HEALTHY OPTIONS COUNSELING SERVICES LLC

3540 wheeler Rd. Suite 609, AUgusta GA 30909

PATIENT REGISTRATION FORM

DATE: _____ **ADULT [ ] CHILD [ ]**

Please complete all areas of form and provide a copy of your insurance card(s)

PATIENT INFORMATION

Patient Name: _____ **Sex: M [ ] F [ ]**

Patient Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Email: _____ **OK to Send you Emails? Yes [ ] No [ ]**

Telephones: Home: (**)** _____ **Work: (** **)** _____ **Cell: (** **)** _____

OK to leave a message at: HOME Yes [ ] No [ ] WORK YES [ ] NO [ ] CELL YES [ ] NO [ ]

SS#: _____ **Date of Birth:** _____ **Employer:** _____

Occupation: _____

Name of Spouse/Partner: _____

Emergency Contact _____ **Phone#:** _____

PERSON RESPONSIBLE FOR PAYMENT (IF NOT THE PATIENT): _____

Responsible Party Billing Address/City/Zip Code: _____

Relationship Contact #: SS#: Date of Birth

PIMARY INSURANCE INFORMATION

Claims Address : _____ **Phone#:** _____

Subscriber Name: _____ **Relationship to patient:** _____

ID#: _____ **GROUP #:** _____ _____

SECONDAY INSURANCE INFORMATION

Claims Address: Phone#:

Subscriber Name: _____ **Relationship to patient:** _____

ID#: GROUP #:

REFERRAL SOURCE/PRIMARY CARE PHYSICIAN: I was referred by: _____

PCP/Phone# (**)** _____ **Email Address if known:** _____

I, _____**, have been given a handout explaining the services and policies of this office. I have had the opportunity to discuss any concerns or questions that I might have. I understand my rights and my responsibilities as outlined in the above-mentioned handout. I am also responsible to pay for all missed appointments and late cancellations.**

Patient and/or Guardian Signature: Date:

HEALTHY OPTIONS COUNSELING SERVICES LLC
(HOPE)

3540 Wheeler Rd. suite 6098 Augusta GA 30909
888 509 9040

HEALTH STATUS QUESTIONNAIRE

Mode of Collection

- ☐ Self-Administered
- ☐ Personal Interview
- ☐ Telephone Interview
- ☐ Mail
- ☐ Other

Referred by: _____ Phone #:_____ _____ _____

Client's Name: _____ Date of Birth: ____ / ____/ _____

Social Security Number: _____ _____ _____

Telephone #: _____

Address: _____

City: _____Zip: _____

Email:_____@_____.____

Insurance Name: _____

Member ID Number _____

Group number: _____

Insurance telephone Number: ( ) _____ _____

Instructions: This survey asks for your views about your physical & mental health. The information will help your health care provider track how you feel.

Answer each question by checking the appropriate box. If you are unsure about how to answer a question, please give the best answer you can.

During the past 4 weeks, have you had any of the following problems with work or other regular daily activities because of any emotional problems (such as feeling depressed or anxious)? Yes □ No□

Cut down the Amount of Time you spent on work or other activities: Yes □ No □

Accomplished less than you would like: Yes □ No□

Didn't do work or other activities as carefully as usual Yes □ No□

1. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

   Not at all □
   Slightly1 □
   Moderately □
   Quite a Bit □
   Extremely □

2. Do you suffer from any pain? How much bodily pain have you had during the past 4 weeks?

   None
   Very Mild □
   Mild □
   Moderate □
   Severe □
   Very Severe □

What kind of pain? _____ Taking pain medication Y [ ] No [ ]
Name of medication and dosage: _____

3. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

   Not at all ☐
   Somewhat ☐
   Moderately ☐
   Quite bit ☐
   Extremely ☐

4. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks?
Did you feel full of pep?
All the time ☐
   Most of the time ☐
   A good bit of the time ☐
   Some of the time ☐
   A Little of the time ☐
   None of the time ☐

5. Have you been a very nervous person?

All the time ☐
Most of the time ☐
A good bit of the time 3 ☐
Some of the time ☐
A Little of the time ☐
None of the time ☐

6. How Much of the time during the past 4 Weeks?
   Have you felt so down in the dumps that nothing could cheer you up?

All the time ☐
Most of the time ☐
A good bit of the time 3 ☐
Some of the time ☐
A Little of the time ☐
None of the time ☐

7. Have you felt calm and peaceful?

All the time ☐
Most of the time ☐
A good bit of the time 3 ☐
Some of the time ☐
A Little of the time ☐
None of the time ☐

8. Did you have a lot of energy?

All the time
Most of the time ☐
A good bit of the time ☐
Some of the time ☐
A Little of the time ☐
None of the time ☐

9. Have you felt downhearted and blue?

All the time
Most of the time ☐
A good bit of the time ☐
Some of the time ☐
A Little of the time ☐
None of the time ☐

Explain what trigger your feelings:

_____

_____

_____

10. Did you feel worn out?

All the time ☐
Most of the time ☐
A good bit of the time ☐
Some of the time ☐
A Little of the time ☐
None of the time ☐

11.Have you been a happy person?

All the time ☐
Most of the time ☐
A good bit of the time ☐
Some of the time ☐
A Little of the time ☐
None of the time ☐

12. How much of the time during the past 4 weeks?
Did you feel tired?

All the time ☐
Most of the time ☐
A good bit of the time ☐
Some of the time ☐
A Little of the time ☐
None of the time ☐

12. During the past 4 weeks, how much time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

All the time ☐
Most of the time ☐
Some of the time ☐
A little of the time ☐
None of the time ☐

19. I expect my mental health state to get worse.

True ☐
Mostly True ☐
Don't Know ☐
Mostly False ☐
False ☐

20. Have you ever been suicidal? Yes ☐ No ☐
21. Have you ever try to commit suicide? Yes ☐ No ☐
22. Do you have any suicidal Ideations? Yes ☐ No ☐
23. Are you suicidal now? Yes ☐ No ☐
24. Do you have a plan? Yes ☐ No ☐

Explain_____

25. Does anyone know you are suicidal? ☐ Yes ☐ No

Please give us the names of the persons you have disclosed being suicidal:

1._____

2. _____

3. _____

Please answer Yes or No for each question.

26. In the past year, have you had two weeks of more during which you felt sad, blue, or depressed; or when you lost all your interest or pleasure in things that you usually cared about or enjoyed? Yes ☐ No ☐

27. Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes? Yes ☐ No ☐

28. Have you felt depressed or sad much of the time in the past year? ☐ No ☐

29. Have you suffered from any emotional, psychological, or physical traumas? Yes ☐ No ☐

Describe the trauma(s) and your age when it happened

_____
_____
_____
_____
_____
_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in? _____

4. Please list any difficulties you experience with your appetite or eating patterns:

_____

_____

5. Are you currently experiencing overwhelming sadness, grief, or depression? Yes [ ] No [ ]

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias? Yes [ ] No [ ]

If yes, when did you begin experiencing this?

_____

_____

7. Are you currently experiencing any chronic pain? Yes [ ] No [ ]

If yes, please describe: _____

8. Do you drink alcohol more than once a week? Yes [ ] No [ ] How Often_____

9. How often do you engage recreational drug use?

[ ] Daily [ ] Weekly [ ] Monthly [ ] Infrequently [ ] Never

What drug (s) _____ _____ _____

10. Are you currently in a romantic relationship? Yes [ ] No [ ]

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.

	Please Circle		List Family Member
Alcohol/Substance Abuse	Yes	No	
Anxiety	Yes	No	

Depression	Yes	No
Domestic Violence	Yes	No
Eating Disorders	Yes	No
Obesity	Yes	No
Obsessive Compulsive Behavior	Yes	No
Schizophrenia	Yes	No
Suicide Attempts	Yes	No

PRESCRIBED MEDICATIONS:

Are you taking any prescribe medications: Yes [ ] No [ ]

List the medications and dosage you are taking:

1. _____ Doses_____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____
7. _____ _____
8. _____ _____
9. _____ _____
10. _____ _____

Are You experiencing any side effects? Describe _____

_____

_____

_____

_____

ADDITIONAL INFORMATION:

1. Are you currently employed? Yes [ ] No [ ]

If yes, what is your current employment situation?

_____

_____

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? **(Optional)** Yes [ ] No [ ]

If yes, describe your faith or belief: _____

_____

3. What do you consider to be some of your strengths?

_____

4. What do you consider to be some of your weaknesses?

5. What would you like to accomplish out of your time in therapy?

GOALS:

1.

2.

3.

4.

Comments:

Signature_____ Date _____ _____ _____

City _____ State _____

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

_____

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.
Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.
Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.
I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____
Client Signature (Client's Parent/Guardian if under 18)

Clinician's Signature_____

Today's Date _____

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COUNSELING DISCLOSURE STATEMENT

Welcome to Healthy Options: We want your experience here to be positive and growth promoting. This disclosure statement is to inform you about your rights as a client, and we will ask you to sign this form to verify that you have received this information. Please take your time and read carefully. If you have any questions, please feel free to ask your counselor.

Mental Health Counseling: We aim to provide counseling services for person dealing with issues impacting their well-being. Our focus involves counseling within a brief intervention framework to maximize your time with your counselor and to enhance your counseling experience with us. In addition, we use other approaches such as problem solving techniques, healthy decision making, and cognitive and behavioral strategies for coping and managing feelings, thoughts, and behavior.

Counselors experience and credentials: Our counselors are Master level and Doctorate level clinicians with more than 30 years of experience. Dr. VAsquez is not a Licensed Psychologis. He is a WA and GA State Licensed Mental Health Counselor fully qualified to provide counseling services in both states. In addition, he holds a Doctorate degree (Ph.D.) in Human Services with emphasis in Psychology, and a Doctorate degree in Psychology (Psy.D.), besides holding a Master's degree in Marriage, Family, and Child Therapy. Dr. Sara Franco holds a Doctorate in Psychology and a Master degree in Marriage, Family, and Child Therapy. Shi is also a Child, Adolescent, and Geriatrics specialist in addition to being a Minority Mental Health Specialist. She is a License Mental Health Counselor Associate. In addition, Dr. Franco is a Nutritional Therapy Professional. Each counselor will inform you regarding his/her credentials, treatment modality, and experience at the time of the intake and thereafter as needed. Please ask questions or express your concerns anytime during intake or during treatment.

Our schedule: Our services are offered all year around, Monday through Friday from 8 am to 5 pm. Services outside these hours can also be arranged on a one to one basis.

Client rights: Counseling is a voluntary act and you have the right to choose counselors who best suit your needs. We will do our best to accommodate your needs or to give you an appropriate referral. You have the right to be treated ethically by our counselors. If you have any questions concerning your rights, questions regarding ethical issues, or if you wish to file a complaint, please contact one of the following:

1. Your current mental health counselor or his/her supervisor
2. The Washington State Department of Health, Counselor License (360)236-4700
3. HSQA Complaint Intake, Post Office Box 47857 Olympia, WA 98504-7857

Healthy Options Confidentiality Policy: We observe confidentiality as required by RCW 18.19.180. To provide effective service, your counselor may discuss your case with other working in or for Healthy Options (i.e., Consulting psychologist, Supervisor, or another counselor within the agency). However, no information about you will be given to anyone outside the agency unless:

1. We have your permission
2. We believe that it is necessary to prevent clear and immediate danger to you or others
3. You indicate that there is reasonable cause to believe that a child, dependent adult, or a vulnerable elderly person has been abused
4. A court orders us to disclose confidential information about you, after we ask the court to stop the order.
5. You waive the privilege by bringing charges against us.

Signature: I have read and understood this disclosure statement and I consent to counseling. Additionally, I consent to the following:

- If my contact information changes, it is my responsibility to notify my counselor or his office about the changes
- I will notify my counselor of his office if I no longer need or want services.
- I understand that I need to cancel my appointments 24 hours in advance, or I will be billed for the session.
- I have read the above information, and I have received a copy of this form for my review.
-

Client Signature _____ Counselor Signature_____Date _____

INFORMED CONSENT FOR PSYCHOTHERAPY & LIFE COUCHING

I, _____, have fully discussed with **Dr. Vasquez [ ], Dr. Franco [ ]** various aspects of the of this contract. This has included a discussion of evaluation and diagnostic formulation, as well as the method of treatment. The nature of the treatment has been described, including the extent, its possible side effects, and possible alternative forms of treatment. I understand I may withdraw from treatment at any time but if I decide to do this I will discuss my plan with **Dr. Vasquez** [ ], **Dr. Franco** [ ] before acting on it.

Dr. Vasquez [ ], Dr. Franco [ ] , has further discussed with me scheduling policies, fees to be charged, and policies regarding payment, missed appointments, matters relating to insurance, and if applicable, preauthorization and utilization review issues.

Some important issues regarding confidentiality need to be understood as we begin our work together. Please review this material carefully so that we may discuss any questions or concerns of yours the next time we meet.

In general, the confidentiality of all communications between a patient and psychologist is protected by law, and I can only release information about our work to others with your written permission. There are a few exceptions, however.

In most judicial proceedings, you have the right to prevent me from testifying. However, in child custody proceedings, adoption proceedings, and proceedings in which your emotional condition is an important element, a judge may require my testimony if it is determined that resolution of the issues before the court requires it. If you are involved in litigation, or are anticipating litigation, and you choose to include your mental or emotional state as part of the litigation, I may have to reveal part or all of your treatment or evaluation records.

If you are called as a witness in criminal proceedings, opposing counsel may have some limited access to your treatment records. Testimony may also be ordered in (a) legal proceeding relating to psychiatric hospitalization; (b) in malpractice and disciplinary proceedings brought against a psychologist; (c) court-ordered psychological evaluations; and (d) certain legal cases where the client has died.

In addition, there are some circumstances when I am required to breach confidentiality without a patient's permission. This occurs if I suspect the neglect or abuse of a minor, in which case I must file a report with the appropriate State agency. If, in my professional judgement, I believe that a patient is threatening serious harm to another, I am required to take protective action which may include notifying the police, warning the intended victim, or seeking the client's hospitalization. If a client threatens to harm himself or herself, I may be required to seek hospitalization.

The clear intent of these requirements is that a psychologist has both a legal and ethical responsibility to take action to protect endangered individuals from harm when his or her professional judgement indicates that such danger exists. Fortunately, these situations rarely arise in my practice.

There are several other matters concerning confidentiality:

1. I may occasionally find it helpful or necessary to consult about a case with another professional. In these consultations, I make every effort to avoid revealing the identity of the client. The consultant is, of course, also legally bound to maintain confidentiality. If I feel that it would be helpful to refer you to another professional for consultation then, of course, with your authorization, I will discuss your case with her or him.

2. I am required to maintain complete treatment records. Patients are entitled to receive a copy of these records, unless I believe the information would be emotionally damaging and, in such cases, the records must be made available to the patient's appropriate designee. Patients will be charged an appropriate fee for preparation.

3. If you use third party reimbursement, I am required to provide the insurer with a clinical diagnosis and sometimes a treatment plan or summary. If you request it, I will provide you with a copy of any report which I submit.

CANCELLATION POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment.

Thank you for your consideration regarding this important matter.

_____

Client Signature (Client's Parent/Guardian if under 18)

_____

Today's Date