

Form 1 Client Registration

This form helps us to get to know you and ensures that we can contact you as needed. Also, we aggregate and analyze the information collected on this form for all of our clients to better plan, fund, and evaluate our efforts. Your personal information is confidential and voluntary.

Form 2 Appointment Reminder Form

Council for Relationships can remind you of your next appointment with your clinician by texting, emailing, or calling you. The automated appointment reminder system is in accordance with all confidentiality laws, and in order to protect your privacy, the reminders will come from an email address or phone number that is not linked to the Council. If you would like to receive automated appointment reminders from the Council, please complete and sign this form.

Form 3 Join Our Email List

If you are interested in receiving information from Council for Relationships on how to foster healthy relationships, let us know! You can update your preferences or unsubscribe at any time.

Form 4 Consent to Treatment

Please review Council for Relationships' policy regarding treatment, which outlines confidentiality, payment and cancellation policies. Please sign the Consent to Treatment Form. If you have any questions, please discuss them with your therapist.

If you were given a professional referral to Council for Relationships, we would like to send our appreciation. Please provide the referring professional's contact information.

Form 5 Notice of HIPAA Policies and Practices Acknowledgement Form

Council for Relationships adheres to HIPAA regulations regarding the privacy of your health information. Please sign the Client Acknowledgement Form to indicate your awareness of this policy. If you would like more information, please discuss with your therapist.

Form 6 Areas of Concern

In order to assist your therapist with understanding your concerns, please take a few minutes to complete this important form.

Council for Relationships - Adult Client [18+ years] Registration Form

First Name: _____ MI: _____ Last Name: _____

Pronouns: _____ DOB [MM/DD/YYYY]: _____ Age: _____

Address: _____ Home Phone: _____

_____ Work Phone: _____

City: _____ Cell Phone: _____

State: _____ Zip Code: _____ Email: _____

Have you been to counseling before? Yes No If Yes, at Council for Relationships? Yes No

Partner's Last Name: _____ Partner's First Name: _____

The information you supply is confidential and voluntary. The following questions provide information which is important to our research and planning efforts. We appreciate your response. If your selection does not appear as an option, please specify your answer in the space provided.

Current Relationship - Please indicate selection from listed options: _____ Time together: _____ years

1. Single 2. Dating 3. Engaged 4. Married 5. Living Together/Partnered 6. Separated 7. Divorced/Annulled 8. Widowed

Children Information

Male

Female

Ages of Children: _____ How many children reside with you? _____

Others in home: Parent/In-Law Grandparent Grandchild Other Family Non-Family

Work Status - Please indicate selection from listed options:

You: _____ Partner (if not present): _____

1. Disabled 2. Employed (Full) 3. Employed (Part) 4. Retired 5. Self-employed 6. Student 7. Unemployed

Occupation You: _____ Partner: _____

Yearly Income You: \$ _____ Household: \$ _____

Veteran/ Military Service

You: Yes No

Partner/ Family: Yes No

Highest Education - Please indicate selection from listed options:

You: _____ Partner (if not present): _____

1. Elementary 2. Middle School 3. High School/GED 4. Some College 5. College Graduate 6. Technical School 7. Post Graduate

Religion - Please indicate selection from listed options:

You: _____ Partner (if not present): _____

1. Agnostic/Atheist 2. Buddhist 3. Catholic 4. Hindu 5. Jewish 6. Muslim

7. Protestant 8. Non-Religious/Secular 9. Other, please specify: _____

Race - Please indicate selection from listed options:

You: _____ Partner (if not present): _____

1. African American/Black 2. American Indian/Alaska Native 3. Asian/Asian American 4. Caucasian/White

5. Hispanic/Latino 6. Multiracial 7. Native Hawaiian/Pacific Rim 8. Other, please specify: _____

Gender - Please indicate selection from listed options:

You: _____ Partner (if not present): _____

1. Female 2. Male 3. Non-Binary 4. Other, please specify: _____

Sexual Orientation - Please indicate selection from listed options:

You: _____ Partner (if not present): _____

1. Bisexual 2. Gay 3. Heterosexual 4. Lesbian 5. Questioning 6. Other, please specify: _____

How did you hear about us? Please check all that apply.

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Community Event | <input type="checkbox"/> Lawyer/ Court | <input type="checkbox"/> Psychology Today | <input type="checkbox"/> Therapist outside of CFR |
| <input type="checkbox"/> Digital Ad | <input type="checkbox"/> News (TV/radio, etc.) | <input type="checkbox"/> Religious Leader | <input type="checkbox"/> Web Search |
| <input type="checkbox"/> Email/ Newsletter | <input type="checkbox"/> Other Organization | <input type="checkbox"/> Self as Previous Client | <input type="checkbox"/> Word of Mouth |
| <input type="checkbox"/> Friends/ Family | <input type="checkbox"/> Presentation | <input type="checkbox"/> Social Media | <input type="checkbox"/> Other/Details: _____ |
| <input type="checkbox"/> Healthcare Provider | <input type="checkbox"/> Print Ad | <input type="checkbox"/> Therapist at CFR | |

THERAPIST USE ONLY Intake Date: _____ Office: _____ Client #: _____ Direct: Y N

Therapist: _____ Intake: \$ _____ Fee: \$ _____

Therapy Type: Individual Couple Family Mediation Psychiatric Co-Parent



APPOINTMENT REMINDER FORM

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Yes, I want to receive appointment reminders from the Council.

Please select one of the following contact methods and provide your corresponding phone number or email address.

Cell phone call: _____

Cell phone text: _____

Home phone call: _____

Home phone text: _____

Work phone call: _____

Work phone text: _____

Email notification: _____

Signature

Date

COUNCIL FOR *Relationships*

Join our Email List to Receive:

- Expert Voices Blog Posts Written by Staff Therapists (2x /month)
- Council for Relationships Updates (2-4x /month)
- Donor-Supported Community Programs (4x /year)
- Fundraising and Special Events (6x /year)

We'll never share your email address. Use the link at the bottom of any email to Update Your Preferences and choose which emails you want to receive from the list above, or unsubscribe.

Please print legibly

Email: _____

Full Name: _____

Signature: _____

➔ Interested in training and education for behavioral health professionals?

Yes, I want to also receive information about **continuing education** for social workers, psychologists, marriage and family therapists, counselors and sex therapists.

Yes, I want to also receive information about the **Post-Graduate Certificate Programs** in Couple and Family, Sex Therapy, or Clergy Training (Master's degree required*).

CONSENT TO TREATMENT

Treatment offered by Council for Relationships (Council) is of a voluntary nature, except when mandated by the court, and may be ended by you at any time. When treatment is mandated by the court, it is your responsibility to share the Court Order with your therapist at the outset of treatment, so that the purpose and terms of the therapy can be clarified, including how communications and information about the therapy are to be shared.

Confidentiality is extremely important to us. Information revealed to us during treatment will be kept strictly confidential. There are exceptions to this, however, that include the following:

- If you disclose your intention to inflict physical harm to yourself or another person;
- If you disclose that physical or sexual abuse or serious neglect of a minor child under the care of a Council clinician has occurred;
- If we receive a signed, valid court order requesting records; and
- In addition, Council clinicians (therapists, psychiatrists, counselors, or clinical supervisors) directly involved in your care may communicate with each other about your treatment. If you were seen previously in therapy at Council, your new therapist may review your prior file in order to insure continuity of your treatment.

Psychotherapy is difficult to describe in general terms. Approaches and techniques vary depending on the problems you have identified, who you are as a person and what special qualities you bring to the therapy, and the training and professional experience of your therapist. In addition, there are different modalities of therapy (individual, couple, family, and group) that may be suitable for you. In some instances, an evaluation for medication may be recommended, and a referral to a psychiatrist or other medical professional with prescribing privileges may be made.

Therapy has both benefits and risks associated with it. On the beneficial side, therapy has been shown to produce lasting change and reduce overall feelings of distress. It can be helpful in resolving specific problems and can lead to improved relationships with significant others in your life. There are, however, no guarantees of success. Risks include intermittent feelings of discomfort (such as sadness, guilt, anxiety, or anger) during and after some sessions as problems are brought to the surface. You may be asked to recall difficult and unpleasant aspects of your personal and family history in order to loosen the grip of these past events on your life now. Occasionally, there is a poor fit between client and therapist.

The work begins with an initial evaluation period, lasting from one to five sessions, depending on the presenting issues and the complexity of your situation. Your collaboration in this process is important to its success, including your active participation in clarifying problems and setting treatment goals with your therapist. At the end of the evaluation, your therapist will share with you initial impressions and provide a preliminary treatment plan. In deciding whether you wish to continue in treatment, you should carefully consider this information and your comfort in working with your therapist. If you have any questions or concerns about your therapist's approach or treatment plan, you should freely communicate them to your therapist.

Payment is due at the time of service, unless other arrangements have been made with your clinician. If your account is more than 90 days in arrears, and you have not agreed to a suitable payment plan, Council may use a collection agency to recover payment.

Occasionally, circumstances arise that necessitates cancellation of an appointment. In this instance, notification must be given at least 24 hours in advance of the appointment time. Council will charge the full fee for a missed appointment or one cancelled with less than 24 hours notice.

I understand that if my therapist is unlicensed and/or in training at Council that they will be supervised regularly by a senior clinician.

In a clinical emergency, if you are unable to reach your therapist, please call 911 and/or present yourself to the nearest emergency room for evaluation.

In case of an emergency, you have my permission to contact the following person:

Emergency Contact Information:

Name of Emergency Contact Relationship to client

Contact number(s)

I have read and understand the information above:

DATE

PA: Name and signature of client or parent/legal guardian (if under 14 years old)

NJ: Name and signature of client or parent/legal guardian (if under 16 years old)

***The consent agreement will remain in effect until therapy has been terminated or there is a lapse in treatment of longer than six months.*

Please allow Council for Relationships to send an appreciation letter to thank the professional who referred you to our services (no clinical information will be included):

Title: _____ First Name: _____ Last Name: _____

Address: _____

Website: _____ Email: _____

Please provide your approving signature: _____



Notice of HIPAA Policies and Practices Acknowledgement Form

Pursuant to HIPAA, Council for Relationships is obligated to request that clients sign an acknowledgement that they have received and reviewed our **Notice of Policies and Practices to Protect the Privacy of your Health Information**. A copy is provided in a binder in each office's waiting room. If you would like a printed copy of this notice, please ask your therapist. It can also be found on the CFR website at www.councilforrelationships.org/clinicalservices. The link is located at the bottom of the page and titled Privacy Policy.

NAME OF CLIENT(S) _____

NAME OF PARENT(S)/LEGAL GUARDIANS OF MINOR CHILDREN OR
OTHER LEGAL REPRESENTATIVE

SIGNATURE OF CLIENT(S) _____

SIGNATURE OF PARENT(S)/LEGAL GUARDIANS OF MINOR CHILDREN
OR OTHER LEGAL REPRESENTATIVE

DATE _____

AREAS OF CONCERN QUESTIONNAIRE

INSTRUCTIONS: The following information will help us to understand your concerns. Please take a few minutes to complete this important form.

Date: _____ Name: _____

Part 1: Please underline any of the following concerns that apply to you.

Part 2: In front of each concern you underline, please rate its severity as:

- 1 = Mildly distressing
- 2 = Moderate
- 3 = Serious
- 4 = Severe
- 5 = Very severely distressing

_____ Family problems	_____ Feeling worthless	_____ Upset stomach
_____ Relationships problems	_____ Drawing away from people	_____ Headaches
_____ Problems at school/work	_____ Lack of interest/enjoyment	_____ Sweating
_____ Health problems	_____ Too many drugs	_____ Lightheaded/dizzy
_____ Financial problems	_____ Too much alcohol	_____ Too much worry
_____ Legal problems	_____ Feel negative about the future	_____ Too many fears
_____ Sad/depressed	_____ Hard to make friends	_____ Feeling guilty
_____ Loss of appetite	_____ Feeling lonely	_____ Feeling angry/frustrated
_____ Loss of weight	_____ Sexual problems	_____ Nightmares
_____ Weight gain	_____ Less energy than usual	_____ Feel ignored/abandoned
_____ Difficulty sleeping	_____ More energy than usual	_____ Too much pain
_____ Quick change of moods	_____ Religious/spiritual issues	_____ Confused
_____ Dwelling on problems	_____ Restless/can't sit still	_____ Laugh without reason
_____ Problems with my breathing	_____ Nervous/tense	_____ Memory problem
_____ Hot or cold spells	_____ Panicky	_____ See/hear strange things
_____ Problems controlling anger or urges	_____ Shaky/trembling	_____ Feel used by people
_____ Feeling suicidal	_____ Feeling others are out to get me	_____ Hard to trust anyone
_____ Stressors related to military deployment	_____ Problems controlling my thoughts	_____ Other

May 2018