will be respected. By signing this form, you are agreeing that we may do this without any additional consents.

Your signature below indicates that you agree to the above terms and conditions:

Printed name: _____

Client Signature: _____ **Date:** _____

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Client Name: _____ DOB: _____

Medical History Form

Here at Phoenix Counseling, LLC we often find that Medical and Emotional Wellness are closely related. The next few pages are about your physical health. All of this information is confidential, and you don't have to answer any questions you are uncomfortable with. If you have questions about the information, please let us know.

General Information

Primary Care Doctor: _____ Phone: _____
Address: _____
Would you like us to have contact with your doctor? _____
Date of last Exam: _____ Results: _____
If it has been more than one year since your last physical health exam, we recommend a follow-up with your primary care doctor.
If you are presently receiving non-routine medical care please explain: _____
_____
IF so, how long have you been under medical care? _____
Height: _____ Weight: _____ BMI (body mass index): _____

Present Medical Concerns: (*check all that apply)*

__ fever
__ bleeding gums
__dizziness
__ convulsions
__ stomach pain
__ blueness of lips/nails
__ night sweating
__ infections or abscesses
__ double vision/ loss of vision
__ severe nose bleeds
__ Nausea or vomiting
__ Coughing/breathing difficulties
__ High blood pressure
__ Pain/difficulty urinating
__ Loss of hearing/buzzing or ringing
__ Migraine or recurrent headaches
__ Blood in urine/ Kidney Stones
__ Spitting up phlegm/mucus/blood
__ Frequent colds or sore throat
__ Numbness or tingling
__ Chronic pain in muscles, bones or extremities

Medical Conditions/ Past History: (*Check all that apply*)

__ Cancer
__ Alzheimer's
__ Cirrhosis
__ Heart attack/heart disease
__ Lupus
__ Lyme Disease
__ Parkinson's Disease
__ Multiple Sclerosis
__ Cystic Fibrosis
__ Cerebral Palsy
__ Muscular Dystrophy
__ Polio
__ Seizure Disorders
__ Urinary tract infections or kidney stones
__ Broken bones
__ Strokes
__ Heart murmur
__ Blood infection
__ Diseases of the arteries
__ Tendency to bleed easily
__ Anemia
__ Ulcers
__ Prostate problems
__ Head injuries
__ Dizziness or fainting
__ Eczema/Psoriasis
__ Mononucleosis
__ Malaria
__Thyroid Problems
__ Pneumonia
__ Allergies/Hay Fever
__ Asthma
__ Abnormal chest X-ray
__ whooping Cough
__ Jaundice
__ Gall Bladder Problems
__ Scarlet Fever/Rheumatic Fever
__ Mumps
__Measles
__ German Measles
__ Chicken Pox

__ Surgery/type? When? _____
__ Hepatitis/ type? When treated? _____
__ TB/ Date of last test:
_____
__ Diabetes/ insulin type & dosage? _____
__ Sexually Transmitted Disease (STD)/ Type & When treated?
_____
__ other: _____

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Client Name: _____ DOB: _____

__ I have never had any of the above

Allergies: *(Circle/Explain)*
Do you have any food allergies? Yes No If yes, please explain: _____

Do you have any allergies/adverse reactions to drugs? Yes No If yes please explain: _____

OB/GYN History: *(Circle/Explain)*
Do you have any menstrual problems? Yes No If yes, please explain: _____

Date of last OBGYN exam: _____

Are you pregnant? Yes NO If yes, are you receiving prenatal care? Yes No

If you have had any of the following please indicate the number:
___ Pregnancies ___ Miscarriages ___ Stillbirths ___ Abortions

Childhood History to be Completed by ALL Clients
Informant (who did you learn this information from): _____ Relationship with informant: _____
Did your mother experience any complications during her pregnancy with you? (i.e. R.H. Neg. toxemia, diabetes, substance abuse)
Yes NO If yes, please specify: _____
Were there any complications during your birth? Yes NO If yes specify: _____
Early development: Did you have any difficulties in the following areas:
Walking: Yes NO If yes explain: _____
Talking: Yes NO If yes explain: _____
Toilet Training: Yes NO If yes explain: _____
Any unusual childhood illness? Yes NO If yes explain: _____
Any child care difficulties? Yes NO If yes explain: _____
Any social/behavioral problems? Yes NO If yes explain: _____

Family Medical History:
Father: Current Age: _____ Current Health: _____ If deceased list the age at death and cause of death:
_____
_____
Mother; Current Age: ____ Current Health:_____ If deceased list the age at death and cause of death:
_____
_____
Number of Siblings: _____
Sibling Health Problems: _____
Spouse Health Problems _____
Children's Health Problems: _____

Family Illnesses: (*Please check if you relatives have any of the following. Please include grandparents, aunts. and uncles, but exclude cousins, relatives by marriage and half relatives)*

__ Heart Attacks/disease
__ Strokes
__ High blood pressure
__ TB
__ Other: _____

__ Congenital Heart Disease
__ Elevated Cholesterol
__ Alzheimer's
__ Sickle Cell Trait/Disease

__ Diabetes
__ Cystic Fibrosis
__ Cancer (specify type_____)

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Client Name:_____ DOB:

Medication List

Current Psychiatric Medications

Medication	Frequency/Dose	Prescribing Dr.	Taking as directed?	Prescribed For?

Current Medical Medications

Medication	Frequency/Dose	Prescribing Dr.	Taking as directed?	Prescribed For?

List Any Over the Counter Medications:

_____

_____

_____

_____

_____

_____

If you need additional space please refer to the back of the page.

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Client Name:_____ DOB:

Client Rights

Right to communicate

- ☐ Every client has the right to receive an orientation to Phoenix Counseling Services, LLC, which includes the responsibilities of the staff and client.
- ☐ Every client has the right to communicate freely and privately with others, included their therapist, the supervisor of the therapist, and any administrative staff.
- ☐ Every client is encouraged to freely communicate their needs and opinions regarding their treatment and the operation of the facility to the owner or his/her designee. This includes the use of evaluation forms.

Right to confidentiality

- ☐ Every client has the right to expect that all records concerning his/her treatment shall be kept confidential and shall only be released by the written permission of the patient except in the circumstances outlined on the consent to treat form.
- ☐ Every patient has the right to have their issues heard within a confidential relationship and to leave treatment should they feel treatment is not safe or useful.

Right to Humane Physical and Psychological Environment

- ☐ Every client has the right to treatment in a setting, which preserves and promotes physical and psychological dignity.
- ☐ Every client has the right to be treatment humanely, respectfully, and with consideration by all staff members.

Right to Treatment

- ☐ Every client has the right to be treated as an individual and evaluated according to his/her individual needs.
- ☐ Every client has the right to receive treatment designed to aid and promote recovery, including receiving an appropriate needs-based individualized treatment plan. The client has the right to participate in development of his/her treatment plan.
- ☐ This treatment shall be in the least restrictive setting to provide adequate treatment.
- ☐ Every client has the right to expect that he/she will be treated by competent staff.
- ☐ Every client has the right to refuse any treatment or procedure offered by the facility. Staff shall inform the client that he/she may be discharged or referred for refusal to fully participate in treatment.
- ☐ Every client has the right to be discharged as soon as treatment is no longer necessary. Every client shall assist in planning activities following discharge that provide continued recovery and emotional health.
- ☐ Every client has the right to examine his/her personal records, subject to the limitations as discussed with your counselor.
- ☐ Every client has the right to receive a copy of any consent form that he/she has signed.
- ☐ Every client has the right to examine and receive an explanation of his/her balance due statement.
- ☐ Every client has the right to request reconsideration of any decision to terminate his/her treatment.

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Client Name:_____ DOB:

Right to Religious Freedom

- ☐ Every client has the right to follow and practice his/her religion. Substantiated ethical convictions held independently of a belief in any religion shall be accorded the same respect as a religious belief.
- ☐ Every client has the right to refuse medication, comply with dietary regimen, and to abstain from religious practice.

Nondiscrimination

- ☐ Admissions, the provision of services, and referrals of clients shall be made without regard to race, color, religious creed, disability, ancestry, marital status, sexual orientation, ethnicity, national origin, age, sex, or Limited English Proficiency. Program services shall be made accessible to eligible persons with disabilities through the most practical and economically feasible methods available. Accessibility for language needs will be provided where reasonably feasible and available. These methods include, but are not limited to, equipment redesign, the provision of an aide, interpreter, and the use of alternative service delivery locations. Structural modifications shall be considered only as a last resort.
- ☐ Every client shall retain all civil rights and liberties except as provided by law. No client shall be deprived of any civil rights solely by reason of being a client.

Grievance and Appeal Procedures

- ☐ Any client has the right to initiate a complaint orally or in writing, concerning the exercise of these right or the quality of the services and treatment. The client may first deliver the complaint to the therapist, secondly to the owner of Phoenix Counseling Services, LLC. The client will be informed as to the disposition of the compliant within 10 working days of each level of the appeal.

If the complaint is in reference to discrimination, complaints may be filed to any of the following:

Phoenix Counseling Services, LLC
2311 Fairfield Rd, suite F
Gettysburg, PA 17325

Bureau of Equal Opportunity
Room 223 Health and Welfare Building
PO Box 2673
Harrisburg, PA 17105

U.S. Dept. of Health & Human SVCS
Suite 372, Public Ledger Bldg.
150 S. Independence Mall West
Philadelphia, PA 19106-9111

PA Human Relations Commission
Harrisburg Regional Office
Riverfront Office Center
1101 S. Front St., 5th Floor
Harrisburg, PA 17104

Phoenix
COUNSELING SERVICES, LLC

Client Name: _____ DOB: _____

Authorization for Release of Information

I, _____ do hereby consent to authorize Phoenix Counseling Services, LLC to release to _____ information from my record(s). The specific information to be received includes:

__ Admission
__ Attendance in Treatment
__ Prognosis/Diagnosis/ Treatment Recommendations
__ Summary of Treatment
__ Patient Data Form
__ Discharge Summary
__ Progress Notes
__ Treatment Plans
__ Aftercare Plans
__ Initial Evaluation
__ Psychiatric/Psychological Evaluation
__ Medical History
__ Medication Management
__ Prescription Medications
__ Other: _____

I, _____ do hereby consent to authorize Phoenix Counseling Services, LLC to receive from _____ information from my record(s). The specific information to be received includes:

__ Admission
__ Attendance in Treatment
__ Prognosis/Diagnosis/ Treatment Recommendations
__ Summary of Treatment
__ Patient Data Form
__ Discharge Summary
__ Progress Notes
__ Treatment Plans
__ Aftercare Plans
__ Initial Evaluation
__ Psychiatric/Psychological Evaluation
__ Medical History
__ Medication Management
__ Prescription Medications
__ Other: _____

I understand that the information is to be used for the purpose of _____

This information is being disclosed from records whose confidentiality may be protected by Pennsylvania Law, Act 63, and/or Pennsylvania P.L. 817, and/or Federal Law 93-282, and/or Federal Regulations, 42 (Drug and Alcohol treatment records). I understand that I have the right to request to inspect materials that shall be released. I understand that I may revoke this authorization at any time by notifying my counselor verbally or in writing. This Authorization shall expire six months after discharge unless an earlier date is specified.

If the client is not in treatment at the time of signing, this authorization will expire three months after signing.

Authorization REVOKED on _____ (Date) at _____ (Time) AM/PM

Staff signature: _____

Signature:

X_____ _____

___ Patient ___ Parent ___Guardian ___Power of Attorney — Date

_____ _____

Signature of Witness — Date

Client has accepted or Rejected a copy of this document