OLIVE

COUNSELING

CENTER

WELCOME TO THE OLIVE COUNSELING CENTER!

Thank you for choosing our counseling center to help you with your counseling needs. We want to take this opportunity to explain our policies and procedures.

APPOINTMENTS:

We consider our appointments very important. Counseling is a commitment to work together. We hope you will also share in this commitment. Please do not miss sessions if possible. Therapy sessions are 50 minutes.

LIMITS OF CONFIDENTIALITY:

Information discussion in the counseling setting is held confidential and will not be shared without the written permission of the client except under the following conditions.

- The client threatens to harm self or another person.
- The client reports the abuse of a child, a person who is elderly, or a person who is disabled.
- The client reports sexual exploitation by a counselor, therapist or other mental health professional.
- Your counseling records by a state or federal court of law if legal action is taken against you.

RECORD MAINTENANCE AND EMERGENCY SITUATIONS:

Psychotherapy records must be maintained in our possession according to state laws. Copies of your records or a summary of such records will be provided upon written request. Reasonable cost of reproduction and time to prepare such records will be charged. If you should experience an emotional or behavioral crisis and we cannot be reached immediately by telephone, you and your family members are instructed to contact the Suicide & Crisis Life Line at 988, dial 911, or present yourself at the nearest hospital emergency room. Our contact number is 850-473-4461.

FINANCIAL RESPONSIBILITY:

You are responsible for full payment of all services regardless of insurance coverage. At the completion of each session you will receive a receipt of service that is appropriate to file with your insurance for reimbursement. Please make checks payable to Olive Baptist Church. Fees are as follows:

Individual Initial Intake Session:	$110.00 (50 minutes)
Individual Session:	$100.00 (50 minutes)
Family/Couple Initial Session:	$135.00 (50 minutes)
Family/Couple Session:	$135.00 (50 minutes)

(We offer a sliding fee scale based on household income. Please let us know if you need this service. We do not want money to be the reason you do not receive help.)

We accept the following major credit cards: Visa, MasterCard, Discover and American Express.

No fees will be charged for appointments canceled 24 hours or more prior to appointment date and time. *If you cancel your appointment less than 24 hours before it is scheduled to take place, you will be subject to a charge of half your session fee.* You will not be seen again until the cancellation charge is paid. To avoid a cancellation fee, please provide cancellation notice at least 24 hours prior to your appointment. Voice mail is available 24 hours a day and messages are checked each business day. You may call 850-473-4461.

SOCIAL MEDIA AND TELECOMMUNICATION

Due to the importance of your confidentiality and the importance of minimizing dual relationships, we do not accept friend or contact requests from current or former clients on any social networking site (Facebook, Instagram, LinkedIn, etc.) We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about this matter.

I have read the Financial and Confidential Policies outlined in this document and agree to comply with these policies. I agree to the limits of confidentiality.

_____

Client's Signature Date

_____

Parent or Guardian's Signature Date

_____

Counselor's Signature Date

_____I have your permission to leave a message at the contact number if I need to reach you or as a courtesy call for an appointment reminder. I cannot ensure confidentiality through a text message.

Olive Counseling Center
1830 E Olive Road
Pensacola, Florida 32514
850-473-4461

FACE SHEET

1. Patient Name: _____
(Last) (First) (MI) (Nickname)

2. Address: _____
Street City State Zip Code

3. Email: _____

4. Home Phone: ( )_____ Cell: ( )_____

5. Work Phone: ( )_____ 6. DOB: _____ Age: _____

7. Sex: M F 8. Marital Status: Single Married Divorced Widowed

9. Employer: _____ 10. Occupation: _____

11. Student/School: _____

12. If dependent child, are custodial parents: ____ Married ____ Separated _____ Divorced ____ Other

13. Religion: _____ 14. REFERRED BY: _____

15. IN CASE OF EMERGENCY NOTIFY:

Name:_____ Relationship: _____ Phone( )_____

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FINANCIALLY RESPONSIBLE PARTY

Guarantor's Name: _____Birth Date: _____

Guarantor's Address:_____

Guarantor's Relationship to Patient: _____

Guarantor's Employer: _____ Phone:( ) _____

___--__

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I understand I am financially responsible for all service rendered to me or the client and agree to pay charges at the time services are provided.

Client Signature_____ Date:_____

Consent to Treatment

I do hereby seek and consent to take part in treatment with _____.
I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or any procedures provided by this therapist. I acknowledge that I have been informed counseling can be a painful process. I have had all my questions answered fully.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court system.)

I know I must call to cancel an appointment at least 24 hours before the time of the appointment to avoid late cancellation charges. I am aware that an agent of my insurance company or third-party payer may be given information about the type(s), cost(s) and providers of any service or treatments I receive. I understand payment for service is due at the end of each session, and I am responsible for full payment regardless of insurance coverage.

My signature below shows I understand and agree with all these statements.

_____

Signature of client (parent, guardian, or other representative) Date

_____

Relationship to Client

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian or other representative.) My observations of this person's behavior and responses give me no reason to believe this person is not fully competent to give informed consent and willing consent.

_____

Therapist Date

Adult Psychosocial Form

Client's Name: _____ Date: _____

Address: _____
Street City State Zip Code

Home Phone: ( ) _____ Cell: ( ) _____

Date of Birth: _____ Age: _____

Email: _____

Emergency Contact: _____ Relationship: _____

Phone: ( ) _____

Reason for seeking services today:

_____

_____

Please check behaviors and symptoms that occur more often than you would like them to:

____Aggression
____Alcohol dependence
____Anger
____Anxiety
____Chronic Pain
____Compulsive behavior
____Concentration Problems
____Cyber addiction
____Depression
____Disorientation
____Distractibility
____Dizziness
____Drug dependence
____Eating Disorder
____Fatigue
____Flashbacks
____Grief
____Hallucinations
____Heart palpitations
____High blood pressure
____Hopelessness
____Hyperactivity
____Impulsivity
____Irritability
____Loneliness
____Memory impairment
____Mood swings
____Obsessive Thoughts
____Panic Attacks
____Phobias/Fears
____Poor judgment
____Self-Esteem Problems
____Sexual Difficulties
____Sleep problems
____Social Withdrawal
____Suicidal thoughts
____Thoughts disorganized
____Trembling
____Unresolved Trauma
____Worrying
____Other (specify):
_____

Employment

Please check employment status:

___employed full-time ___employed part-time ___unemployed ___disabled ___retired

If currently employed, please list job information below:

Employer	Job Title	How long there?

Family/Living Situation

_____Single _____Partnered _____Married _____Separated _____Divorced _____Widowed

Name of Spouse or Partner: _____ Age: _____

How long together? _____

Children:

_____ Age:_____ Living with you? ___Yes ___No
_____ Age:_____ Living with you? ___Yes ___No
_____ Age:_____ Living with you? ___Yes ___No
_____ Age:_____ Living with you? ___Yes ___No
_____ Age:_____ Living with you? ___Yes ___No

Counseling/Prior Treatment History

Have you had any prior professional counseling or psychiatric treatment? Yes No

If yes, please list most recent treatment episodes, who treated you, and outcome below:

Approximate Treatment Dates:	Treatment Provider/Facility:	Outcome:

Medication and Chemical Use History

Have you ever been treated for alcohol or drug dependence/abuse? ___Yes ___No
Have you ever felt like you should cut down on alcohol or other drug use? ___Yes ___No
Has a friend or relative ever discussed concerns about your drug use? ___Yes ___No
Have you ever felt guilty about your drinking or drug use? ___Yes ___No
Have you had withdrawal symptoms when trying to stop using drugs or alcohol? __Yes___No
Is there a history of problems with alcohol or drug use in your family? ___Yes ___No

Medical/ Physical Health

List any current health Concerns:

Primary Care Physician:

Name: _____ Phone: ( )_____

Current Prescribed Medications:	Dosage:	Frequency:	Purpose:	Side Effects:

Family History/Development

List any pertinent family history of medical, mental health, or substance abuse problems:

Have you ever been a victim of sexual, physical, emotional, or verbal abuse? __Yes __No

Are there other unusual/traumatic circumstances that affected your development? __Yes __ No

If Yes, please describe: _____

Spiritual History

Religious upbringing: _____ Present Affiliation: _____

Is this an important part of your life? _____Why/why not?_____

_____

Where are you at spiritually right now? _____

_____

_____

Family of Origin Information

Parents:

Father alive? _____ Where residing? _____ Status of Relationship: _____

Mother alive? _____Where residing?_____ Status of Relationship:_____

Siblings:

Circle your place in the family. If a sibling is deceased, put an X through the placement number.

#1 M F Age:_____

#2 M F Age:_____

#3 M F Age:_____

#4 M F Age:_____

#5 M F Age:_____

#6 M F Age:_____

Family alcoholism or domestic violence? _____
Sexual Addictions or Abuse?_____

Parents divorced? _____ If yes, what year?_____ Your age at the time:_____
If deceased, what year? _____Your age at the time_____ Cause of death_____
Any step-parents? _____ If yes, describe when and your relationship with them:

_____
_____

If raised by someone other than your birth parents, describe the situation in some detail:

_____
_____

Tell anything else in the space below that you think would be helpful for me, as your therapist, to know:

_____
_____
_____

Please state what you would like to work on in therapy:

_____
_____
_____

_____ _____
Therapist's Signature Date

Adverse Childhood Experience (ACE) Questionnaire
Finding your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** ...
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 ____

2. Did a parent or other adult in the household **often** ...
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 ____

3. Did an adult or person at least 5 years older than you **ever**...
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 ____

4. Did you **often** feel that ...
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 ____

5. Did you **often** feel that ...
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 ____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 ____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 ____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 ____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 ____

10. Did a household member go to prison?
    Yes No If yes enter 1 ____

Now add up your "Yes" answers: This is your ACE Score TOTAL ____