CLIENT INFORMATION SHEET

(THIS PAGE IS FOR CLIENT'S USING THEIR INSURANCE)

Today's Date: _____ Provider's Name/Agency: SANKOFA HOLISTIC COUNSELING SERVICES

Name of Insurance:_____ I.D. Number:_____

SSN#_____

Client's Name: _____ _____ _____
First Name Middle Name Last Name

Client's Birth Date: _____ Birthplace: _____
City State/Country Zip code

❒Male ❒Female ❒ Other (specify): _____Pronouns_____Client's Marital Status: _____

Client's Ethnicity: _____ Client's Mother's Birthplace: _____
City State/Country

Client's Current Address: _____
Street address City Zip code

Client's Home Phone Number: _____ Work Phone Number: _____
(If client is child, parent/guardian's work number)

Client's Current Employer's or School's Name: _____

Client's Preferred Language:_____ Does the client want a translator? ❒ Yes ❒ No
If a family member translates for the client, does the client agree to this plan? ❒ Yes ❒ No

Once you arrive here, do you have trouble walking to the office? ❒ Yes ❒ No
If yes, what can the provider do to help you? _____

Who else may the provider talk with about your services? Examples: Family, Friend, Other Mental Health Provider, Doctor, Probation Officer, Minister, etc.

Name	Relationship	Phone Number	Gave Release? (Provider) Y/N

How did you hear about this provider? _____

Emergency Contact Person:

Name: _____ **Phone Number:** _____

Relationship: _____ **Gave Release? (Provider): ❒ Yes ❒ No**

Your Signature: _____
If you are not the client, what is your relationship to client?: _____

CLIENT INFORMATION AND CLIENT CONSENT

*Once you have fully read and understand the information below, please sign and date the **Client Consent** on the last page.*

CLIENT / THERAPIST RELATIONSHIP:
You and your Therapist (including Therapist Intern) have a professional relationship existing exclusively for therapeutic treatment. This relationship functions most effectively when it remains strictly professional and involves only the therapeutic aspect. Your Therapist can best serve your needs by focusing solely on therapy and avoiding any type of social or business relationship.

INFORMATION ABOUT YOUR THERAPIST:
At an appropriate time, I will discuss my professional background with you and provide you with information regarding my experience, education, and professional orientation. You are free to ask questions at any time about my professional background, experience and professional orientation.

AVAILABLE SERVICES:
I offer a range of counseling services, including individual, couples and family-dyads services. Effective psychotherapy is founded on mutual understanding and good rapport between client and therapist. It is my intent to convey the policies and procedures used in my practice, and I will be pleased to discuss any questions or concerns you may have.

RISKS AND BENEFITS:
Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, anxiety and sadness. At times the process may result in changes that were not originally intended. The benefits of counseling can far outweigh any discomfort encountered during the process. Some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, greater self-understanding, a wider sense of choice and the resolution of specific concerns. I cannot guarantee these benefits. However, it is my desired intention to work with you to attain your personal goals for counseling and or psychotherapy.

ABOUT THE THERAPY PROCESS:
Based upon the information that you provide to me and the specifics of your situation, I will provide recommendations to you regarding your treatment. I believe that therapists and clients are partners in the therapeutic process. You have the right to agree or disagree with any recommendations. Periodically, I will provide feedback to you regarding your progress.

Due to the varying nature and severity of problems and the individuality of each client, I am unable to predict the length of your therapy, nor can a specific outcome or result be guaranteed.

COUNSELING & PSYCHOTHERAPY:
I provide counseling and psychotherapy services designed to address many of the issues that clients are managing. Counseling is referred to as "a shorter-term consultation on issues where most of the relevant input is easily brought to consciousness. When an important decision needs to be made in one's personal or professional life, sessions of counseling can clarify the deeper values that are at stake. Also, it can provide a framework in which what seems overwhelming can be managed by providing containment and structure to the process. Psychotherapy is referred to as "longer-term" work that occurs at a deeper level of consciousness. Both counseling and psychotherapy requires a relationship of respect, support and deep honesty.

CONFIDENTIALITY:
I abide by all ethical standards prescribed by state and federal law. I am required by practice guidelines and **standards of care to *keep* records of *your counseling. These records* are *confidential*** with the exceptions noted below and in the **Notice of Privacy Practices provided to you**.

Discussions between a Therapist and client are confidential and considered privileged. NO information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; danger to self or others; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board. If you have any questions regarding confidentiality, you should bring them to the attention of the Therapist when you and the Therapist discuss this matter further. By signing this Information and Consent Form, you are giving consent to the undersigned Therapist to share confidential information with all persons mandated by law and with the agency that referred you and the insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing and holding harmless the undersigned Therapist from any departure from your right of confidentiality that may result.

MINORS AND CONFIDENTIALITY:
Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, in the exercising my professional judgment, I may discuss the treatment progress of a minor client with the parent or caretaker. Clients who minors and their parents are urged to discuss any questions or concerns that they have on this topic with me.

APPOINTMENTS:
Appointments are typically scheduled on a weekly basis and are approximately 50 minutes long. Couples and Family-dyads could be extended for 80-minute sessions. If you must cancel or reschedule your appointment, I ask that you call me at least 48 hours in advance. This will free your appointment time for another client. If you fail to notify me within 24 hours prior to your scheduled time of a cancellation, you will be charged the full rate for your missed session. **A persistent pattern of missed appointments may cause your treatment with our office to be terminated.**

FEE SCHEDULE:

Diagnostic & Evaluation Session -1st Visit (50 minutes)	**$**
Therapeutic Session- Individuals (50 min)	**$**
Therapeutic Sessions-Couples/ Family	**$**

* A reasonable fee will be charged for copies of any records requested by the Client.
*Fees are subject to change with adequate notice.

PAYMENT/INSURANCE FILING:
Clients are expected to pay the Agreed Fee per 50/80-minute session at the time of each appointment. Payment must be made prior to your session. If you are using a Managed Care/PPO/HMO insurance plan and wish to file your own claim, full payment is expected at the time of service and I will provide you with a statement of services rendered.

EMERGENCIES:
In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance or have someone take you to the nearest emergency room for help. If you encounter a personal emergency which does not require 911 assistance, please contact my office regarding the nature and urgency of circumstances. I will make every attempt to schedule you as soon as possible or offer other options.

Because clients may be scheduled back-to-back, it is not always possible to return a call immediately. However, I will make every effort to respond to your emergency in a timely manner. Once again, if you are experiencing a life- threatening emergency, call 911 or have someone take you to the nearest emergency room for help.

DUTY TO WARN/ DUTY TO PROTECT:
If my Therapist believes that I (or my child if child is the client) am in any physical or emotional danger to myself or another human being, I hereby specifically give consent to my Therapist to contact any person who is in a position to prevent harm to me or another, including, but not limited to, the person in danger. I also give consent to my Therapist to contact the following person(s) in addition to any medical or law enforcement personnel deemed appropriate:

Name: **Phone Number:**

_____ _____

TERMINATION OF THERAPY:
The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

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CLIENT INFORMED CONSENT

CONSENT TO TREATMENT AND ACKNOWLEGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES:

By signing this Informed Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understand ***Sankofa's Client Information Form***, and agree to the terms and conditions contained in this form. I have been given a copy of the ***Notice of Privacy Practices***. I have been given an appropriate opportunity to ask any questions of request clarification or anything that is unclear to me. I am voluntarily. agreeing to receive mental health assessment, treatment and services for myself and or minor child. I understand that I may stop such treatment or services at any time. ***Please ask your therapist to address any questions or concerns that you have about this information before you sign.***

Client Name (Print)

_____

Client's or Guardian Signature

_____

Date_____

Treating Therapist_____

Therapist's Signature_____

Date_____

CLIENT INTAKE FORM

Please provide the following information for our records. **Leave blank any question you would rather not answer**. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session or allow yourself thirty minutes prior to your appointment to complete the form in the office.

Name:_____
(Last) (First) (Middle Initial)

Insurance_____ Member ID #_____

SS#_____ Birthdate: _____/_____/_____Age_____

Gender Identity: _____

Sexual Orientation: _____

Pronouns: _____

Marital Status:
Never married Partnered Married Separated Divorced Widowed

Number of Children/Ages:_____

Local Address:_____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( )_____ May we leave a message? Yes No

Cell/Other Phone: ( )_____May we leave a message? Yes No
May we text you? Yes No

E-Mail:_____May we e-mail you? Yes No

*Please be aware that e-mail might not be confidential

Referred by:_____

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? Yes No

Have you had previous psychotherapy?
No Yes, at previous therapist's name:_____

Are you currently taking prescribed psychiatric medication (antidepressants or others)?

No Yes If Yes, please list:_____

If No, have you been previously prescribed psychiatric medication?

No Yes If Yes, please list:_____

HEALTH & SOCIAL INFORMATION

1. How is your physical health at present?
   Poor Unsatisfactory Satisfactory Good Very Good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

   _____

   _____

3. Are you having any problems with your sleep habits? No Yes

4. If yes, check where applicable:

   Sleeping too little Sleeping too much Poor quality sleep Disturbing dreams

   Other

5. Are you having difficulty with appetite or eating habits? No Yes

   If yes, check where applicable: Eating Less Eating More Binging
   Restricting

6. Do you regularly use alcohol? No Yes

   In a typical month, how often do you have 4 or more drinks in a 24-hour period?__

7. How often do you engage in recreational drug use?
   Daily Weekly Monthly Rarely Never

   Have you had suicidal thoughts recently? Frequently Sometimes Rarely
   Never

8. Have you had them in the past? Frequently Sometimes Rarely
   Never

9. Are you currently in a romantic relationship? No Yes

   Partner/Spouse Name:_____

   If Yes, how long have you been in this relationship? _____

   On a scale of 1-10, how would you rate the quality of your current relationship? __

10. In the last year, have you experienced any significant life changes or stressors:

_____

Have you ever experienced:

Extreme depressed mood: No Yes

Wild mood swings: No

Yes Rapid speech: No Yes

Extreme anxiety: No Yes

Panic Attacks: No Yes

Phobias: No Yes

Sleep Disturbances: No Yes

Hallucinations: No Yes

Unexplained losses of time: No Yes

Unexplained memory lapses: No

Yes Alcohol/Substance Abuse: No

Yes Frequent Body Complaints: No

Yes Eating Disorder: No Yes

Body Image Problems: No Yes

Repetitive Thoughts (e.g. Obsessions): No Yes

Repetitive Behaviors (e.g. Frequent Checking, Hand Washing): No Yes

Homicidal Thoughts: No Yes

Suicide Attempt: No Yes

OCCUPATIONAL INFORMATION:

Are you currently employed? No Yes

If yes, who is your current employer:_____

If yes, are you happy at your current position:_____

Please list any work-related stressors:_____

RELIGIOUS/SPIRITUAL INFORMATION:

Do you consider yourself to be religious? No Yes

If yes, what is your faith?_____

If no, do you consider yourself to be spiritual? No Yes

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (check any that apply and list family member, e.g., sibling, parent, uncle, etc.):

Difficulty			**Family Member**
Depression:	No	Yes	_____
Bipolar Disorder:	No	Yes	_____
Anxiety Disorders:	No	Yes	_____
Panic Attacks:	No	Yes	_____
Schizophrenia:	No	Yes	_____
Alcohol/Substance Abuse:	No	Yes	_____
Eating Disorders:	No	Yes	_____
Learning Disabilities:	No	Yes	_____
Trauma History:	No	Yes	_____
Suicide Attempts:	No	Yes	_____

OTHER INFORMATION:

What do you consider to be your strengths?_____

_____

_____

What do you like most about yourself? _____

_____

_____

What are effective coping strategies that you have learned? _____

_____

_____

What are your goals for therapy? _____

_____

_____

Emergency Contact (Name/Phone Number): _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. YOUR THERAPIST AND SANKOFA HOLISTIC COUNSELING SERVICES, INC. (SHCS) HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

a. Your therapist and SHCS are legally required to protect the privacy of your PHI, which includes information that can be used to identify you that has been created or received about your past, present, or future health or condition, the provision of health care to you, or the payments for this health care. We must provide you with this Notice about our privacy practices, and such Notice must explain how, when, and why we will "use" and "disclose" your PHI. A "use" of PHI occurs when we share, examine, utilize, apply, or analyze such information within our practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of our practice. With some exceptions, we will not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. We are legally and ethically required to follow the privacy practices described in this Notice.

b. SHCS reserves the right to change the terms of this Notice and its privacy policies at any time. Any changes will apply to PHI on file with SHCS and your therapist already. Before SHCS makes any important changes to its policies, SHCS will promptly change this Notice and post a new copy of it in our office. You can also request a copy of this Notice from your therapist, or you can view a copy of it in our office, which is located at the below-listed address.

II **HOW SHCS AND/OR YOUR THERAPIST MAY USE AND DISCLOSE YOUR PHI**

c. For some disclosures, SHCS and/or your therapist will need your prior authorization; for others (i.e. medical emergency) your prior authorization is not required.

d. The following use and disclosures may be done and do not require your prior written consent:
   i. Treatment: PHI disclosure to a physician or other healthcare provider to coordinate treatment.
   ii. Payment: PHI disclosure to obtain payment for services SHCS and your therapist provide to you.
   iii. Healthcare Operations: PHI disclosure in the course of operations for this practice including quality assessment and improvement activities. SHCS may also use or disclose your PHI to accountants, attorneys, consultants, and others to make sure we are complying with applicable laws.
   iv. Medical or Psychiatric Emergency:
      1. Therapists must notify relevant others if a clinical determination is made that you intend to harm another individual
      2. Therapists must notify support personnel (e.g. police, family, emergency contact, friends, social support system) to help protect you should you become self-destructive
      3. Therapists must notify the police and/or appropriate child protective service if there is any suspected incidence(s) of child abuse, neglect, or molestation
      4. Therapists must notify the police and/or appropriate adult protective service if there is any incidence(s) of physical abuse of an elderly person
      5. Therapists must release information subpoenaed by the court as appropriate
      6. Therapists may choose to not release information where, in the therapist's judgment, such disclosure would be destructive to the individual client.

e. The following use and disclosures may be done and do not require your consent:
   i. Disclosure is required by federal, state, or local law; judicial or administrative proceedings; or law enforcement.
   ii. For public health activities.
   iii. For health oversight activities.
   iv. To avoid harm (as described under the above section iv.)
   v. For specific government functions.
   vi. For workers' compensation purposes.

f. You have the opportunity to object to the following use and purposes:

g. Disclosure to family, friends, or others involved in your healthcare. SHCS and/or your therapist may obtain your consent retroactively in emergency situations.

i. Revocation of written consent to disclose and/or use PHI. You must make a request to revoke any authorization in writing. Any request to revoke authorization will apply to future use and/or disclosure of your PHI but cannot be applied retroactively to any disclosure SHCS or your therapist have made in reliance to the original authorization to disclose

II. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

a. **The right to request limits on uses and disclosures of your PHI.** You have the right to ask that SHCS and your therapist limit how we use and disclose your PHI. We will consider your request, but we are not legally required to accept it. If we can accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

b. **The right to choose how we send PHI to you.** You have the right to ask that SHCS and your therapist send information to you at an alternative address (for example, sending information to your work address rather than to your home address) or by alternate means (for example, electronic format instead of regular mail). We must agree to your request so long as we can easily provide the PHI to you in the format you requested.

c. **The right to see and get copies of your PHI.** In most cases, you have the right to look at or get copies of your PHI that SHCS and your therapist have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days of receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, the reasons for the denial and explain your right to have the denial reviewed. If you request copies of your PHI, we will charge you $.10 for each page copied. Instead of providing the PHI you requested, we may provide you with a summary explanation of the PHI as long as you agree to that and to the cost in advance. SHCS will charge $50 per hour to prepare summary reports of PHI, copies of PHI, or other reports as you request (i.e. to coordinate care with other health providers or in the course of legal proceedings).

d. **The right to get a list of the disclosures SHCS and/or your therapist have made.** You have the right to get a list of instances in which SHCS and/or your therapist have disclosed your PHI. The list will not include uses or disclosures that your have already consented to, such as those made for treatment, payment, or health care operations, directly to you, or to your family. The list also won't include uses or disclosures made for national security purposes, or to corrections or law enforcement personnel. We will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list you'll receive will include disclosures made in the last six years unless you request a shorter time period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you a reasonable cost-based fee for each additional request. SHCS will charge $50 per hour to prepare additional disclosure listings requested during the same calendar year.

e. **The right to correct or update your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that SHCS and/or your therapist correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request to correct or update your PHI. We may deny your request in writing if the PHI is correct and complete, not created by SHCS or your therapist, not allowed to be disclosed, and/or not part of my records. Our written denial will state the reason(s) for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your initial request and the denial be attached to all future disclosures of your PHI. If we approve your request, we'll make the change to your PHI, tell you that we've done it, and tell others that need to know about the change to you PHI.

f. **The right to get this notice by e-mail.** You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of it.

III. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES. If you think that we may have violated your privacy rights, or you disagree with a decision we have made about access to your PHI, you may file a complaint with the Secretary of the Department of Health and Human Services. Otherwise, for questions or other concerns, please contact

IV. Claudius Johnson, LCSW (SHCS' Chief Executive Officer) at the below-listed telephone number and address.

V. EFFECTIVE DATE OF THIS NOTICE: Opening date of business – June 02, 2015

Form created/effective: June 02, 2018