Rise Up Mental Health Care ~ #7 Rosemar Circle Parkersburg WV, 26104

Phone 304-422-7999 Fax 681-661-0257

CONSENT TO RECEIVE PSYCHOTHERAPY SERVICES:

This consent form explains the nature of the psychological services that you are about to receive.

Nature of treatment: (i) Evaluation and treatment planning: Approximately 1-3 sessions, (ii) Intervention: Depends on many factors, such as the nature of your difficulties and readiness for change, (iii) Termination: Approximately 1-2 sessions, involves developing a "toolbox" of strategies that may be used to help you maintain your treatment gains and reduce the likelihood of relapse and/or reoccurrence. Treatment effectiveness varies from person to person. Discussing, working with, and changing thoughts, feelings, and behaviors may be painful and challenging at times.

Services are by appointment only; in an emergency, please call 911 or go to the emergency room. Fees and payment: Sessions are approximately 30-50 minutes in length. Every attempt is made to see clients on time. To work towards this goal, payment is due at the start of each session, and sessions are to end no later than 10-minutes to the hour unless agreed upon. Please arrive on time for the session, arriving more than 10 min late for a 60-minute session will limit the time in session and the one-hour fee will still apply. Arriving more than 5 minutes late for a 30-minute session will result in cancelation of the appointment and fees will apply. Every attempt will be made to reschedule you as soon as available.

Payments can be made bv cash. debit, or credit card.
TWENTY-FOUR (24) hours' notice is required to CANCEL OR RESECHEDULE an appointment to avoid being billed for the full fee of the missed session. THE ONLY EXCEPTIONS ARE UNEXPECTED ILLNESS OR EMERGENCIES. Missed sessions will be billed to you directly and expected payment prior to any following visits.

Confidentiality: Psychological records may include items such as personal information, progress notes, and evaluations, and will be shredded 7 years after your file has been closed. No information about you can be released to a third party without your prior written consent, or verbal consent in the case of an emergency. Exceptions include: (1) when children are under 14 years of age, and their parents/legal guardians want access to the file, (2) risk of imminent danger, such as suicide, death, risk of a child running away, or serious bodily harm to an identifiable person or group, (2) suspected or known abuse or neglect of a child or older adult,

(3) unsafe operation of a motor vehicle, (4) requests ordered by a court of law (5) access is required by other personnel (e.g., administrative staff) to carry out their professional duties. Therapists must, as soon as the interest of their client so requires, receive supervision, consult another therapist, a member of another professional order, or another competent person. Disclosure of identifying information will be minimized, and names will not be released without consent.

Mutual rights and responsibilities: The relationship must remain limited to a respectful therapeutic framework. You may refuse any therapeutic suggestions offered to you, or to suspend or cease treatment at any time without penalty. If you decide to stop treatment for any reason, please notify your therapist so that your file can be closed and/or you can be referred to another resource. If you stop treatment without an explanation, your file will automatically be closed after 30 days. Consent to treatment: I have read and understood the above information, and any questions that I had have been answered. I agree with the above consent form, and freely consent to receive psychological services.

Name of client*: ____________________

Signature: ____________________ Date: ____________________

*For clients ages 13 and younger:

Name of parent/guardian: ____________________

Signature: ____________________ Date: ____________________

Name of parent/guardian: ____________________

Signature: ____________________ Date: ____________________

THERAPY INTAKE FORM

To be completed by individuals ages 14+

First name: ______________________ Last name: ______________________

Age: ________ Birthday: ______________ Ethnicity: __________
Religion: ______________ Marital Status: ____________________
Sex/gender: __________________
Home address: ______________________________
Cell#- ______________________________ Home #: ________________________
Work #: ____________________________ Email: ____________________________

Name of emergency contact: ________________________ Phone: ________________

For clients under 18 years of age:
Name of parent/legal guardian: ________________________ Phone: ________________

Name of parent/legal guardian: ______________________ Phone: ________________

EMPLOYMENT INFORMAITON•.
◆ Full-time or • Part-time at: __________________ Position: ____________________

◆ Not working

ACADEMIC INFORMATION: • Not attending school.
Highest level completed: ______________

THE REASONS FOR YOUR VISIT: ________________________

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How intense is your emotional distress? (Mild) 12 3 4 5 6 7 8 9 10 (Severe) Please describe:

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Overall, how much do the problems affect your ability to perform at work or school, get along with others, and perform daily tasks such as chores? (Mildly disruptive) 1 2 3 4 5 (Incapacitating) Please describe:

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When did these problems start? What was going on in your life at that time?

PSYCHIATRIC AND MEDICAL HISTORY Please list any psychiatric or "mental" problems you have been diagnosed with:

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Please list any medical or "physical" problems that you have been diagnosed with:

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Please list any medications you currently take, and what you take them for:

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Family doctor: ______________________ Phone: ______________________

Psychiatrist: ______________________ Phone: ______________________

MENTAL HEALTH TREATMENT HISTORY Have you ever been hospitalized for psychological or psychiatric reasons? • No • Yes If yes, please describe when and where you were hospitalized, and for which reasons.

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Please tell us about any other mental health professionals or treatment that you have had in the past.

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<u>CURRENT HABITS</u>: Please circle any current habits.
Smoking: Gambling: Drinking: Drug use: Caffeine intake: Exercise: Eating: Sleeping: Fun and relaxation: other not listed:____

What are your goals for therapy?

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