OASIS WELLNESS AND COUNSELING

HEAL • RESTORE • TRANSFORM

Client Intake Form

Name: ____

Date of Birth: ____

Address: ____

Cell Phone Number: ____

Email address: ____

Will you accept text message appointments reminders? _________________________________

How do you hear about this practice? ____

Have you previously been in counseling? ____

Emergency Contact Name, Number and Relationship: ___________________________________

____

Briefly describe the issues/problems that led you to counseling: ___________________________

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What goals would you like to achieve in counseling? ____________________________________

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Date of last physical: ____

Do you have any current or recent medical concerns? ___________________________________

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Please describe any history of surgeries, significant medical conditions, ER visits, or major illnesses: ____

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Present medication and purpose: ____

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Relationship status: ____

Do you have children? ____

If so, names and ages? ____

Who do you live with? ____

____

Are you employed? ____

If so, where? ____

Have you ever been arrested? ____

If so, when and what charges? ____

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Describe any current legal concerns: ____

____

Anything else I should know? ____

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Oasis Wellness and Counseling

Policies and Consent for Treatment

Financial Policy: Counseling sessions are $100 for counseling sessions and $150 for hypnotherapy sessions, unless otherwise stated. Full payment is due at the time of service (unless prior arrangements have been made). Please feel free to ask if you have any questions about my financial policy.

Cancellation Policy: Please help us to serve you and others better by keeping your scheduled appointments. If you need to cancel or reschedule, please give me as much time as possible so that I can give that time to someone else in need. Unless cancelled within 24 hours in advance, our policy is to charge the full rate for any missed appointments. This will be billed to you and required to pay prior to any rescheduled appointment.

Confidentiality: Federal and state laws protect your confidentiality (see 42 I.S.C 290dd-3 and 290ee-3 for federal laws 42 CFR Part , 491.0147 FL). Your counselor will not share your information with anyone outside of Oasis Wellness and Counseling unless you give your permission, except required by law. HIPAA (Health Insurance Portability and Accountability Act) laws allow you to access your file and protect the electronic transfer of information.

Exceptions to Confidentiality: Federal regulations do not protect from disclosure of information related to a client's involvement in a crime against property or personnel. We are required under state law to report suspected abuse of a child, elderly person, or individual with a disability. We may share limited information in the event of an emergency or in the event of a court order signed by the judge. We have the option of breeching confidentiality if you report a specific plan or intent to cause serious bodily harm to yourself or someone else.

Consent to Treat: I am seeking voluntary outpatient counseling with Oasis Wellness and Counseling. I understand that I have rights and responsibilities regarding my participation in treatment, including the right to discontinue counseling. I am strongly encouraged to discuss my treatment plan and status in treatment with my counselor. With my signature below, I acknowledge that I have read, understand, and agree to all of the above.

With my signature, I acknowledge that I understand the above information and consent to treatment with Oasis Wellness and Counseling and with my counselor, Amy Triplett, LMHC.

_______________________________________ _______________________________________

Print Client's Name **Client's Signature**

_____________________________________ **Date**