



WELCOME!

Thank you for considering Full Circle Counseling & Coaching at this difficult time of your life. You will experience an atmosphere of safety, concern, and a professional approach to you and your situation.

To better assist you, please fill out these forms as fully and openly as possible. This information will help me assist you more rapidly when we have our first session. Please bring your completed forms and insurance card with you at your first appointment.

Your appointment is on _____ @ _____. I require 24 hour cancellation notice. Otherwise, you will be billed for the full amount of the session. More than two late cancellations or no shows will suspend counseling until your life situation permits you to make your appointments on time. Likewise, I will provide you with the same consideration. I understand there are last minute unavoidable emergencies that may prevent you from attending. We can discuss this on a case by case basis. I am on call 24 hours a day. In the event that I am on vacation or will not be available by phone, I will arrange for emergencies with a colleague. We will discuss when it is appropriate to reach me in an emergency during your session. Please use the main office number @ (503) 588-2113. If you are experiencing a mental health emergency. You can also call the Psychiatric Crisis Center at (503) 585-4949. If it is a very dangerous life threatening situation I urge you to call 911.

How to find my office: Heading south on Commercial from downtown, stay in the far left lane. Shortly after the Liberty and Commercial Street "split" (near Gatti and Gatti attorney's office) turn left on Superior, then make another left onto Liberty Street SE as if you were heading back toward downtown. Immediately get into the far right lane. You will see NorthWest Center For Change on the right. Drive slightly past it and turn into the first driveway on the right (1644 Liberty) take another right in the driveway and drive all the way back to building # 1700. My office building is located directly behind NW Center for Change. Park in the driveway, and I will meet you in the lobby upstairs. I look forward to seeing you soon!

Sincerely,

Elizabeth Hartshorn, MS, LPC

FULL CIRCLE COUNSELING INFORMED CONSENT

CONFIDENTIALITY STATEMENT:

All information shared in this treatment is confidential except in circumstances governed by law. If you would like me to consult with another healthcare professional, you will need to sign a “release of information” form. This permission can be revoked by you at any time.

FINANCIAL AGREEMENT:

Your fee per visit is \$_____. Your estimated out-of-pocket/co-payment is_____and is payable at the time of treatment. I accept cash, check, cashiers check.

NO -SHOW AND CANCELLATION POLICY:

Your visit has been reserved for you. Without notice, I cannot schedule another client in your place. Therefore, **24 hours notice is required for cancellation or you will be charged.**

EMERGENCIES:

I am on call 24 hours in the event of an emergency. Should I not be available you can call the emergency numbers given to you at your initial visit.

STATEMENT OF UNDERSTANDING:

I have read and understand this information sheet and informed consent.

Client or Guardian

Date

Provider

Date



COUNSELING FEES

2011 Fee Rate:

Initial Intake & Evaluation.....\$187.50
75-90 minutes

Individual Session.....\$125.00
45-60 minutes

SAME DAY CANCELLATION/MISSED APPOINTMENT.....\$125.00

Contracted Fee:

- As stated above, with insurance co-pay of \$_____ to be paid at time of session.
- Employee Assistance Program: No co-pay or fee is required from you. You are eligible for _____ sessions. If you choose to continue on with counseling after you have used your EAP benefit, the fee structure above will apply. If you miss a scheduled appointment without 24 hour cancellation, it will reduce one session per missed appointment.

You agree to the above payment contract and understand that you will be responsible for payment. Any and all fees not paid by a third party payer (Insurance) are your responsibility, regardless of what you may expect the insurance benefit to cover.

Request for Treatment

I am requesting treatment for myself and/or _____ from Elizabeth Hartshorn, MS, LPC of Full Circle Counseling & Consulting. I have been provided with and have read and understand the written information about the client rights, grievance procedures, agency rights insurance and fee policies. I understand that the above named client will receive a mental health diagnosis used to meet insurance and state requirements.

Client: _____ Therapist: _____

Full Circle Counseling Client Intake Form

This information is confidential and protected under Federal Law. It cannot be released without your written consent. Please answer the questions thoughtfully and truthfully.

Date _____ Email Address _____

How did you hear about Full Circle? _____

Your Name: _____

Address: _____

City _____ State _____ Zip _____

Cell _____ Work _____ Home _____

Can I leave a message on your Cell? Work? Home? Email?

Age _____ DOB _____

Insurance Information:

Insurance _____

Who is the Policy Holder? _____

Insurance Mailing Address _____

Insurance ID # _____

Insured's Group# _____

Insured's DOB _____

Insurance Phone # _____

Insured's Employer _____

Emergency Contact _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Phone # Cell _____ Work _____ Home _____

What Symptoms or situations have prompted you to seek counseling? _____

Medical Information:

Are you currently being treated for any medical condition? If so please describe.

Medication:

Please list all medications and herbal supplements and why you are using them:

Have you ever seen a therapist or other mental health provider prior to coming here? _____

What were you treated for and when did you see that provider? _____

Are you currently receiving mental health services elsewhere? _____

Mental Status:

Have you heard or seen things that others do not? _____

Do you hear voices or noises in your head that you cannot control? _____

Do you ever have experiences or thoughts that seem strange to others? _____

Do you have a history of . . .

Depression? Anxiety? Addiction?

Have you ever experienced any significant trauma or abuse as a child or adult? _____

Was it reported? When and to whom? _____

Do any family members have a history of Depression, Suicide, Mental Illness or Addiction?

If so, who and what? _____

Have you ever or do you currently self-injure? Such as cutting, "carving" sticking pins in your skin, pulling out eyelashes, pulling out your hair, bulimia, etc. _____

Have you ever thought about ending your life or contemplating suicide? _____

Have you ever attempted suicide? _____

If so, when, how did you attempt and were you hospitalized? _____

Are you thinking about Suicide or ending your life now? _____

Were you ever hospitalized for a psychiatric condition? _____

Have you ever had thoughts of wanting to kill or harm others? _____

Substance Use:

Please state which substances you currently use, how much and frequency:

Caffeine _____

Tobacco _____

Alcohol _____

Marijuana _____

Amphetamines or Diet Pills _____

Cocaine _____

Inhalants _____

Hallucinogens or Ecstasy _____

Opiates- Heroin/Methadone _____

Prescription Pills-Oxycodone, Xanax, Vicodin, etc. _____

Have you ever had an Eating Disorder? _____

Do you gamble? How much, how often? _____

Do you have concerns about your sexuality? _____

Legal History:

Have you ever been arrested? _____

Are you involved in any legal issues currently? _____

Family Information:

Who is living in your home now? _____

How many children do you have? _____

How many times have you been married? _____

If not married do you have a Significant Other? _____

Who are the important people in your life now? _____

Activities:

Do you have an active social life? _____

What are your hobbies? _____

Educational History:

Highest Level of Education _____ Major _____

Employment:

Are you satisfied with your job? _____

How long have you been with your current employer and what do you do? _____

Motivation Level:

On a scale of one to ten, ten being the highest, how much do you believe that your problems will get better? 1 2 3 4 5 6 7 8 9 10

On a scale of one to ten, ten being the highest, how motivated are you to participate in counseling and get better? 1 2 3 4 5 6 7 8 9 10

What things have you tried in the past that have helped your symptoms or problems?

Describe the last time you felt really happy or content with your life. What was happening at that time? Who was in your life? _____

What else should I know about you that will help me to help you get better? _____

Please sign acknowledging that you have received the Professional Disclosure Statement for Elizabeth Hartshorn LPC and Informed Consent

Signature _____ Date _____

FOR OFFICE USE ONLY

Diagnostic Assessment:

AXIS I: _____

AXIS II: _____

AXIS III: _____

AXIS IV: _____

AXIS V: _____

GAF at Intake

Treatment Recommendations and Referrals: _____

Therapist _____ Date _____