Client Information

Note: These forms will be kept as part of your confidential mental health record.
Feel free to indicate N/A if you feel a question does not apply to you.

Today's Date: _____

Name: _____ **Preferred Name:** _____

Date of Birth: _____ **Age:**_____

Address: _____

(street, city, state, zip)

Email:_____

Okay to Email? Yes / No

Phone: (_____) - _____ - _____

Okay to leave a voicemail? Yes / No

Okay to text? Yes / No

Appointment Reminders? Text Email Both None

Sex assigned at birth: _____ **Gender Identity:** _____

Ethnic/Racial Identification: _____

Religious and/or Spiritual Identity: _____

Relationship Status: *(please check all that apply)*

____ Single ____ Dating ____ Married ____ Partnered/Committed Relationship

____ Separated ____ Divorced ____ Widowed ____ Other _____

Sexual Orientation: _____

Please list any other aspects of your identity and/or culture that are important to you:

_____

What specific concerns or experiences have influenced your decision to seek services now?

_____

_____

_____

How long have you been experiencing these symptoms? _____

Previous Counseling or Psychiatric Experience? Yes / No

If yes, please describe: _____

_____

Personal History: please check any of the following that apply to you (current or past)

- ☐ Concerns related to your weight, body image/composition, eating behaviors, and/or muscle acquisition
- ☐ Trauma: _____
- ☐ Concerns with drug or alcohol use
- ☐ Trouble with the law and/or incarceration
- ☐ Incidents of self-harm (i.e. harming yourself on purpose)
- ☐ Thoughts of suicide or suicide attempts
- ☐ Psychiatric Hospitalization
- ☐ Diagnosed disability (mobility impairment, visual or auditory impairment, physical/health related disorders, learning disorders/ADHD, psychological disorder/condition etc.)
  Please specify: _____
- ☐ Other_____

Family History

_____ Physical/sexual abuse/domestic violence
_____ Serious medical problems
_____ Hospitalized for mental/emotional disorder
_____ Imprisoned or in trouble with the law
_____ Significant problems with alcohol/drugs
_____ Learning disability
_____ Diagnosed or suspected mental health concern
_____ Suicide attempts and/or completed suicide

Please explain:_____

_____

_____

Medical History (current or past injuries, surgeries, significant illnesses, or physical health issues):

_____

_____

Currently taking any medications and/or supplements: Yes / No

If yes, what type and dose: _____

Primary Care Doctor: _____ **Phone:** _____

Psychiatrist: _____ **Phone:** _____

- **How would you rate the quality and amount of sleep you get currently?**

  Excellent Good Fair Needs Improvement Poor

- **How often do you eat healthy, regular meals?**

  Always Most of the time Sometimes Rarely Hardly Ever

- **Do you own or have access to a firearm?** YES / NO

• **Do you have any concerns about your use of alcohol or other drugs** YES / NO

If yes, explain: _____

• **Do you have any other habits or behaviors that are potentially harmful or disruptive (i.e. internet use, video game use, gambling, pornography use, unsafe sex practices, etc.)?** YES NO

If yes, please specify: _____

What coping skills or practices do you currently utilize to support your well-being and manage stress or difficult life circumstances? _____

_____

List your important relationships

Name	Age	Relationship to you

Student: Yes / No Full-time / Part-time

School:_____ Year/Grade:_____

Major or Program: _____ Extracurriculars:_____

Employed: Yes / No Full-time / Part-time

Place of Employment: _____ Job title:_____

Please rate your level of satisfaction with the following at this time:

- Your academic performance: High Adequate Fair Poor N/A
- Your physical health and well-being: High Adequate Fair Poor N/A
- Your spiritual/emotional health and well-being: High Adequate Fair Poor N/A
- Your social/relational life: High Adequate Fair Poor N/A
- Your career/job performance: High Adequate Fair Poor N/A
- Your finances: High Adequate Fair Poor N/A

How did you find out about our practices/services? _____

_____

Disclosure Statement and Informed Consent Agreement

Welcome to Arena Counseling and Wellness. Our practice operates from a wellness model which views symptoms and behaviors as normal responses to abnormal circumstances. Life happens and we survive the best we can with what we have. Sometimes we find ways of surviving that were necessary in the past, but no longer serve us in the present. Hurt, fear, or anger often end up driving our lives: when we heal our pain it allows us to change our behaviors, our beliefs about ourselves, our relationships, and our lives. In this process, we will work with you to gain insight into the underlying unmet needs and emotions that drive your behaviors. Change comes from understanding, awareness, and self-compassion. It is our goal to empower you, to walk with you on the journey of self-discovery, and to help you feel the freedom of your authentic self. Growth exists right outside our comfort zones, together we hope to explore what stepping out into new ways of being looks like for you.

Disclosure Statement

This is a statement of your rights and responsibilities for our therapeutic relationship. The Disclosure Statement is designed to inform you of professional credentials, types of service offered, fee schedule, and therapeutic orientation and style. Please let your counselor know if you have any questions or concerns about this disclosure statement. You may revoke this agreement in writing at any time.

Client's Rights and Responsibilities

As a client, you have the right to choose a counselor/therapist who best suits your needs and purposes. Please be advised that you may ask questions about treatment at any time, and you may also choose to terminate/end therapy at any time. Please read this professional disclosure statement prior to beginning services.

Counseling Philosophy

The hope is that the work between client and therapist is a soft place for you to land and, as you may already know, therapy can also be an intense, engaging, and collaborative process. When you arrive at your session, some of it may feel uncomfortable or unfamiliar. Much of the time will be spent talking and exploring themes in your life, but therapy may also involve activities, experiments, and movements designed to increase self-awareness.

The purpose of therapy is for you to more deeply discover who you are, what you want, and how to get it. Because this is a process that can only happen within you, you are responsible for your self-growth. This means that sessions won't necessarily focus on how to control your feelings, but on how you can feel your feelings and experiences – both joy and sorrow – with more depth and authenticity. This awareness creates choice; choice is empowering.

During therapy your therapist will strive to honor you and your personal experiences and perspectives. They will also endeavor to provide you with feedback about how your thinking patterns, feelings, gestures, and other behaviors that may be outside your awareness. In some ways, your therapist serves as a mirror, designed to help you know yourself better. Often, your therapist will simply tell you what they see, what they think, and their internal reflections on you and your choices. However, you are always in control and you always have the choice about what you would like or not like to be explored in session.
Therapy is not as much a place to detach from the world and personal experiences; rather it is a place to engage them. Our purpose together is to empower you to face and embrace all of life. Therefore, much of the therapeutic process is a real, authentic, mini-life experience wherein you confront the challenges of life and existence within the relatively safe confines of the therapeutic office. We will use therapy for practicing life, rather than avoiding it.

Risks of Counseling/Psychotherapy

Counseling may feel challenging and difficult at certain points in time. For instance, you may feel anger, sadness, guilt, grief, loss, frustration, and a host of other emotions, which make you uncomfortable. We will discuss these feelings in session. Although the expectation is that you will benefit from counseling, no specific results can be guaranteed.

Appointments & Contact

You may confidentially request an appointment by calling or texting (352)-329-2040 or emailing info@arenacounselingandwellness.com, but please be aware that email is a less secure form of communication. If you choose to initiate email contact, please limit your contact only to scheduling of appointments. This will maximize your privacy and safety.

We do provide services via phone or videoconference with a scheduled session. Phone, email, or text contact is to be used primarily for scheduling purposes.

Arena Counseling and Wellness is not able to respond or intervene in clinical emergencies (suicide attempts, runaways, behavioral aggression, abuse episodes etc.) and you should dial 911 or go to your nearest hospital emergency room. Please then leave a message that you have experienced a crisis, the nature of the problem, and a number at which you can be reached and someone from our team will reach out to you.

Here are some resources available 24/7:

Alachua County Crisis Line

352-264-6789

Alachua County Crisis Center

John Henry Thomas, M.D. Center
218 SE 24th Street
Gainesville, FL 32641
Phone: 352-264-6789

National Suicide Hotline

1-800-SUICIDE
(1-800-784-2433)

National Suicide Prevention Lifeline

1-800-273-TALK
(1-800-273-8255)

Attendance and Fees:

Costs for services are as follows:

Senior Therapists/Specialty Services (LCSW/LMHC/PhD)

Individual psychotherapy: $145 (60mins) | $200 (90 mins)

Couples psychotherapy: $175 (60mins) | $250 (90 mins)

Therapists (RMHCI)

Individual psychotherapy: $125 (60mins) | $175 (90 mins)

Couples psychotherapy: $150 (60mins) | $225 (90 mins)

Payment can be made by cash, check, and most major credit cards. Fees are due at time of service. A $25 charge will be applied to your account for any returned checks. If payment for services is not received within 14 days, you will be contacted by certified mail. If payment is then not received within 30 days from the original invoice, we reserve the right to initiate the use of a collection agency. Please keep in mind that this may warrant a limit to your confidentiality. Chargeable time includes therapy sessions, writing of reports and correspondence, and contacts with other professionals on your behalf. If services are required for court related issues which may include depositions, court room testimony, preparation time, travel time from and to the office, and waiting to testify; the fee is $300.00 per hour. You are responsible for all payments for services at time of service. If you have concerns about making a payment for services, please discuss your concerns with your therapist immediately.

At therapist discretion, Arena Counseling and Wellness is able to provide medical documentation depending on need and circumstances. The fee for therapeutic letters is billed at the same hourly rate as the established session fee.

Arena Counseling and Wellness does not contract with any third party insurance at this time due to the limits on services and confidentiality required by most insurance policies. Your therapist can provide a superbill for you to submit to your insurance company. We also have a ***sliding scale* offering reduced rates based on need and availability. We do not want financial limitations to prevent you from seeking mental health services, so please let your therapist know if you need to discuss sliding scale options or referrals to another provider. **

Appointments are approximately 50 minutes or 80 minutes of client contact time each hour with the other 10 minutes used for fee collection and documentation. Appointment times are reserved exclusively for you and your family members. Thus no shows, same-day cancellations, or reschedules made under 24 hours will be charged a standard session fee. There will be no charge for cancellations made 24 hours in advance. If you are running late, call and come anyway, and use the remaining time already reserved for you. It is also important for therapy to be effective to establish a consistent schedule. Frequent changes in appointments distract from the necessary therapeutic rhythm essential for meaningful and lasting results. Clients who repeatedly reschedule and/or miss appointments may be referred to another practitioner; please be aware that Arena Counseling and Wellness reserves the right to withdraw from providing clinical services if this occurs.

_____By initialing, I acknowledge and understand the attendance and fees policy

Confidentiality: Confidentiality refers to the protected nature in which your personal health information is held. This information, known as PHI or EPHI (protected health information or electronic protected health information), is protected both legally and ethically. Therefore, Arena Counseling and Wellness will protect your information and will not share it with others outside of the agency (except in the limited circumstances outlined below) without your express permission.

Below are some of the cases in which the law dictates that your signed authorization may not be required in order to release information:

• Threat to self: If a patient seriously threatens to harm himself/herself, the therapist may be obligated to seek hospitalization for him/her, or to contact family members or others involved in your welfare who can help provide protection.

• Threat to others: If the therapist determines that there is a probability that the patient will inflict imminent physical injury on another person, he or she may be required to take protective action by disclosing information to medical or law enforcement personnel, providing warning to an identified victim, or by securing hospitalization of the patient.

• Vulnerable populations: If the therapist has cause to believe that a child under 18 has been or may be abused or neglected (including physical injury, substantial threat of harm, mental or emotional injury, or any kind of sexual contact or conduct), or that a child is a victim of a sexual offense, or that an elderly or disabled person is in a state of abuse, neglect or exploitation, the law requires that the therapist make a report to the appropriate governmental agency, usually the department of family and protective services (DFPS). Once such report is filed, the therapist may be required to provide additional information.

• Sexual exploitation by another provider: If a therapist has reason to believe that you have been the victim of sexual exploitation by a former therapist, he or she is obligated to contact the licensing board which oversees the professional activities of the therapist in question.

• Courts of Law: If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected under applicable law. However, records may be released pursuant to a validly issued subpoena or court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order your therapist to disclose information. If a government agency is requesting the information for health oversight activities, the therapist may be required to provide it for them. If a patient files a complaint or lawsuit against a therapist, he or she may disclose relevant information regarding that patient. If any such situation arises, the therapist will make every effort to fully discuss it with you before taking any action, and limit disclosure to only what is necessary.

• Consultation: In situations where specific legal advice is required to protect your client rights as well as Arena Counseling and Wellness ethical and professional standards, the therapist may choose to seek formal legal advice. Additionally, consultation is a regular component of provision of counseling services, and therapists may consult with a mental health professional if needed to improve the quality of care provided to you. In these cases, your therapist will do what is possible to protect your identity to the best of their legal and ethical responsibility. If your therapist has a need to identify you in any way during consultation, treatment planning, or discussion with concerned parties, he or she will seek consultation with you to obtain your consent prior to any disclosures. In this case, your therapist will provide you with a consent form for the release of confidential information, which can be revoked or revised by you at time thereafter.

• Minors: If you are a minor under the age of 18, please be advised that your parent or legal guardian must give permission for Arena Counseling and Wellness to provide clinical services to you. In this case, your parents/legal guardian are also allowed access to your PHI. If this applies to you, your therapist will attempt to clarify all limits of confidentiality and roles within the therapy relationship at the onset of your work together.

Records: Your therapist is legally required to keep records which include specific information related to each session as well as treatment plan, diagnoses, and progress when warranted. All records are kept in a securely locked location and/or password protected and/or marked 'confidential'. No one outside of Arena Counseling and Wellness staff can have access to your records without your express permission except in the outlined limitations to confidentiality listed above.

Consent for Treatment

You will be given a copy of the Notice of Privacy Practices, and you will be asked to sign client consent for use and disclosure of protected health information. Please discuss any questions or concerns you have about entering a counseling relationship or the counseling process with your therapist.

By your signature below, you are indicating: (1) that you voluntarily agree to receive mental health assessment and mental health treatment and that you authorize Arena Counseling and Wellness to provide such assessment and treatment as is considered necessary and advisable; (2) that you understand and agree that you will participate in the planning of your care and treatment, that you may stop such treatment at any time; and (3) that you have read and understood this statement and you have had sufficient opportunity to ask questions about, and seek clarification of anything unclear to you; and (4) that you were provided with a copy of this statement.

By my signature, I acknowledge that I have read and understand this therapist disclosure statement. I consent to therapy at Arena Counseling and Wellness according to the terms described here. I have read the preceding information and understand my rights as a client.

Emergency Contact: _____

Phone:_____ Relationship to you: _____

_____ By initialing, I acknowledge Arena Counseling and Wellness is authorized to contact this person in the event of an emergency to ensure client health and safety

My signature below evidences my consent for treatment.

Signature

_____

Printed Name

_____

Date

_____

Consent to Electronic Communication

Electronic communication: if I choose at any time to engage in electronic communication via e-mail, text message, or telehealth sessions with my provider, I acknowledge that this form of communication is not as secure and the confidentiality of information cannot be guaranteed.

At Arena Counseling and Wellness your privacy and confidentiality is of the utmost importance. In the event that sessions are based over the phone or online, it is imperative we inform you that complete privacy cannot be guaranteed as it is not conducted in the privacy of a counseling room. It is advised you select a private and secure location for the duration of your session. As another protective measure, we ask that you notify your therapist if your physical address for the session is different from the one on this form

Your therapist will provide you a link for Doxy, which is our telehealth service provider. Doxy is a service offered to you at no additional cost. It is HIPAA compliant and does not require any downloads, just follow the link and it will bring you into the online waiting room.

Signature **Printed Name**

____ __________________________________

Date

____

- -

Minor Consent to Treatment Authorization

I acknowledge that I am under the age of 18 and require parental or legal guardian consent to engage in psychological services. My signature below indicates my assent to treatment.

Signature **Printed Name**

____ __________________________________

Date

____

Parent/Legal Guardian Signature **Printed Name**

____ __________________________________

Date

____