AVENUES
UNLIMITED
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Name:_____ Gender:_____

Birthdate:_____ Today's Date:_____

Address:_____City:_____ State:_____Zip:_____

Home Phone:_____Work Phone:_____ Ext:_____

Mobile Phone:_____Fax:_____

Email:_____Social Security Number:_____

In Case of Emergency Please Notify:_____

Emergency Contact Number: _____

How did you learn about Avenues Unlimited?:_____

EMPLOYMENT

Occupation:_____

Employer:_____

Spouse's Name: _ _____

Place of Employment:_____

EDUCATION

Self:_____

Spouse:_____

CHILDREN

Name(s):_____ Age(s):_____Sex(M/F):_____

_____ _____ _____

_____ _____ _____

MEDICAL

Name/Address of Internist or General Practitioner:_ _____

Name/Address of Psychiatrist:_____

Previous Psychotherapist(s):_____

Illness Requiring Medical or Hospital Treatment in Last 12 Months: _____

Current Medication(s):_ _____

_____

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ESTIMATE YOUR CURRENT WEEKLY USE:

Alcohol:_____Caffiene:_____Tobacco:_____Marijuana:_____Other:_____

CURRENT/PRIMARY ISSUES FOR WHICH YOU SEEK PSYCHOTHERAPY

_____

_____

_____

RELEASE OF INFORMATION

I hereby request that _____

at (address)_____ furnish Avenues Unlimited, with the following information_____

_____

_____

_____

Signed:_____ Date:_____

I hereby grant permission to Avenues Unlimited to provide the following personal information_____

_____

_____

_____

_____

to:_____

Signed:_____ Date:_____

I have been informed of the limits of confidentiality. Initial:_____

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CONSENT TO TREAT

I, _____ , give my permission and consent to Avenues Unlimited
(print name)

Counseling Center, Inc., to provide me psychotherapeutic treatment to _____.
(print name(s) of patients)

While Avenues Unlimited will endeavor to provide you with standard of care treatment, I fully understand that because of factors beyond Avenues Unlimited's control, particular outcomes cannot be guaranteed. Furthermore, I understand the I/he/she/we may experience emotional strains because of the counseling or therapy, feel worse during the treatment and make life changes which could be difficult.

I understand that Avenues Unlimited is not providing emergency services, and I have been informed of whom to call upon in an emergency or during such time as treatment from Avenues Unlimited is unavailable.

I understand that regular attendance as recommended by Avenues Unlimited will facilitate maximum therapeutic benefits, but that I/we am/are free to discontinue treatment at any time. If I decide to do so I will notify Avenues Unlimited at least two weeks in advance so that effective planning for continuing care can be implemented.

Sign_ _____Date_____

CANCELLATION POLICY

I understand that there is a 48 hour (or two working day) rescheduling policy. A rescheduling charge of $_____ will result if I do not give notice in this time frame.

Sign_ _____Date_____

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LIMITS OF CONFIDENTIALITY

The contents of counseling, intake and/or assessment sessions are confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian, except as required by law. It is the policy of this center not to release any information about a client without a signed release of information, or as otherwise required by law. Noted exceptions are as follows:

DUTY TO WARN AND PROTECT

When a client discloses intentions or a plan to harm another person, Avenues Unlimited is required by law to warn the intended victim and report identifying information to legal authorities. In cases in which the client discloses or implies a plan for suicide, Avenues Unlimited is required to notify legal authorities and make reasonable attempts to notify the family of the client.

ABUSE OF CHILDREN AND VULNERABLE ADULTS

If a client discloses or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult); or a child (or vulnerable adult) is in danger of abuse, Avenues Unlimited is required to report this information to the appropriate social service and/or legal authorities.

PRENATAL EXPOSURE TO CONTROLLED SUBSTANCES

Avenues Unlimited is required by law to report admitted prenatal exposure to controlled substances that are potentially harmful.

IN THE EVENT OF A CLIENT'S DEATH

In the event of a client's death, the spouse or parents of a deceased client have a right to access a client's treatment records.

PROFESSIONAL MISCONDUCT

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

COURT ORDERS

Health care professionals are required to release records of clients when a court order has been entered.

MINORS/GUARDIANSHIP

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

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OTHER PROVISIONS

Payment for services is due and payable at the time services are rendered by Avenues Unlimited. In the event that you fail to pay for any such services when rendered, Avenues Unlimited reserves the right to turn delinquent accounts over to collection agencies and/or attorneys without prior notice. Unpaid account balances accrue interest at the rate of 1.5% per month until paid. Further, in the event Avenues Unlimited incurs attorney's fees and/or court costs to collect delinquent account balances, client agrees to pay or reimburse Avenues Unlimited for same. Avenues Unlimited may report delinquent account balances to credit reporting agencies, and the client's credit report may state the amount owed, time frame and the name of the clinic.

Avenues Unlimited may furnish insurance companies and other third-party payers information regarding services rendered by Avenues Unlimited to clients. Information which may be furnished by Avenues Unlimited to these parties includes a description of the type of services, date/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, case notes and summaries. Please note that Avenues Unlimited does not accept insurance payments unless otherwise agreed to in writing between Avenues Unlimited and client.

When couples, groups or families are receiving services, separate files are kept for individuals for information disclosed that is of a confidential nature. This information includes (a) testing results, (b) information given to the mental health professional not in the presence of the other person(s) utilizing services, (c) information received from other sources about the client, (d) diagnosis, (e) treatment plan, (f) individual reports/summaries and (h) information that has been requested to be separate. The material disclosed in conjoint family or couples sessions in which each part discloses such information in each other's presences, is kept in each file in the form of case notes.

In the event Avenues Unlimited must telephone or e-mail the client for purposes such as appointments, cancellations or reminders or to give or receive other information, efforts are made to preserve confidentiality. Please list where we may reach you by phone and/or e-mail and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only.

If this information is not provided to us (below) we will adhere to the following procedures when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information we will say that this is a personal call. We will not identify the clinic to protect confidentiality. If we reach an answering machine or voice mail we will follow the same guidelines.

PLEASE CHECK PLACES IN WHICH YOU MAY BE REACHED BY PHONE OR E-MAIL.

Include phone numbers and how you would like us to identify ourselves when phoning you.

☐ Home Phone Number_____How should we identify ourselves?_____

☐ Work Phone Number_____How should we identify ourselves?_____

☐ Other Phone Number_____How should we identify ourselves?_____

☐ E-mail_____

I AGREE TO THE ABOVE LIMITS OF CONFIDENTIALITY AND UNDERSTAND THEIR MEANINGS AND RAMIFICATIONS.

Client's Name (Please print)_ _____

Client's or Guardian's Signature_____ Date_____