



Progressive Counseling & Hypnosis REGISTRATION FORM

(Please Print)

Today's Date:		PCP:						
PATIENT INFORMATION								
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital Status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>		
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not, what is your legal name? (Former name):		Birth Date:		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:			Cell Phone:		Home Phone no.:			
P.O. Box:		City:		State:		ZIP Code:		
Occupation:		Employer:			Employer Phone no.:			
Referred by (Please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance plan		<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work		<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Other		
E-Mail Address:								

INSURANCE INFORMATION							
(Please give your insurance card to Jennifer so a copy can be made)							
Person responsible for bill:		Birth date:		Address (if different):		Home phone no.:	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:		Employer:		Employer address:		Employer phone no.:	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance		<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]
<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> [Insurance]	<input type="checkbox"/> Welfare (Please provide coupon)		<input type="checkbox"/> Other		
Subscriber's name:		Subscriber's S.S. no.:		Birth date:	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):			Subscriber's name:		Group no.:		Policy no.:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

IN CASE OF EMERGENCY							
Name of local friend or relative (not living at same address):			Relationship to patient:		Home Phone no.:		Work Phone no.:
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Jennifer Molinari, LCPC, NCC to release any information required to process my claims.							
Patient/Guardian Signature					Date		



Progressive Counseling & Hypnosis
Jennifer Molinari, LCPC, NCC
7350 Grace Drive
Columbia, MD 21044
(410) 707-5786
jenmolslight@gmail.com
www.jennifermolinari.com

Practice Policy/Bill of Rights

Client Bill of Rights:

Each client has the right to:

1. Be treated with dignity and respect.
2. Receive treatment, care and services that are adequate, appropriate, and in compliance with local, state, and federal laws and regulations.
3. Not be physically or mentally abused.
4. Be free of discrimination.
5. Be free from restraints.
6. Have all confidentiality laws strictly adhered to (HIPAA).
7. Have all fees and services explained prior to receiving services.
8. Refuse participation in any experimental research unless the research complies with 45 CFR Part 46 (the code for the Federal Regulations Protection of Human Subjects.)

Confidentiality of Patient Records:

Federal Law and Regulations protect the confidentiality of patient records maintained by Progressive Counseling & Hypnosis/Jennifer Molinari, LCPC,NCC. Progressive Counseling& Hypnosis/Jennifer Molinari, LCPC, NCC may not reveal identifying information to any outside third party unless:

1. The patient consents in writing
2. The disclosure is allowed by court order
3. The disclosure is made to medical personnel in an emergency or to qualified personnel for research, audit, or program evaluation.

Violation of Federal Law and Regulations by a therapist is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal guidelines. Federal law and Regulations do not protect information about crimes committed by a patient in the presence of a therapist of against a coworker in the same office, or about any threat to commit such a crime. Federal Law and Regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state and local authorities.

Electronic Communications:

Progressive Counseling & Hypnosis/Jennifer Molinari, LCPC, NCC cannot ensure the confidentiality and privacy of communications through electronic media, including text messages. Electronic communications are one of the least secure ways to communicate. If you choose to communicate via email or text messaging for issues regarding scheduling or cancellations, Jennifer will do so. Jennifer will do the best on her end to maintain privacy and confidentiality through keeping her cell phone password protected and verifying user identities when texts and emails are exchanged (you will be asked to devise a code word for verification purposes when exchanging texts and e-mails to verify the identity of the sender/responder.)

Please be advised that any email sent via computer in a work-place environment is legally accessible by your employer. In addition, please remember that even when you think you have deleted a message that copies will still remain in “cyberspace” and could potentially be retrieved by law enforcement, ISP professionals and possibly hackers.

Jennifer will try to return messages in a timely manner; however, she cannot guarantee immediate responses. It can take 24 to 48 hours (or longer due to certain circumstances-illness, vacation etc.) for Jennifer to respond to messages (voice, text, and e-mail.) If you have an emergency, Jennifer requests that you call 911 or go to your nearest ER.

Jennifer requests that you do not use these methods of communication to discuss therapeutic content and/or requests for assistance with emergencies.

Jennifer is ethically and legally obligated to maintain records of all correspondences both in person and via electronic communication such as emailing or text messaging. These records include a brief synopsis of the conversation along with any observations or plans for the next meeting. The limits of confidentiality apply to all forms of communication including electronic and written communications. Please see Jennifer’s separate intake form on the limits of confidentiality.

Internet Searches:

While Jennifer’s present or potential clients might conduct online searches about her practice and/or her, Jennifer does not search her clients with Google, Facebook, or other search engines unless there is a clinical need to do so, as in the case of a crisis or to assure your physical well-being. If clients ask Jennifer to conduct such searches or review their websites or profiles and she deems that it might be helpful, Jennifer will consider it on a case by case basis and only after discussing possible impacts to the professional relationship and your privacy.

Acknowledgement and Consent Regarding Notice of Privacy Practices:

Progressive Counseling & Hypnosis/Jennifer Molinari, LCPC, NCC's Notice of Privacy Practice is provided to each client and is available upon request. The Notice of Privacy Practices of Progressive Counseling & Hypnosis/Jennifer Molinari, LCPC, NCC provides information about how Progressive Counseling & Hypnosis/Jennifer Molinari, LCPC, NCC may use and disclose your protected health information (PHI.) The Notice of Privacy Practices states that Progressive Counseling & Hypnosis/Jennifer Molinari, LCPC, NCC has the right to change her terms. If this should happen, client's will be provided with a written copy of the new Privacy Policy Notice.

You have the right to revoke this consent, in writing, except where Progressive Counseling & Hypnosis/Jennifer Molinari, LCPC, NCC has already made disclosures in reliance to your prior consent. You have the right to request restrictions on how your PHI may be used or disclosed for treatment, payment, and health care operations. Progressive Counseling & Hypnosis/Jennifer Molinari, LCPC, NCC is not required to agree to your restrictions, but if she does, it is bound by it's agreement with you.

By signing the form provided to you, you consent to the use and disclosure of your PHI for treatment, payment, and healthcare operations as described in the Notice of Privacy Practices. You specifically consent to Progressive Counseling & Hypnosis/Jennifer Molinari, LCPC, NCC communicating with you using the contact information you provide, as further described in the Notice of Privacy Practices.

Fee Schedule:

Intake: \$150

*Missed Appointment: \$60

Written Report: \$40 per report

Court Appearance: \$200 per hour
(minimum of \$1,600 per day)

Letters/Forms: \$25

Outside Correspondence (over 5 min.) \$45

*Hypnosis Initial Session: \$175

*Hypnosis Reinforcement: \$125

Individual Counseling (45-50 min.): \$125

Disability/Worker's Comp: \$300

Crisis Session: \$150

Bounced Checks: \$25

* Yoga Nidra (Individual): \$50

* Yoga Nidra Group (5 or more \$25pp)

* Online Video Session (HIPAA Compliant): \$65 with insurance and \$125 (for out-of-network)

*Payment is out-of-pocket (no insurance accepted)

Jennifer does offer a sliding pay scale if needed

Appointments/Scheduling:

1. Appointments can be made by phone or e-mail. Current clients can text.
2. Intakes are 50-60 minutes and regular sessions are 45-50 minutes long (unless other arrangements are made.)
3. If you arrive late to your session the time will not be made up.
4. If you arrive 15 minutes or later (and you do not contact Jennifer) then your appointment may be cancelled. You will then be charged a missed appointment fee.
5. If Jennifer is late to a session the time WILL be made up. Time will either be tacked on to the end of your session OR it will be tacked on to the end of future sessions.
6. If you need to cancel your appointment then you must provide 24 hour advance notice to avoid a \$60 fee.
7. Jennifer will do her best to provide reminder calls. However, these calls are a courtesy and if one is not received it is not an indication that your appointment has been cancelled. Jennifer will contact you directly via phone, e-mail, or text if she needs to cancel your appointment. Not showing for your appointment because you did not receive a reminder call will result in a no show fee of \$65.

Please note that the office may be locked when you arrive for your appointment. This DOES NOT mean your appointment has been cancelled. Please wait for Ms. Molinari to arrive. If Ms. Molinari is late, the time will be made up at the end of the session (or at the end of a future session.)

Fees/Payment:

1. Payment for sessions will be collected at the time of service.
2. Payment can be made by cash, check, or credit card.
(Checks to be made payable to Jennifer Molinari)
3. There is a \$25 fee for bounced checks.
4. Missed sessions and appointments cancelled less than 24 hours prior to your appointment will be billed at \$60 for each missed and/or last minute cancelled session regardless of the reason.
5. Clients are strongly advised to provide credit card/debit card information to be kept on file to save time with session payments and to allow Jennifer the ability to collect funds in the event of a missed appointment. Signing the authorization will allow Jennifer to bill your card without further consent if you miss an appointment or do not cancel your appointment 24 hours in advance. If there is a dire emergency and your credit card gets billed there are no refunds. You will simply have a credit that will be applied towards your next session.
6. There are no payment refunds.

Failure to Pay:

You agree that failure to pay within 10 days of service, may, at the option of Jennifer, be construed as a discharge of service by the client. You agree that if any unpaid balance is not received within 60 days that your account will be forwarded to a collection agency. You further agree that in the event that legal action is taken to collect the money, you will pay the amount owed plus 40% of the collection fees. You

agree that information pertinent to the collection of any amount due will be released to a third- party collection agency or attorney. You further agree and consent to suit being held in Howard County, MD and waive any right to claim improper jurisdiction and/or venue.

Insurance:

At this time, Jennifer is paneled with Aetna, Magellan, Carefirst BCBS Insurance Companies. Jennifer does utilize services from an external billing company (Stone Creek Medical Billing) to submit claims and handle insurance billing.

If you are paying for sessions out-of-pocket due to being out-of-network, then you will be provided with a completed claim form at the end of the month to provide to your insurance company for reimbursement. Jennifer does not guarantee reimbursement from your insurance company. You will need to contact your insurance company prior to starting services to verify if you have out-of-network mental health benefits. You will be responsible for the full payment regardless of what your insurance company covers.

It is your responsibility to call your insurance company prior to services to verify your mental health benefits (if you have mental health coverage, what your deductible is, co-insurance, and what your copay is.) If you don't have mental health coverage you will pay the full cost for services. If you have a deductible you will pay the "allowable amount" determined your insurance company (usually between \$55-\$65 dollars) for each session until your deductible is met (it is your responsibility to keep track of your deductible.) If you are covered and have no deductible (or your deductible has been met), then you will be responsible for your copay for each session. It is your responsibility to find out your copay amount prior to your sessions.

Any costs not covered by your insurance (regardless of the reason) are to be paid out-of-pocket in-full.

Court Appearances:

Jennifer charges \$200 per hour, with a minimum of \$1,600 per day for any court appearance (whether requested or summoned.) In the case of minors, parents/legal guardians are responsible for the fees. You will be charged per hour for travel time, consultation time, preparation time, and any time spent waiting. A deposit of \$1,600 must be paid prior to the court appearance. If a court date is cancelled or rescheduled, then Jennifer must be given 10 days' notice. If 10 -day notice is not provide, then Jennifer may still charge \$1,600 for each day if she is unable to reschedule appointment and for preparation time, administrative time, and for the reports that were already completed.

Understanding Separate Practices:

Progressive Counseling & Hypnosis/Jennifer Molinari, LCPC, NCC practices at two separate office locations. Jennifer Molinari, LCPC,NCC has a private practice located at Grace Drive in Columbia, MD and she is affiliated with a larger group practice in Columbia (Congruent Counseling.) Each of these practices are completely separate entities and are in no way affiliated with each other.

In addition, Jennifer Molinari is in no way affiliated with any of the other practitioners at the Grace Drive office location.

Telephone/Internet Sessions:

If you need to talk to Jennifer before your next scheduled session then you can arrange a telephone or internet video session. Telephone and internet sessions can NOT be submitted to the insurance companies for reimbursement and are an out-of-pocket charge. Please note that privacy can't be guaranteed for telephone/internet sessions. In addition, the sessions will be documented (as all sessions are documented) and that the limits of confidentiality apply to telephone and internet sessions.

If you are a current client and are using your insurance you will be charged the full amount that your insurance would normally reimburse to Jennifer (usually around \$60.) Sessions must be paid by credit card at the time of service. Your credit card will be billed \$60 for missed sessions or sessions that are cancelled less than 24 hours prior to your appointment. There are no refunds.

Therapist and Client Contact Outside of Sessions:

In order for therapists to provide the best care, it is important for them to be healthy too. They need a balance between work and their private lives. If there is ever a life -threatening emergency, please call 911. If you have an issue that is NOT life threatening and need to talk to Jennifer before your next appointment, then please feel free to leave a confidential message for Jennifer at 410-707-5786. Jennifer will do her best to return your call within 24-48 hours. Jennifer will not return phone calls when no message is left. Jennifer asks that if you know that a conversation will take longer than 10 minutes to please schedule and appointment.

Client Signature

Date

Therapist Signature

Date



Progressive Counseling & Hypnosis Communications Policy

These are the most effective ways to get in touch with Jennifer:

- By phone (for non-emergencies only) please call: 410.707.5786.
- You may leave messages on Jennifer's voicemail (which is confidential.) Jennifer will do her best to return calls within 24-48 hours Monday-Friday between 9am and 5pm.
- If you wish to communicate with Jennifer by email or text message, please read and complete the *Consent For Non-Secure Communications* form included with these office policies.
- If you have an emergency, please call 911 or go to your nearest emergency room.

Jennifer subscribes to the following service(s) that can allow for more private communication. None of the services will cost you money. However, each requires setup before they can be used. Please notify Jennifer if you would like to use any of these services:

- Encrypted email through Hushmail.

Please refrain from making contact with Jennifer using social media messaging systems such as Facebook Messenger or Twitter. These methods have very poor security, and she is not prepared to watch them closely for important messages from clients.

It is important to communicate and also keep the confidential space that is vital to therapy. Please speak with Jennifer about any concerns you have regarding her preferred communication methods.

Response Time

Jennifer may not be able to respond to your e-mail messages, calls, or texts immediately (especially on weekends or during vacation.) You can usually expect a response within 24-48 hours. Jennifer may occasionally reply more quickly than that or on weekends, but please be aware that this will not always be possible. Be aware that there may be times when Jennifer is unable to receive or respond to messages, such as when she is out of cellular range or out of town.

Progressive Counseling & Hypnosis
7350 Grace Drive
Columbia, MD 21044
410.707.5786
jenmolslight@gmail.com
www.jennifermolinari.com

Emergency Contact

If you are ever experiencing an emergency, including a mental health crisis, please call 911.

Disclosure Regarding Third-Party Access to Communications

This is to inform you that if we use electronic communications methods (email, texting, online video etc.) that our communications are insecure. There are various technicians and administrators who maintain these services and who may have access to the content of our communications.

Of special consideration are work email addresses. If you use your work email to communicate with me, your employer may access our email communications. There may be similar issues involved in school email or other email accounts associated with organizations with which you are affiliated.

Additionally, people with access to your computer, mobile phone, and/or other devices may also have access to your email and/or text messages. Please take a moment to contemplate the risks involved if any of these persons were to access the messages we exchange with each other.

I understand the risk of using electronic forms of communications and still want to use these methods of communication:

Signature: _____ Date: _____

Code: _____ (Optional, but recommended for texting to confirm your identity. Use any code you would like.)

I understand the risk of using electronic forms of communication and wish only to communicate by phone:

Signature: _____ Date: _____

Best contact number: _____



Progressive Counseling

*Mind~Body~Spirit
In Harmony*

Jennifer Molinari, LCPC, NCC

Progressive Counseling & Hypnosis



My Private Practice Social Media Policy

This document outlines my office policies related to the use of Social Media. Please read this document so that you understand how I conduct myself on the Internet as a mental health professional and how you can expect me to respond to various situations and interactions in relation to the internet.

If you have any questions regarding anything in this document, then please bring them up at your next session. As new technology develops and the Internet changes, I may need to update this policy. If I need to do so, I will notify you in writing of any policy changes and you will receive an updated policy.

“Friending”

I do not accept friend requests or contact requests from current or former clients on any social media networking site (Facebook, LinkedIn, etc.). I 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.

“Fanning”

I keep a Facebook Page for my professional practice. You are welcome to view my Facebook Page and read or share articles there. Please be aware that if you comment on Facebook or share information that your identity may be revealed to others and that your relationship with me will not be confidential.

I do not accept clients as “Fans” of this page. Again, I believe that this could compromise confidentiality. In addition, it is against my board’s Ethical Code to solicit client endorsements so becoming a “fan” of my page comes too close to an implied request for a public endorsement.



You may be able to subscribe to the page via RSS without becoming a “fan” and without creating a visible, public link to my page. You are more than welcome to do this.

“Following”

I occasionally publish newsletters and I may in the future begin a blog on my website. I also do publish posts to Twitter. I have no expectation for you to “follow” me. However, if you choose to follow me and use an easily recognizable name on Twitter (for example), then we will need to discuss the possible impact at your next scheduled session. My primary concern is for your privacy. If you share this concern, there are private ways to follow me such as using an RSS feed or a locked Twitter list.

Interaction on Social Media Sites

If you do choose to follow me on social media sites, please note that I will not follow you back. I only follow other health professionals. My reasoning is that viewing a client’s online content outside of therapy can create confusion and can blur the boundaries of the therapeutic relationship for both of us and it could potentially have a negative impact on your treatment. If there are things from your online life that you wish to share with me please bring them to your sessions where we can view and explore them together.

Instant Messaging on Social Media

Please do not use instant messaging on any of the social media sites (Facebook, LinkedIn, Twitter etc.) to contact me. These sites are not secure and I may not get these messages in a timely fashion. Do not use wall postings, @replies, or other means of engaging with me in public online. It could compromise your confidentiality and these exchanges could become part of your legal medical record and would then need to become documented and archived in your chart.



Texting

I do permit texting through mobile/cell phones for the sole purpose of scheduling appointments. It is recommended that you have a code in your text messages that alerts me that you are the actual sender and receiver of text communications. I have been experimenting with different HIPAA compliant texting apps and am hoping to find one that is user friendly to use exclusively. All of these apps require the recipient to download the app on their phone. If I invite you to use a HIPAA texting app for confidential texting and you do not want to download the app, please be aware that texting through your phone could pose a risk to confidentiality.

Please do not include any content in text messages regarding clinical issues or topics that we would discuss in your session. SMS texts are again considered part of your medical file and have to be documented and archived in your chart.

The Best Ways to Communicate

The safest way to communicate with me is by phone and e-mail. If you have an emergency, please call 911 or go to your nearest emergency room.

For non-emergencies please call: 410.707.5786. You may leave messages on my confidential voicemail. I will my best to return calls within 24 to 48 hours. Response times may be longer if am on vacation, if there is illness, etc.

If you wish to communicate with me by email or text message, please read and complete the *Consent for Non-Secure Communications* form. I use two email platforms: Gmail (not-HIPPA compliant) and Hushmail (HIPPA compliant.) You are welcome to use either platform. With Hushmail there are many security measures and everything is password protected. With Gmail there are no real protections and I can not guarantee confidentiality.



Use of Search Engines

It is not a part of my regular practice to search for clients on Google or Facebook or any other search engine. Extremely rare exceptions may be made if there is a crisis. If I have a reason to suspect that you are in danger and you have not been in contact with me via our usual means (coming to appointments, phone, or email) then I might use a search engine to find you or someone close to you to check on your status to ensure your welfare. These are very unusual circumstances and if I ever need to resort to such means, I will fully document it and will discuss it with you at your next appointment.

Google Reader

I do not follow current or former clients on Google Reader and I do not use Google Reader to share articles. If there are things you want to share with me and that you feel are relevant to your treatment, then please bring these items to your session.

Business Review Sites

You may find my business on sites such as Yelp, Health grades, Yahoo Local, Bing etc. On some of these sites, users are able to rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has chosen to add itself to the site. If you find my business listed on any of these sites, please be aware that with some of these listings I did not add my business and my listings are NOT a request for testimonials, ratings, or endorsements from you as my client. It is considered unethical for counselors to solicit testimonials.

Of course, you have the right to express yourself on any site you choose. However, due to confidentiality, I cannot respond to any reviews on these sites whether they are positive or negative. I urge you to take your own privacy as seriously as I take my commitment of confidentiality with you. Please be aware that if you use these sites to communicate indirectly



with me about your feelings regarding our work that there is a good chance I will never see it. In addition, even if I do see it I won't be able to comment.

On that note, if we are working together, I hope that out of mutual respect and consideration, that you will discuss your feelings and reactions to our work directly in your sessions and during the therapy process. The way you feel regarding the therapeutic relationship is a very important part of your therapy, even when you think our relationship is not a good fit.

You are always welcome to share that you are in therapy with me and how you feel about the treatment I have provided you wherever and with whomever you want. However, I am unable to request testimonials and to respond to comments on any of these sites in order to protect your confidentiality.

If you choose to write something on a business review site for any reason, please keep in mind that you are sharing personally revealing information in a public forum. You will want to take your own privacy and protection into consideration.

If you ever feel that I have done something harmful and unethical and you do not feel you can come to me to discuss the issue then you can always contact the Maryland Board of Professional Counselors. They oversee licensing and can review my practices.

Maryland Board of Professional Counselors:

4201 Patterson Avenue
Baltimore, Maryland 21215-2299
Phone: 410-764-4732
Fax:410-358-1610

Location-Based Services

If you use a location-based service on your mobile phone, you may wish to be aware of privacy issues related to using these services. I do not place my business in check-in locations on sites such as Foursquare, Gowalla, Loopt, etc. However, if you have GPS tracking enabled on your device, it is possible that others may figure out that you are a therapy client due to regular check-ins at my office. Please be aware of this risk if you are intentionally "checking-in" from my office or if you have a passive LBS app enabled on your phone.



Cell Phones and Confidentiality During Your Session

Please be aware of the risk of confidentiality and having your cell phone on during your sessions. Occasionally buttons can be pressed accidentally resulting in someone being called without your knowledge. If this happens, your therapy session may not be confidential and our conversation may be overheard by a third-party. There have been incidents of clients accidentally calling a third party and having their session overheard. To prevent this risk, you might want to turn your cell phone off during your session.

Email

You are welcome to send me emails. I use G Suite which is a HIPAA compliant e-mail server. Please remember that emails are retained in the logs of your and my Internet providers. While it is unlikely that anyone will look at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet Provider. You should also know that all e-mail correspondences become part of your legal medical record.

Dual Relationships/Public Encounters

The therapeutic relationship is a very special and unique relationship. However, it is purely a professional relationship. Sometimes client's feel close to their therapists due to the amount of disclosure that occurs during sessions. It is important to remember that therapists can not be "friends" with clients or have any relationship with clients outside of sessions for any reason (even if the therapeutic relationship has ended.) Since I live and work in the community, there is a good chance I may run into you in a public setting. If there is a possibility of us running into each other in public, then we should discuss how you would like to handle this type of a situation.

As a therapist, I will not come up to you to say "hello" as this could compromise your confidentiality (you may have to explain to others how you know me.) Please don't take this personally. You are welcome to acknowledge me and say "hello" in public as long as you are



aware that this could reveal how we know each other. I will not be offended if you choose to not acknowledge me or say “hello” in public.

Conclusion

Thank you for taking the time to read and view my Social Media Policy. If you have any questions or concerns, please feel free to contact me so that we can discuss them.

Please complete the following:

1) For e-mail communication, I prefer to use:

Gmail (non-HIPAA compliant) Hushmail (HIPAA Compliant)

2) I consent to communication through text message: Yes No

3) Can messages be left on the phone number you have provided? Yes No

4) Occasionally, mail may need to be sent to your home address (bills, etc.) is this O.K.?
 Yes No

If no, please provide an alternate address below to send mail if needed.

*The content of this form was adapted and modified from Keely Kolmes', Psy.D. Social Media Policy
Jennifer Molinari, LCPC, NCC 7350 Grace Drive Columbia, MD 21044 410.707.5786
Website: www.jennifermolinari.com Email: jenmolight@gmail.com



HIPPA PRIVACY POLICY (Keep for Your Records)

This notice describes how psychological and medical information about you may be used and disclosed. It also describes how you can get access to your protected health information.

PLEASE REVIEW IT CAREFULLY

I am required to provide you with this Notice of Privacy Practices under the Federal Health Insurance Portability and Accountability Act (HIPPA). I am required by law to:

- Maintain privacy of your Protected Health Information (PHI)
- Provide this Notice of my legal duties and privacy practices for use and disclosure of your Protected Health Information.
- Follow the terms of this Notice.
- Communicate any changes of this Notice to you.

This Notice describes how I may use or disclose your Protected Health Information, with whom this information may be shared, and the safeguards I have in place to protect your information. This Notice describes your right to approve or refuse the release of specific information, except when the release is required or authorized by law.

I will provide you with an Acknowledgement and Consent Form by which you can acknowledge your receipt of this Notice and you can consent to my use and disclosure of your Protected Health Information (as described in this Notice.) My intention is to make you aware of the possible uses and disclosures of your Protected Health Information.

1. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use and or disclose your Protected Health Information (PHI), for treatment, payment, and health care operation purposes with your written authorization.

2. Definitions

The following are a list of definitions to help clarify terms used in this document: a.

“PHI” refers to information in your health record that could identify you.

- b. “Treatment” is providing, coordinating, and managing your health care and other services related to your health care. An example of treatment would be consulting

with another health care provider such as your primary care physician, psychiatrist, or another therapist.

- c. *"Payment"* refers to obtaining reimbursement for your health care. Examples of payment are when your PHI is disclosed to your insurance company to obtain reimbursement for your health care or to determine your eligibility for coverage.
- d. *"Health Care Operations"* are activities that relate to the performance and operations of my practice. Examples of health care operations are quality assessments, improvement activities, business related matters (such as audits and administrative services, case management, and case coordination.)
- e. *"Use"* refers to activities within the office such as sharing, utilizing, examining, and analyzing information that identifies you.
- f. *"Disclosure"* refers to activities outside of the office such as releasing, transferring, or providing access to information about you to other parties.
- g. *"Authorizations"* refers to your written permission for me to disclose confidential mental health information. All authorizations to disclose information must be on a legal form.

3. Other Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when appropriate authorization is obtained. If I am requested to release information outside of treatment, payment, or health care operations, then I will obtain written authorization from you, the client, before releasing any information. This same process is in effect for releasing "Progress Notes." "Progress Notes" or "Psychotherapy Notes" are the notes that I write regarding the conversations we have during your private, group, joint, or family counseling sessions. Progress Notes have a higher degree of protection than PHI.

You may revoke all authorizations of PHI or Progress Notes at any time provided that your request is in writing. You may not revoke your authorization to the extent that:

- a. I have relied on that authorization to perform services.
- b. The authorization was obtained under a condition of obtaining insurance coverage.

4. Uses and Disclosures without Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- a. ***Child Abuse:*** If there is reason to believe that a child has been subjected to abuse or neglect (regardless of when it occurred or if the perpetrator is deceased), then I am required to report my belief to the appropriate authorities (CPS, Police, etc.)
- b. ***Adult and Domestic Abuse:*** I may disclose PHI if I believe that you are a victim of abuse, neglect, self-neglect, or exploitation to the appropriate authorities (APS, Police etc.)
- c. ***Payment:*** Your PHI will be used (as needed) to obtain payment or for you to receive reimbursement.

- d. **Health Care Operations:** I may use or disclose PHI to support daily activities providing health care. These activities may include performing quality assessments, oversight and reviews, licensing, communicating a product or service, or conducting or arranging health care activities. I may call you by name in the waiting room when I am ready to see you for an appointment, I may contact you regarding your satisfaction with my services, to schedule or cancel appointments, or to provide you with behavioral health information.
- e. **Treatment:** I will use or disclose your PHI to provide, coordinate, and manage your behavioral health care and related services. This might involve talking to specialists or other providers. I may have to disclose PHI at an office visit or when I need to contact you. I will assume that the contact information you provide will be accurate and will be a safe and appropriate way for me to call you, send e-mails, send faxes, or mail without having to call you first for permission.
- f. **Required by Law or Government:** If I receive a subpoena from the Maryland Board of Professional Counselors because they are investigating my practice, then any PHI information may be disclosed to the Board. I will provide your PHI if law regulations require the use or disclosure. I may provide PHI to a government oversight agency for activities authorized by law. These oversight agencies might include government agencies or their subcontractors who oversee health care systems, government benefit and regulatory programs, and civil rights laws.
- g. **Public Health Research:** I may disclose your PHI to public health authorities permitted by law to collect or review information. Such disclosure may be necessary to control disease, injury, disability, report births, deaths, child abuse or neglect, report reactions to medications or problems with products, providing notice to a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition. I may also provide PHI to researchers when authorized by law.
- h. **Judicial and Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information regarding your diagnosis and/or your treatment or if there is a request for your records, then I will not provide your PHI without your written permission or a court order (as this information is privileged under State Law.) This privilege does not apply when you are being evaluated by a third party or when the evaluation is court ordered. You will be notified in advance if this is the case.
- i. **Serious Threat to Health or Safety:** If I believe there is a threat of harm against another individual or if I feel there is a clear and imminent risk of physical harm or mental injury being inflicted upon another individual then it is within my rights to disclose necessary information to protect that individual from harm. In addition, if you feel that there is a serious risk of physical or mental injury or the risk of death to you, then I will provide the necessary disclosures in order to protect you from harm.
- j. **Disclosures upon Death:** I may disclose your PHI to coroners and medical examiners for the performance of duties authorized by law; to funeral directors and for cadaver organ, eye, or tissue donations.
- k. **Other Individuals Involved in Your Healthcare:** With your permission, I may disclose information to a family member, relative, close friend, or other person you

identify to me if your PHI is directly related to that person's involvement in your care. I may also give your PHI to someone who helps pay for your care. I may use or disclose information to notify or assist family members or personal representatives of your location, general condition, or death if necessary. Finally, I may use or disclose your information to an authorized public or private entity to assist in disaster relief efforts and to coordinate use and disclosures to family or other individuals involved in your health care.

- I. **Parental Access:** Some state laws concerning minors permit or require disclosure of PHI to parents and/or guardians. I will act consistently with Maryland Law and will make disclosures in accordance with such law and applicable federal law. If there is a conflict between laws, HIPPA requires that the more stringent law apply.

5. Patient's Rights and Therapist's Duties

Patient's Rights:

- a. **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of PHI. However, I am not required to agree and follow the restrictions you request.
- b. **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and at an alternative location. For example, you may not want your spouse or family to know you are seeing a therapist. At your request, I can send bills/correspondences to another address. Or, you can request to have a session by phone or e-mail rather than in person.
- c. **Right to Inspect and Copy:** You have the right to inspect and/or obtain a copy of your PHI from your mental health record. I have the right to deny access if I feel it is necessary. You also have the right to inspect and/or obtain a copy of your Progress Notes. I may deny you access if I feel the disclosure of the records would be a disservice to you and your health (mental and/or physical.)
- d. **Right to Request an Amendment:** If you believe the information I have provided about you is incomplete or incorrect, you may request an amendment to your PHI as long as I maintain this information. I am not required to agree to an amendment.
- e. **Right to Obtain a Paper Copy:** You may obtain a paper copy of my Notice of Privacy Practices.

Therapist's Duties:

- a. I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practice policies with respect of PHI.
- b. I reserve the right to change the privacy policies and practices described in this notice. If I change any of my privacy policies then I am required to inform you of these changes.
- c. If I change any of my privacy policies and/or procedures then I will provide you with a revised copy of this document in person or by mail.

Progressive Counseling & Hypnosis
Jennifer Molinari, LCPC, NCC
7350 Grace Drive
Columbia, MD 21044
410.707.5786
jenmolslight@gmail.com
www.jennifermolinari.com

6. Complaints

- a. If you are concerned that I have violated your privacy rights, or if you disagree with a decision I have made in regards to you having access to your records then you may contact me to discuss your concern.
- b. If you feel after our discussion that I have not adequately addressed your concerns, then you can send a written complaint to the Secretary of the U.S. Department of Health and Human Services in Washington, D.C. I can provide you with the address upon request. No retaliation will occur against you for filing a complaint.

7. Effective Date, Restrictions, and Changes to Privacy Policy

- a. I reserve the right to change the terms of this notice and to make new provisions to this notice. You will be notified of any changes to this notice and will be provided with a new copy of this document in-person or by mail. You may contact me at (410) 707--5786 or at jenmolslight@gmail.com if you want further information or have questions about this notice.



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (You may refuse to sign this form)

I have received a copy of Progressive Counseling & Hypnosis /Jennifer Molinari, LCPC, NCC's
Notice of Privacy Practices.

(Print Name)

(Signature)

(Date)

For Office Use Only

- Individual Refused to Sign
 Communication barriers prohibited obtaining the acknowledgement
 An emergency situation prevented Jennifer Molinari, LCPC, NCC from obtaining
acknowledgement Other:
-
-

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Progressive Counseling & Hypnosis

Contract for Personal Services

I, _____, understand that Jennifer Molinari, LCPC, NCC is a Licensed Clinical Professional Counselor and a National Certified Counselor in the State of Maryland. In consideration of the promises and conditions herein, I seek and it is my intent to hire Ms. Molinari for counseling services.

I agree to provide current, complete, and accurate information about myself as required on Ms. Molinari's registration forms and during our sessions in order to receive the best quality care. I will notify Ms. Molinari of any changes to my personal information or in regards to my personal well-being.

No one representing Progressive Counseling & Hypnosis/Jennifer Molinari, LCPC, NCC offers me false hopes, false promises, expectations, warranties, or assurances of the successes or outcomes of Ms. Molinari's work. I take responsibility for the outcomes of my therapy. I realize that therapy is a partnership and that the outcome of my sessions largely depends on the effort I put forth in and outside of my sessions. I realize that Ms. Molinari can't "fix me" or "make me change." I agree to partake in Ms. Molinari's services at my own risk.

I have read and understand Ms. Molinari's financial policies and agree and adhere to these policies. I agree to provide 24 hours' notice prior to the cancellation of my appointment. I agree to provide credit card information to be kept on file and to be possibly charged (in the amount of \$65) in the event that I miss an appointment or do not provide adequate notice when canceling an appointment. I understand that reminder texts/calls are a courtesy and that missing an appointment because I didn't receive a reminder is not an excuse for missing an appointment. I also agree to participate in a closing session before terminating services with Ms. Molinari for any reason.

Signature

Date

Provider's Signature

Date

Progressive Counseling & Hypnosis
7350 Grace Drive
Columbia, MD 21044
410.707.5786
jenmolslight@gmail.com
www.jennifermolinari.com



Progressive Counseling

Missed and Cancelled Appointment Policy

I understand that if I miss an appointment or cancel an appointment with less than 24 hour notice that I will be charged \$65 for the missed/cancelled appointment (this charge is not covered by insurance.)

I understand that I will be charged regardless of the reason for my missed/cancelled appointment. I have the option of paying by credit card, check, or cash (if needed, a payment plan can be discussed.)

I understand that this charge is not a punishment and is due to the fact that appointment slots that are missed or cancelled last minute generally cannot be filled. This can result in a significant financial loss for Jennifer.

Client Signature

Date



Credit Card Authorization Form

(To Be Completed By All Clients)

Credit Card Billing Information:	
Name:	
Person Authorizing:	
Credit Card Type:	Visa () MasterCard () American Express () Discover ()
Credit Card Number:	
CVC Code (3 digits on back of card):	
Expiration Date:	
Billing Address:	
City:	
State/Province:	
Zip Code:	
Phone Number:	
E-mail address:	

I understand that my credit card information is being kept on file. I also understand that my credit card will **only** be billed in the event that I miss or cancel an appointment (without providing 24-hour notice.) I understand if I am billed that it is not a punishment. I understand that Ms. Molinari is still required to pay rent and business related expenses even when I cannot attend my appointment. I understand that appointments canceled with less than 24-hour notice are hard to fill and that I have to be billed to offset costs. I understand that funds charged to my card cannot be refunded. If Jennifer decides charges were incurred in error, then there will be a credit applied to my next session.

I authorize Progressive Counseling & Hypnosis/Jennifer Molinari, LCPC, and NCC to charge my credit card in the amount of \$65 if I miss an appointment (or fail to cancel an appointment within 24 hours prior to my appointment) without additional consent. I will receive an e-mail receipt if my credit card is billed. I understand that if Jennifer is unable to bill my credit card due to invalid credit card information and me have an outstanding balance that is 60 days past due that my account will be forwarded to the collections agency.

Signature

Date



Progressive Counseling & Hypnosis Release of Information Form

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:

Date of Birth:

I, _____, authorize **Jennifer Mollnari, LCPC, NCC dba Progressive Counseling** to release and discuss all pertinent mental health, healthcare, and billing information with:

Name

Address:

City:

State:

Zip Code:

The following information may be exchanged:

- _____ Full client record
- _____ Progress and attendance reports
- _____ Admission and discharge diagnosis and recommendations
- _____ Reason for termination of treatment and discharge summary
- _____ Other _____

The above information will be exchanged for the following reason(s):

- _____ To coordinate treatment
- _____ As required by my employer or EAP
- _____ To assist my attorney
- _____ Other _____

I understand that my records are protected under Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that the information has already been disclosed in reliance with this consent.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____ Witness Signature: _____ Date: _____

This release is valid for one year starting the date this form is signed.

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Progressive Counseling & Hypnosis Primary Care Physician (PCP) Notification

It is often helpful to notify your doctor of your mental health treatment so that your doctor can provide Jennifer with information regarding possible medical issues that may affect your mental health treatment. In some cases, medications or medical issues can cause or worsen mental health issues. Most insurance companies also request that therapists notify primary care physicians about a client's mental health treatment.

Please check the appropriate box below. Checking the "Yes" box and signing this form will allow Jennifer Molinari, LCPC, NCC to notify your primary care physician that you are receiving treatment.

Yes, I would like Jennifer to notify my PCP.

No, I would **NOT** like Jennifer to notify my PCP.

If you check yes, please fill out the rest of this form to the best of your ability.

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www.jennifermolinari.com

I give permission for Jennifer Molinari, LCPC, NCC to notify my PCP that I, _____,
am being seen by Jennifer Molinari, LCPC, NCC. I understand that a copy of this letter will be
placed in my chart and I encourage my doctor to discuss my treatment with Jennifer and myself.

Dr. _____

Address: _____

Phone Number: _____ Fax Number: _____

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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Date: _____

Dear Dr. _____:

I have received written authorization from a mutual patient named _____ asking me to notify you that I am currently providing them with counseling services for _____.

This mutual patient felt that it was important for me to contact you in the event that you ever need/want to collaborate on treatment or in the event that you feel a medical issue could affect this client's mental health treatment.

If you have any questions, comments, or concerns please contact Jennifer by phone at 410-707-5786. You may also reach Jennifer by e-mail at: progressivecounselingandhypnosis@hushmail.com

Sincerely,

Client's Signature

Date

Jennifer Molinari, LCPC, NCC

PROGRESSIVE COUNSELING & HYPNOSIS

LIFE HISTORY QUESTIONNAIRE

NAME OF CLIENT: _____ DATE: _____

The information you provide will help in the planning of your counseling, and assist you and your therapist in clarifying your therapy goals. Please be as open and honest as possible. This questionnaire will be kept in your private confidential file.

Current Status:

Are you married? Yes No

If not have you been married/partnered before? Yes No

If yes, when and for how long? _____

Approximately how many significant intimate relationships (e.g. lasting 6 months or more) have you been involved in? _____ Are you in one now? Yes No I think so

What is your sexual orientation? _____

Please list the names of your children or dependents.

Names of Children	Date of Birth	Age	Lives With You?
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

List others who may live with you including their ages and occupations (e.g. brother 16, student, mother-in-law 55, etc.)

Please check any past, present, or impending special problems in your family:

- | | | |
|--|---|---|
| <input type="checkbox"/> Deaths | <input type="checkbox"/> Divorce | <input type="checkbox"/> Frequent relocations |
| <input type="checkbox"/> Serious illness | <input type="checkbox"/> Debilitating injuries/disabilities | <input type="checkbox"/> Alcohol/drug abuse |
| <input type="checkbox"/> Psychiatric disorder | <input type="checkbox"/> Physical/sexual abuse | <input type="checkbox"/> Legal problems |
| <input type="checkbox"/> Financial crisis/unemployment | <input type="checkbox"/> Attempted/completed suicide | <input type="checkbox"/> Eating disorders |
| <input type="checkbox"/> Other _____ | | |

Please specify family member(s), with special problems, and approximate year of occurrence (e.g. mother, serious illness, 1998.) _____

What is your ethnic background?

- | | |
|---|---|
| <input type="checkbox"/> African/African American | <input type="checkbox"/> Asian American/ Chinese/ Filipino/ Japanese/ Korean/
Vietnamese |
| <input type="checkbox"/> East Indian/Pakistani | <input type="checkbox"/> Latino/ Hispanic/ Mexican-American/ Puerto Rican |
| <input type="checkbox"/> Middle Eastern | <input type="checkbox"/> Native American/ Alaskan Native |
| <input type="checkbox"/> Polynesian/Micronesian | |
| <input type="checkbox"/> White/Caucasian | <input type="checkbox"/> Other (specify) _____ |

How much do you identify with your ethnic heritage? (Check one):

- Not at all A little Somewhat Moderately Strongly

Were you and both your biological parents born in the United States? Yes No Unsure

If no, who was foreign-born, where and what was the approximate age of immigration to the USA? (e.g. myself, Korea, 12; father Korea, 40; etc.) _____

Does your family speak a language other than English at home? (Check one):

- Not at all Very little Sometimes Frequently Always

Family History:

In general, how happy or adjusted were you growing up? (Check one):

- Not at all A little About average Substantial Completely

How much is your family a source of emotional support for you now? (Check one):

- None A little Somewhat Substantial Very strong

How much conflict in values do you currently experience with your parents? (Check one):

- Very little or none Some Moderate Strong Extreme

Who in your family do you currently feel closest to? _____

distant from? _____ In most conflict with? _____

Do you have any siblings? If so, please list:

How was conflict handled in your family? Please, describe:

How did your parents get along?

What else do you feel I should know about your family?

Educational Background:

Where did you attend high school? _____

Did you attend college/professional school and/or graduate school? When, where, degree earned?

Any plans to further your education? Yes No

If so, when and what?

Religion/Spirituality:

Religious/Spiritual preference: _____

Do you consider yourself a religious person? Yes No or spiritual person? Yes No

Comment: _____

Faith: Group/Denomination in which you were raised: _____

Current Congregation: _____

How active are you? Inactive Slightly Moderate Very

Symptoms Checklist:

Reason for seeking treatment:

What is the nature of the problem you are experiencing?

Briefly describe how the problem noted above causes you difficult.

Directions:

Please check all the items below that you currently experience or have difficulty with, and feel free to add any others at the bottom under "Other Concerns or Issues." You may add details as needed to clarify at the end of this questionnaire.

- | | | |
|---|---|--|
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Grieving, Mourning | <input type="checkbox"/> Physical Problems |
| <input type="checkbox"/> Abuse - Emotional | <input type="checkbox"/> Guilt | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Abuse - Neglect | <input type="checkbox"/> Headaches, Pains | <input type="checkbox"/> Poor Self-care |
| <input type="checkbox"/> Abuse - sexual | <input type="checkbox"/> Health, Illness | <input type="checkbox"/> Pornography Use |
| <input type="checkbox"/> Adoption | <input type="checkbox"/> Hearing Voices | <input type="checkbox"/> Procrastination |
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Hostility | <input type="checkbox"/> Relationship Problems |
| <input type="checkbox"/> Alcohol Use | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Relaxation |
| <input type="checkbox"/> Ambition | <input type="checkbox"/> Impulsive Spending | <input type="checkbox"/> Re-marriage |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Impulsiveness | <input type="checkbox"/> Risk-taking |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Incest | <input type="checkbox"/> Sadness |
| <input type="checkbox"/> Arguing | <input type="checkbox"/> Indecision | <input type="checkbox"/> School Problems |
| <input type="checkbox"/> Attention Problems | <input type="checkbox"/> Inferiority Feelings | <input type="checkbox"/> Self Abuse - burning |
| <input type="checkbox"/> Career Concerns | <input type="checkbox"/> Infertility | <input type="checkbox"/> Self Abuse - cutting |

<input type="checkbox"/> Childhood Issues	<input type="checkbox"/> Inhibitions	<input type="checkbox"/> Self Abuse - other
<input type="checkbox"/> Children – care of	<input type="checkbox"/> Interpersonal	<input type="checkbox"/> Self Abuse - scratching
<input type="checkbox"/> Children - custody	<input type="checkbox"/> Irresponsibility	<input type="checkbox"/> Self Abuse – pulling hair
<input type="checkbox"/> Children - management	<input type="checkbox"/> Irritability	<input type="checkbox"/> Self-centeredness
<input type="checkbox"/> Choices I've Made	<input type="checkbox"/> Judgment Problems	<input type="checkbox"/> Self-control
<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Laziness	<input type="checkbox"/> Self-esteem
<input type="checkbox"/> Codependence	<input type="checkbox"/> Legal Matters,	<input type="checkbox"/> Self-neglect, Poor Self-
<input type="checkbox"/> Communication	<input type="checkbox"/> Loneliness	<input type="checkbox"/> Separation
<input type="checkbox"/> Compulsive Spending	<input type="checkbox"/> Loss of Control	<input type="checkbox"/> Sexual Addiction
<input type="checkbox"/> Confusion	<input type="checkbox"/> Losses	<input type="checkbox"/> Sexual Conflicts
<input type="checkbox"/> Constant Conflicts	<input type="checkbox"/> Loss of Interest In	<input type="checkbox"/> Sexual Desire
<input type="checkbox"/> Crying	<input type="checkbox"/> Loss of Interest	<input type="checkbox"/> Shyness
<input type="checkbox"/> Deaths	<input type="checkbox"/> Low Energy	<input type="checkbox"/> Smoking
<input type="checkbox"/> Debt	<input type="checkbox"/> Low Frustration	<input type="checkbox"/> Spirituality
<input type="checkbox"/> Decision Making	<input type="checkbox"/> Low Income	<input type="checkbox"/> Step-parenting
<input type="checkbox"/> Dependence	<input type="checkbox"/> Low Mood	<input type="checkbox"/> Stress
<input type="checkbox"/> Depression	<input type="checkbox"/> Marital Conflict	<input type="checkbox"/> Stress-management
<input type="checkbox"/> Distractibility	<input type="checkbox"/> Marital Distance	<input type="checkbox"/> Suspiciousness
<input type="checkbox"/> Divorce/Separation	<input type="checkbox"/> Marital	<input type="checkbox"/> Temper Problems
<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Medical Concerns	<input type="checkbox"/> Tension/Stress
<input type="checkbox"/> Drug Abuse – over the counter	<input type="checkbox"/> Memory Problems	<input type="checkbox"/> Thought
<input type="checkbox"/> Drug Abuse - prescription	<input type="checkbox"/> Menopause	<input type="checkbox"/> Threats of Violence
<input type="checkbox"/> Drug Abuse – street drugs	<input type="checkbox"/> Menstrual Problems	<input type="checkbox"/> Tiredness
<input type="checkbox"/> Drug Abuse - Alcohol	<input type="checkbox"/> Mixed feelings	<input type="checkbox"/> Tobacco Use
<input type="checkbox"/> Education	<input type="checkbox"/> Mood swings	<input type="checkbox"/> Unhappiness
<input type="checkbox"/> Employment – lack of	<input type="checkbox"/> Motivation	<input type="checkbox"/> Violence
<input type="checkbox"/> Employment - overdoing	<input type="checkbox"/> Mourning	<input type="checkbox"/> Violence – Victim of
<input type="checkbox"/> Employment Problems	<input type="checkbox"/> Nail-biting	<input type="checkbox"/> Weight and Diet issues
<input type="checkbox"/> Employment - Termination	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Withdrawal - isolating
<input type="checkbox"/> Emptiness	<input type="checkbox"/> Nightmares	<input type="checkbox"/> Work Problems
<input type="checkbox"/> Exhaustion	<input type="checkbox"/> Obsessions,	<input type="checkbox"/> Worry All the Time
<input type="checkbox"/> Failure	<input type="checkbox"/> Outbursts	<input type="checkbox"/> Other concerns or
<input type="checkbox"/> Fatigue, Low Energy	<input type="checkbox"/> Oversensitive to	<input type="checkbox"/> issues:
<input type="checkbox"/> Fears, Phobia	<input type="checkbox"/> Oversensitive to	
<input type="checkbox"/> Feelings of	<input type="checkbox"/> Overweight	
<input type="checkbox"/> Financial Troubles	<input type="checkbox"/> Panic or Anxiety	
<input type="checkbox"/> Friendship Problems	<input type="checkbox"/> Parenting	
<input type="checkbox"/> Gambling	<input type="checkbox"/> Perfectionism	
<input type="checkbox"/> Gender Identity	<input type="checkbox"/> Pessimism	
<input type="checkbox"/> Goals Not Being Met	<input type="checkbox"/> Phobias	

Health History:

How is your physical health at present? Poor Unsatisfactory Satisfactory Good Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, diabetes, headaches, etc.) _____

Are you presently taking any prescribed or non-prescribed medication? Yes No

Please indicate _____

Are you having any problems with your sleep habits? Yes No

If yes, check where applicable:

- Sleeping too little Sleeping too much Poor quality sleep
 Disturbing dreams Other _____

How many times per week do you exercise? _____ About how long each time? _____

Are you having any difficulty with appetite or eating habits? Yes No

- If yes, check where applicable: Eating less Eating more Binging Poor appetite
 Making myself vomit Significant weight change (last two months)

Do you regularly use alcohol? Yes No

In a typical month, how often do you have four or more drinks in a 24-hour period? _____

Do you consider your alcohol consumption a problem? Yes No Unsure

How often do you engage in recreational drug use? Daily Weekly Monthly Rarely Never

Do you consider this drug use a problem? Yes No Unsure

Do you have any problems or worries about sexual functioning? Yes No

If yes, check where applicable:

- Lack of desire Performance problem Difficulty maintaining arousal
 Worried about sexually transmitted disease Sexual impulsiveness
 Other _____

Have you seen another therapist before? Yes No

If yes, who did you see? _____

Why did you discontinue counseling with your previous therapist?

What was helpful about your previous counseling experience?

What was not helpful about your previous counseling experience?

Have you ever been hospitalized for psychological/emotional difficulties? Yes No

If yes, please note dates of hospitalization

Are you (or have you been) on any medication for your psychological problems? Yes No

If yes, please note the type of medication, the dosage, and the dates you used this medication

Briefly describe again the problem that brought you here.

Problem Intensity: How would you rate the intensity of the problem or concern that brought you in? (Circle the appropriate number):

1 2 3 4 5 6 7 8 9 10
Not intense Moderately intense Extremely intense

Problem Duration: Approximately how long have you had the current problem (in months or years)?

Coping Strategies: In what ways have you attempted to cope with this problem _____

Have you had suicidal thoughts in the last few months?

Frequently Sometimes Rarely Never

Have you had them in the past?

Frequently Sometimes Rarely Never

Have you ever intentionally inflicted any harm upon yourself? Yes No Unsure

Expectations:

What do you hope to accomplish by coming to therapy? Be as specific as possible.

How motivated are you to make changes in your life in order to accomplish your goals?

1 2 3 4 5 6 7 8 9 10
Not Motivated Moderately Motivated Extremely Motivated

If you are a 5 or below in terms of being motivated, what needs to happen in order to make your motivation level a 10?

Who do you have to support you with making positive changes in your life? Please list them:

Would you like anyone else involved in the counseling with you? (family members, friends, etc.)

****Please read about Jennifer's limits with confidentiality before answering these questions:****

Abuse History:

Have you ever experienced sexual assault, unwanted sex or uncomfortable touching?

- Frequently A few times Once Never Unsure

Is there a concern about violence in your life today ?

Please explain: _____

Have you experienced abuse?

- None Unsure Emotional Physical Sexual

Have your experienced a traumatic event that you feel is currently contributing to your presenting issue? If so, please explain:

Please list any other information that you believe will be helpful for your therapist to know.