Turning American Families Around
Individual, Marital and Family Counseling

CLIENT FULL NAME _____ DATE OF BIRTH _____ AGE _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

PHONE (GIVE PHONE NUMBERS WE CAN CALL YOU ON ONLY) HOME _____ CELL _____ WORK _____

E-MAIL (PRINT CLEARLY) _____ CAN WE EMAIL YOU? _____ CAN WE TEXT YOU? _____

BILLING INFORMATION

INSURED NAME _____ DOB _____

RELATIONSHIP TO CLIENT _____ PHONE _____

BILLING ADDRESS _____

CITY _____ ST. _____ ZIP _____

E-MAIL WE MAY CONTACT YOU AT _____

PRIMARY INSURANCE COMPANY _____

MENTAL HEALTH PHONE # _____ COPAY _____ DEDUCTIBLE _____

Card Number _____ Group # _____

(YOU MAY CONTACT INSURANCE COMPANY TO GET THIS INFORMATION AND AUTHORIZATION #)

SECONDARY INSURANCE COMPANY _____

MENTAL HEALTH PHONE # _____ COPAY _____ DEDUCTIBLE _____

Card Number _____ Group # _____

(YOU MAY CONTACT INSURANCE COMPANY TO GET THIS INFORMATION AND AUTHORIZATION #)

EMPLOYEE ASSISTANCE PROGRAM (EAP) EAP COMPANY NAME _____

PHONE # _____ AUTHORIZATION # _____

NUMBER OF UNITS AUTHORIZED _____

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT FOR SERVICES RENDERED REGARDLESS OF REIMBURSEMENT FOR THESE SERVICES BY MY INSURANCE COMPANY AND THAT ANY INACCURACY IN INFORMATION ON THIS FORM MAY RESULT IN NONPAYENT BY MY INSURANCE COMPANY.

Signature to contact your insurance company _____ Date _____

ALL COPAYS AND BALANCES ARE DUE IN FULL AT THE BEGINNING OF YOUR APPOINTMENT

Turning American Families Around
Office of E. Michael Priddy, MA, LCPC
P.O. Box 24131, Overland Park, Ks 66283

Credit Card on File Authorization

Please complete this form if you would like Turning American Families Around to keep your credit card information on file for future charges. The use of this form is optional and for your convenience. By utilizing this service it does not take up valuable session time to complete credit/debit card transactions. You may elect to provide payment information with each charge if you do not wish to keep your credit card on file.

Information to be completed by card holder:

Card Holder Name: _____

Card Number_____

Card Type: (circle one) Visa MasterCard Discover American Express

Expiration Date: _____

Security Code: _____ (3 digit code on the front or back of your card)

Billing Address and Zip Code: _____

Phone: _____

Email: _____

Would you like for us to send you a receipt by text or by email? _____

I, _____, authorize Turning American Families Around to charge the above credit card account for psychotherapy services. I agree to update any information regarding this account. The above information is complete and correct

_____ _____
Cardholder Signature Date

IMPORTANT SIGNATURES: Please read and initial the statements you agree to:

_____ I understand I have made a voluntary choice to be involved in counseling provided by a mental health professional as defined by Kansas and Missouri law. I understand counseling is a cooperative effort between me and my counselor and I agree to keep him aware of my needs, resolving any difficulties which may arise.

_____ I am free to terminate counseling at any time.

_____ I understand I am consenting only to those mental health services that my counselor is qualified to provide within the scope of the professional (or his/her supervisor's) license, certification, and training he/ she has obtained.

_____ I understand my treatment will be kept in confidence. Release of information will only occur by my informed, signed, and witnessed consent. The only exceptions to this are those required/allowed by law, including but not limited to perpetration of child abuse, elder abuse, sexual abuse, danger to self or others, and treatment of minors.

_____ I authorize my counselor to release necessary medical information to appropriate third parties for reimbursement purposes and/or to persons authorized to conduct service utilization reviews. I authorize my insurance company to assign benefits to Turning American Families Around or E. Michael Priddy, MA, LCPC.

_____ I agree to notify my counselor immediately whenever I have lost insurance coverage or I have changes in my employment health insurance.

_____ I authorize my counselor to contact my Primary Care Physician to coordinate services if necessary.

_____ I understand and agree: I am personally and fully responsible to pay for all services rendered; if I have insurance with a carrier which has a contract with Elton M. Priddy, MA, LCPC his office will file claims on my behalf and I agree to pay the balance of any and all services.

_____ I have received a copy of HIPPA -Policies and Practices to Protect the Privacy of Your Health Information
(see attached document).

_____ I understand that all fees or co-pay are due at the beginning of each session.

_____ I understand the Cancellation Missed Appointment Policy.

_____ Litigation Limitation – Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agree that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injury, lawsuits, etc.) neither you (client) nor your attorney, nor anyone else acting on your behalf will call on your therapist to testify in court or any other proceeding, nor will a disclosure of psychotherapy records be requested.

_____ All information that I have reported are true and accurate to the best of my knowledge.

Client Signature _____ Date: _____

Client Signature _____ Date: _____

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Consent to Leave Information

Turning American Families Around has adopted a policy that requires our staff to obtain authorization from the client to leave detail messages for the client if they are not available. This policy is to protect the privacy of the client and also to protect Turning American Families Around and its staff from violating the client's confidentially. If there is not a signed consent on file, our staff will only leave their name and phone number on an answering machine, voice mail, or with the person answering the phone asking the patient to return the call.
By completing the consent form below, you are allowing the staff of Turning American Families Around to leave a detailed message on an answering machine, voice mail or with a specific individual. You can specify what information can be left and with whom.
I give my consent to the staff of Turning American Families Around to leave a message regarding appointment times, billing and other information necessary.

___ On answering machine or voice mail at home.

___ On an answering machine or voice mail at work.

___ On cell phone via voice mail or text messages

___ Automated text appointment reminder (need mobile/cell phone number) _____

___ With _____Relationship _____

___ With _____Relationship _____

___ I do not want messages left at home, work, or with any other person.

___ Correspondence may be sent via e-mail at _____

___ Correspondence may be sent via US Postal Service to my home address.

EMERGENCY CONTACT INFORMATION: In case of emergency who may we contact on your behalf?

Name _____ Phone _____

Email Address _____ Relationship to you _____

Client Signature _____ Date _____

Client Signature _____ Date _____

Witness _____ Date _____

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Intake Information - Please answer all the questions to the best of your ability.

CLIENT FULL NAME _____DATE OF BIRTH _____ AGE _____

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ PARTNERED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

WHAT IS YOUR SPOUSES NAME _____ DOB _____ AGE _____

EMPLOYMENT STATUS ☐ FULL TIME ☐ PART TIME ☐ UNEMPLOYED ☐ RETIRED ☐ DISABLED ☐ LAYED

OFF EDUCATION ☐ HIGH SCHOOL ☐ COLLEGE ☐ GRADUATE SCHOOL +

REASON FOR SEEKING COUNSELING

_____
_____
_____
_____

PREVIOUS MARRIAGES OR RELATIONSHIP WITH A SIGNIFIGANT OTHER – 1ST (YRS _____) 2ND (YRS_____) 3RD (YRS _____)

CHILDRENS NAMES, AGES, (INCLUDING PREVIOUS RELATIONSHIPS IF APPLICABLE)

_____ _____ CUSTODY SPLIT _____
_____ _____ CUSTODY SPLIT _____
_____ _____ CUSTODY SPLIT _____
_____ _____ CUSTODY SPLIT _____
_____ _____ CUSTODY SPLIT _____
_____ _____ CUSTODY SPLIT _____

CHURCH AFFILIATION ☐ YES ☐ NO – IF YES WHAT CHURCH _____

DO YOU WANT TO INCORPORATE A CHRISTIAN MODEL OF COUNSELING ☐ YES ☐ NO _____

WHAT GOALS WOULD YOU LIKE TO ACCOMPLISH IN COUNSELING? _____
_____
_____
_____
_____

MEDICATIONS

1. _____ PURPOSE _____
2. _____ PURPOSE _____
3. _____ PURPOSE _____
4. _____ PURPOSE _____

Have you ever considered suicide? ☐ yes ☐ no If so, when? _____

Have you ever attempted suicide? ☐ yes ☐ no If so, when? _____

Other Helpful Information _____
_____
_____
_____
_____

Counseling Goal Sheet
E. Michael Priddy, MA, LCPC

Name _____ DOB _____
Date Completed _____

Please identify the main problem that has brought you to counseling and rate its severity:
_____
_____
_____
_____

On a continuum "None" to "Extreme", how much distress are you experiencing from this problem
_____ None _____ Some _____ A large amount _____ Extreme

_____ Current thoughts of hurting yourself _____ Current Plan on hurting yourself

Please identify three (3) main goals that you would like to address in counseling:
_____
_____
_____

What about your present behavior do you want to change? _____
_____
_____

What feelings do you want to alter (increase or decrease)? _____
_____

What benefits do you expect to derive from therapy? _____
_____

How would you describe the ideal therapist interaction for you? _____
_____

What do you think therapy will do for you? _____
_____

How long do you think therapy should last? _____
_____

Other thoughts or concerns that you have about counseling/therapy? _____
_____
_____
_____

Signature _____ Date _____

SOCIAL HISTORY

NAME _____ AGE _____ DATE OF BIRTH _____

GENERAL PHYSICAL HEALTH (CIRCLE ONE) - VERY GOOD GOOD AVERAGE POOR IMPROVING DECLINING

_____
_____
_____

Have you been in counseling in the past? When _____ Who did you see? _____

Check any of the following which are presently causing you difficulty:

___ Abuse ___ ADHD ___ Addictions ___ Adult Children ___ Affair ___ Anger ___Ambition ___ Anxiety ___ Appetite

___Assertiveness ___ Bullying ___Children ___ Concentration ___Confusion ___Dating ___ Decision making ___Divorce

___Education ___Energy ___ Extended Family ___Fears ___Finances ___Food ___Friends ___Guilt ___Headaches

___ Health Problems ___ Inferiority ___Infidelity ___ In-laws ___Insomnia ___Legal matters ___ Loneliness ___Marriage

___Memory ___My Past ___My Thoughts ___Nervousness ___Nightmares ___ OCD ___Parenting ___ Parents ___ Pornography

___Premarital ___ Relaxation ___Religion ___ Sadness ___School ___Self-Concept ___ Self-Control ___Separation

___Sexual problems ___Shyness ___Sleep ___ Stress ___Temper ___Tiredness ___ Ulcers ___Unhappiness ___Work

Depression (Explain) _____
_____
_____

Suicidal/Homicidal Thoughts (Explain) _____
_____
_____

Drug/Alcohol Use (Explain) _____
_____
_____

What are some strength's you have in your life _____
_____
_____

Did you experience any childhood trauma(s) that has strongly impacted your life (divorce of a parent, loss of a close relative, abandonment by a parent, etc. bullying)? If yes, please explain.

_____
_____
_____
_____

Have you ever been physically, sexually, or emotionally abused? If yes, at what age? Please indicate the abuser (parent, friend, teacher, etc.) and the type of abuse

_____
_____
_____

_____
_____

List two items that are causing you the MOST difficulty from the list above. _____ _____

Has there been a history of family mental health diagnosis and treatment?. _____

Depression _____

Bipolar Disorder _____

Anxiety Disorder _____

Drug/Alcohol Addiction _____

Obsessive/Compulsive Disorder _____

Schizophrenia _____

Suicide _____

Other _____

Average hours of sleep per night _____

Appetite: __ normal __disrupted __ decreased __ increased __ wt gain __ wt loss

Tell me about your family of origin? _____
_____
_____
_____
_____
_____

Do you feel like you have friends and social support? ___ yes ___ no Explain _____
_____
_____
_____

Do you participate in leisure activities/recreation or physical exercise? ___ yes ___ no Explain _____
_____
_____
_____

Please provide any additional information which you feel may be useful to your therapy. (Additional space use backside of this page)
_____
_____
_____
_____
_____
_____

Signature _____ Date _____