



Integrative Counseling and Psychological Services  
[www.sollarsassociates.com](http://www.sollarsassociates.com)

Administrative Office  
 1777 Axtell Dr., Suite 101, Troy, MI 48084  
 Fax: (248) 385-1193 Phone: (248) 787-0855

### Client Information Form

Today's Date::		Date of Intake:	
Client Name:		Therapist Name:	
Client Gender:		Client DOB:	
Guardian's Name:		Client / Guardian Phone Number:	
Type of Counseling:		Client / Guardian Email Address:	
Location:		Availability:	
Insurance Carrier:		Diagnosis (Therapist to Complete)	
OR Cash Client:		Patient Profile Completed:	

### Personal Information

Employer	
Position	
How long at current job	
Education	
Marital / Relationship Status	
Significant Other's Name	
Significant Other's Age and Sex	
How long together?	
Names and ages of Children	
Emergency Contact	

### Medical and Health History

List any allergies you have	
Primary Care Physician's Name	
Primary Care Physician's Address	
Date of your most recent physical exam	

Name of Medication	Dosage	Name of Doctor	First Prescribed?

Current Health Problem	Past Health Problems	Major Operations	Date

Former Therapist's Name	Dates of Service

Substance Abuse Treatment Location and Dates of Service	Inpatient Psychiatric Treatment Location and Dates of Service

Substance	Amount Used	Frequency of Use
Cigarettes		
Alcohol		
Pills (not prescribed)		
Marijuana		
Cocaine (in any form)		
LSD		
Heroin		
Other (please list)		

### Reasons for Seeking Counseling

Problem	Current	Past
Difficulty falling asleep or staying asleep		
Sleeping too much		
Changes in appetite, weight loss or weight gain		
Frequent crying		
Panic attacks or anxiety attacks		
Thoughts of killing or hurting myself		
Attempts to hurt or kill myself		
Problems concentrating		
Difficulty at school		
Bedwetting or other elimination problems		
Problems remembering things		
Difficulty completing routines/daily activities		
Periods of daily sadness lasting more than two weeks		

I startle easily		
Can't stop remembering upsetting events		
Difficulty controlling my temper		
I physically hurt other people		
Conflicts with peers		
Difficulty in social interactions		
I break things sometimes		
I worry a lot		
Little or no interest in sex		
I feel tired almost everyday		
Feelings of unreality		
Made myself throw up in order to lose weight		
Used laxatives or exercised excessively to lose weight		
I often feel like I am an outsider		
Sexual problems		
Worry that something is wrong with my body		
Frequent arguments with the people I live with		
I hear voices in my head		
Please make note of any other concern not listed above		

Please explain your faith/religious/spiritual perspective

Is there anything else that you would like me to know about you - now or in your past?

**-----SIGNATURES SECTION-----**

**Consent to Treatment**

I hereby consent for Sollars & Associates to provide evaluation and treatment to me

**Services Agreement and HIPAA**

This form has three purposes. First, it tells you about my procedures and policies concerning important aspects of your psychotherapy. Please let me know if you have concerns about any of the policies. Your first visit will help me get a general understanding of your situation in order to determine how I might best help you. Because I want you to participate actively in planning your counseling, don't hesitate to ask questions.

Psychotherapy is a way of talking through your problems in order to begin resolving them. You will need to take an active part in psychotherapy by working on and thinking about the things you talk about with your therapist. Psychotherapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and feeling much less distressed. However, there are no guarantees of what you will experience, and at times a psychotherapy session may leave you with unhappy feelings.

Second, this form is an Agreement between you and Sollars and Associates, Inc. You may revoke (cancel) this Agreement in writing at any time. That revocation will be binding on Sollars and Associates, Inc. unless I have already relied on this agreement to take action or if you have not paid your bill in full.

Finally, this form also contains information about a federal law that affects your privacy rights. This law, called HIPAA (Health Insurance Portability and Accountability Act), regulates the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. HIPAA requires that we give you a Notice of Privacy Practices (the Notice). The Notice, which is attached to this Agreement, explains HIPAA's application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Please take home the Notice and read it before your next session; you and your therapist can discuss any questions you may have about it next time.

Appointments Appointments can be scheduled by calling (248)613-5377. Please leave a message. *If you need to cancel an appointment please notify me at least 24 hours before the session. Ask your therapist to discuss their cancellation policy*

Telephone Calls If you receive my voicemail, please leave a message and I will get back to you within 24 hours.

Emergencies *In emergencies, please call Common Ground at 1(800) 231-1127, Detroit-Wayne County Community Mental Health at (866) 289-2641, or go to your nearest hospital emergency room. An emergency is generally a situation in which you are in danger of harm or have hurt yourself or someone else.*

Confidentiality and Files The laws governing confidentiality can be quite complex. The attached Notice explains some specific Patient Rights that you have under the HIPAA law. We will maintain a Clinical Record file on your case, which is the property of Sollars and Associates, Inc. You may examine and/or receive a copy of your file *if* you request it in writing *and* the request is signed by you *and* dated not more than 60 days from the date it is submitted. There may be a charge for writing reports or for copying materials. In most situations, Sollars and Associates, Inc. can release information about your treatment to others *only* if you sign a written authorization form for each release. However, I am a *mandated reporter* and there are a few situations where I am required to disclose information to authorities. These situations are listed on following pages

Electronic Communication The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks: a. Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients. b. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient. c. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy. d. Employers and on-line services have a right to inspect emails sent through their company systems. e. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection. f. Email and texts can be used as evidence in court. g. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party. 2.

Conditions for the use of email and texts Therapist cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Therapist is not liable for improper disclosure of confidential information that is not caused by Therapist's intentional misconduct. Clients/Parent's/Legal Guardians must acknowledge and consent to the following conditions: a. Email and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time. b. Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations. c. Email messages may be printed and filed into the client's medical record. Texts may be printed and filed as well. d. Provider will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law. e. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information. f. Provider is not liable for breaches of confidentiality caused by the client or any third party.

Your signature on this agreement is written, advance consent for the following releases of information:

Your therapist may occasionally find it helpful to consult with other health and mental health professionals about a case. During consultations, your therapist makes every effort to avoid revealing the identity of patients. The other professionals are also legally bound to keep the information confidential. The therapist will note all consultations in your Clinical Record.

Your therapist may find it helpful to receive or exchange information with your primary care physician or other health and mental health professionals who are currently treating you. Your signature on this Agreement is written, advance consent for me to release information to these professionals. A record of any disclosure will be kept in your Clinical Record.



Initial here if you do NOT wish us to release any information to other mental health and health professional who are currently treating you.

**There are some situations where Sollars and Associates, Inc. is required to disclose information without your consent or authorization**

- If a client is clearly likely to seriously harm him/herself, we may be required to take action to prevent self-destruction.
- If there is a clear risk that a client plans to seriously harm another person, we may have a duty to warn the potential victim; or disclose the risk to appropriate public authorities.

- If a therapist suspects that abuse of a child or senior citizen may have taken place, the therapist is required to report the suspected abuse to the Department of Social and Health Services.
- If the client is a minor, younger than age 13, both parents have access to the minor client's complete clinical Record, including Psychotherapy Notes, unless there is a court order prohibiting one of the parents from access.
- If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis, or treatment, such information is protected by the counselor-client privilege law. Sollars and Associates, Inc. cannot provide any information without your (or your personal or legal representative's) written authorization. However, if a court orders or subpoenas Sollars and Associates, Inc. to disclose information, we are required by law to provide it. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.
- If a client files a complaint or lawsuit against Sollars and Associates, Inc. or any of its staff, Sollars and Associates, Inc. may disclose relevant information regarding that patient in order to defend itself.
- If a client files a worker's compensation claim, the client must sign an authorization so that Sollars and Associates, Inc. may release the information, records, or reports relevant to the claim.
- Sollars and Associates, Inc. may present disguised case material in seminars, classes, or scientific writings. In this situation all identifying information and Protected Health Information is removed, and client confidentiality and anonymity is maintained.

Please let your therapist know if you are in need of any of the following: vocational, spiritual, legal, educational, cultural assessments and services

Please inform your therapist if you have any infectious disease which may endanger others

Your signature below indicates that you have read this Agreement and agree to its terms, and also serves as an acknowledgement that you have received the HIPAA Notice of Privacy Practices described above. You also understand that you are entering into treatment voluntarily and may discontinue treatment at any time.

### **Cancellation Policy**

Your appointments are very important to me and time is reserved especially for you. In my desire to be effective and fair to all clients, the following policies are honored:

#### Payment

In order to schedule an appointment I require a credit card number on hold. You will not be charged until the time of service and you're free to use another form of payment at your session. This credit card will be kept on file to be charged should any of the following occasions arise or to pay for co-pays and deductibles. PLEASE COMPLETE CREDIT CARD FORM. If you agree to pay by check or cash, the fee must be paid on or before the next session.

#### Cancellations

24 hour advance notice is required when canceling an appointment. This allows the opportunity for someone else to schedule an appointment. If you are unable to give 24 hours advance notice you will be charged the amount of \$\_\_\_\_\_ for your missed appointment to the credit card on file unless you bring in another form of payment to your next session.

#### Missed Session

Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "no-show." They will be charged for their "missed" appointment to the credit card on file.

#### Late Arrivals

If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. You may also be billed for the portion of the missed session that cannot be billed to insurance.

This cancellation policy allows me to help as many people as possible and keep my schedule filled. Your signature indicates you have read, understood, and agree to the terms stated above.

You are welcome to discuss any of this information with me and we will note any exceptions to these policies:

### **Custody / Payment of Fees for Minor Child**

If there is a custody agreement in place, Sollars & Associates must receive a copy before services are rendered. The parent or legal guardian who brings a minor child for treatment or evaluation services is responsible for payment of the fees regardless of

which parent is the insurance subscriber. This includes cash fees as well as co-payments and deductible fees related to insurance benefits. A monthly statement of charges and payments will be provided. I understand the above policy and take responsibility for treatment and evaluation fees.

Minor Child's Name	
Custody Agreement Received	

### Summary of Signatures

I have read, understood and agreed to the following sections of this electronic document:

	<b>Consent to Treatment</b>		<b>Cancellation Policy</b>
	<b>Services Agreement and HIPAA</b>		<b>Payment of Fees for Minor Child (if applicable)</b>

<b>Client's Electronic Signature</b>	
<b>Client's Printed Name</b>	
<b>Date</b>	
<b>Email address</b>	
<b>Check the box to the right if you permit Sollars &amp; Associates to email you with information about our services, special events and matters of interest</b>	
<b>Therapist's Electronic Signature/Credentials</b>	
<b>Therapist's Printed Name</b>	