LEHIGH VALLEY COUNSELORS
HELP · HOPE · HEALING

NEW CLIENT QUESTIONNAIRE

Welcome to Lehigh Valley Counselors! Thank you for taking a few minutes to fill out this form. The information you provide is confidential and will be helpful for you and your counselor when you meet for the first time. If you have any questions, just ask.

If you are currently experiencing a crisis please call your County Crisis Number, go to your nearest emergency room, or call 911 for immediate help.

Name _____ Date of Birth ____/____/____

Address _____
Street City State Zip

Phone (Primary)_____ (Secondary)_____

Email (Please print Clearly) _____

Ethnicity _____ Where did you grow up? _____

Education _____Occupation_____

What is your religious background/involvement? _____

Emergency contact person _____
Name Relationship Phone Address

Closest Relationships (please list name, birth date, relationship, and whether they live with you).

Name	Birth Date	Relationship	Live with you?
_____	_____	_____	_____
_____	_____	_____	_____

Please describe your current living arrangements (Do you live with others?)

_____

Have you participated in any therapy before? Y ___ N ___ If yes, when? _____ Reason _____

Do you have an existing Mental Health Diagnosis? Y ___ N ___ If yes, please list _____

Are you currently seeing a psychiatrist or therapist? Y ___ N ___

Have you or a family member ever been hospitalized for mental or emotional illness? Y ___ N ___
If yes, please list dates, location, and reason for hospitalization.

_____

Substance abuse/ addiction history? Y ___ N ___ If yes, when? _____ Substance of choice _____

Legal History (arrests, prison, DUI/DWI, parking tickets?) _____

Medical Information: Doctor's name and phone _____

May we send your doctor a short note, letting him/her know that you've come to see us? (we do not release details other than your name for referral purposes) Y ___ N ___

Are you on any medications Y ___ N ___ If yes, what are you taking and what are you taking it for?

_____

_____

Have you served in the US Military? Y ___ N ___

Branch _____ Served from _____ to _____

How can we help? Please tell us in your own words what brings you here today _____

_____

_____

What are your 2 most important goals for therapy?

1. _____

2. _____

Common problem/system checklist. Please fill in as follows: 0 – None, 1 – Mild, 2 – Moderate, 3 - Severe

___ Marriage	___ Divorce/Separation	___ Alcohol/Drugs	___ God/Faith
___ Pre-Marital	___ Child Custody	___ Other Addictions	___ Faith Community
___ Being Single	___ Disable	___ Grief/Loss	___ Past Hurts
___ Sexual Issues	___ Work/Career	___ Depression	___ Codependency
___ Family	___ School/Learning	___ Fear/Anxiety	___ Intimacy
___ Children	___ Money/Budgeting	___ Anger Control	___ Communication
___ Parents	___ Aging/Dependency	___ Loneliness	___ Self-esteem
___ In-laws	___ Weight Control	___ Mood Swings	___ Stress Control

Family Information: Marital Status (Please check all that apply):

Single ___ Dating ___ Committed Relationship ___ Engaged ___ Married ___

Separated ___ Divorced ___ Widowed ___ (How long has this been your status? _____)

Significant Other's Name (if applicable) _____ Age _____ Occupation _____

I would describe my friendships as: Close ___ Somewhat Close ___ Distant ___ Conflicted ___

I would describe my relationship with my mother as: Close ___ Somewhat Close ___ Distant ___ Conflicted ___

I would describe my relationship with my father as: Close ___ Somewhat Close ___ Distant ___ Conflicted ___

How many siblings do you have? Brothers ___ Sisters ___ How would you describe your relationship? _____

_____

Crisis Information:

Are you currently having any suicidal thoughts, feelings, or actions? Yes ___ No ___

If yes, please describe _____

Are you currently having any homicidal or violent thoughts or feelings, or anger-control problems? Yes ___ No ___

If yes, please describe _____

If you answered yes to either of the above please go to your nearest emergency room, or call 911 for immediate help.

Have you ever had any issues, hospitalizations, or imprisonments for suicidal or assaultive behavior? Yes ___ No ___

If yes, please describe _____

Are there any current threats of significant loss or harm (illness, divorce, custody, job, etc.)? Yes ___ No ___

If yes, please describe _____

How did you hear about us? _____

Thank you for taking the time to fill out this information sheet.
It will be reviewed with you during your first counseling session.

PLEASE SEE NEXT PAGE →

Consent and Services Agreement

Welcome to your first session at Lehigh Valley Counselors! Please review this form carefully, and feel free to ask us any questions.

About our Services. It's our goal to offer a positive, empowering, and life-enriching experience for our clients. The potential benefits of counseling are many and include improved functioning, relationships, self-image, mood, and the attainment of personal goals. However, in some cases persons have reported feeling worse after counseling. Clients understand that healing and growth is difficult, and some discomfort will likely be a part of the counseling process.

Confidentiality. Your confidentiality and privacy are extremely important to us. Lehigh Valley Counselors is considered a "covered entity" under HIPAA, meaning that we comply with HIPAA privacy rules. Our full notice of privacy practices can also be found on our website at www.lehighvalleycounselors.com. All communications and records with your counselor are held in strict confidence. Information may be released, in accordance with state law, when (1) the client signs a written consent to release; (2) the client expresses serious intent to harm self or someone else; (3) there is reasonable suspicion of abuse against a minor, elderly person, or dependent adult; (4) for billing purposes; or (5) a subpoena or court order is received. In compliance with ethical codes, including section 2.2 of the AAMFT Code of Ethics, when providing couple, family, or group treatment, your counselor will not disclose information outside the treatment context without a written authorization from each individual competent to execute a release. The client agrees to this policy regardless of who is paying for services, and regardless of who is listed as the 'identified patient' for 3rd party payments.

Electronic Communication & Online Counseling. Telephone (including voice and text), email, and videoconference are not encrypted methods of communication, and some confidentiality risk exists with their use. Our team communicates using these mediums. Occasionally, your counselor, or someone from our team, may follow up with you by telephone or email for scheduling, billing, quality assurance, or other reasons. If you would prefer not to be contacted by email, simply inform your counselor and your preferences will be respected. If you and your counselor are participating in distance counseling sessions the counselor will abide by the laws and ethical codes of his/her state of licensure. While a growing base of research has shown that distance counseling services—through various electronic means—can be effective, such services are relatively new in comparison to traditional (in-person) counseling, which has a much longer track record of positive outcomes. Distance counseling may not be appropriate for some clients and for the treatment of some mental health issues.

Scheduling and Cancellations. Appointments can be cancelled/rescheduled as long as 24 hours notice is provided. If less than the required notice is given, the client agrees to pay a fee of **$60.00** (insurance will not pay for missed appointments). Please note that we do need to enforce this policy.

Conflicts. We work hard to ensure that you have a positive experience. If you have a negative experience, please tell us and we will try and make it right. If a conflict occurs, it is agreed that any disputes shall be negotiated directly between the parties. If these negotiations are not satisfactory, then the parties agree to mediate any differences. Litigation shall be considered only if these methods are given a good faith effort.

Emergency Contacts. Your counselor will establish emergency contacts for you, such as a family member, a mobile phone, or work phone number. These contacts may be used if your counselor perceives a need. If you are in crisis and cannot reach your counselor, please go to your nearest emergency room or call 911.

Payment. Payment, including insurance co-pays, is due at the time of the service. Client gives the practice permission to charge his/her credit/debit card on file for any outstanding fees. *Clients understand they are fully responsible for all fees if insurance or other vendor does not pay for any reason.*

I have been provided a Notice of Privacy Practices, Patient Bill of Rights, and I have read and fully understand and agree to honor this agreement.

Client Signature _____ Date _____

Significant Other's Signature _____ Date _____
(if requesting Couple's Sessions)

Parent/Guardian Signature _____ Date _____
(if applicable)

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

I,_____,HEREBY AUTHORIZE THE RELEASE OF MY HEALTH INFORMATION AS LISTED BELOW:

Patient Name:_____ **Date of Birth:**_____

Address (street, city, state, zip):_____

Telephone: _____

Provider or facility authorized to release information: Theodoredis Counseling LLC dba Lehigh Valley Counselors

Address (street, city, state, zip) 2045 Westgate Drive, Suite 206, Bethlehem, PA 18017

Person or entity authorized to receive information: _____

Address (street, city, state, zip)_____

Dates of Service: ■ All ☐ Specific Dates of Services:_____

Description of Information: ☐ Entire Record ☐ Others:_____

Special Records: **Include the following medical records if such information is included in your records. Checking the boxes is not a representation that such information exists. (See waiver below).**

■ Include Drug and Alcohol Treatment Records (protected by the Pennsylvania Drug & Alcohol Abuse Control Act, 71 P.S. § 1690.108)

■ Include Mental Health Records (protected by the Mental Health Procedures Act, 50 P.S. § 7111)

☐ Include AIDS/HIV – Related Records (protected by Confidentiality of HIV-Related Information Act, 35 P.S. § 7607)

☐ All AIDS/HIV-Related Record ☐ Limited AIDS/HIV-Related as follows: _____

☐ Include Sexual Abuse/Assault and Domestic Violence Counseling Records (protected by 42 Pa.C.S.A. § 5945.1 and 23 Pa.C.S.A. § 6116, respectively)

Purpose of Release of Information: ☐ Transferring Medical Care ☐ Moving ■ Other Insurance, Medical,

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1. This authorization will expire: ■ Date:_____ ☐ Event:_____ ■ One year unless otherwise specified, this authorization will expire 1 year after the date of this request.
2. I understand that I may revoke this authorization at any time by notifying my provider or by notifying the provider or entity that is authorized to receive these records. I understand that revocation will not have any effect on actions taken prior to any revocation.
3. This authorization is voluntary.
4. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations. .
5. I understand that this information may be re-released by the recipient and no longer protected.
6. By signing below, I certify that I understand the nature of this Release.
7. I understand that the provider named above may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
8. If mental health records are being released as permitted by the Mental Health Protection Act, I understand that I have a right subject to 55 Pa. Code § 5100.33, to inspect the material to be released.
9. If AIDS or HIV-related information is being released, this information has been disclosed to you from records protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.
10. **By signing below, I authorize the release of the medical information requested and specifically waive the confidentiality protection afforded by Pennsylvania statutory law for the Special Records indicated above.**

    This waiver is applicable only to this request and is not meant to be a general waiver.

_____ _____

Signature of Patient or Patient's Representative/Guardian **Date**

_____ _____

Printed Name of Patient's Representative/Guardian **Relationship to the Patient**

Date Copied & Notified:_____

Credit Card Authorization Form

Client Name: _____

Cardholder Name: _____

Credit Card #: _____

Type of Card: _____ MasterCard _____ Visa _____ Discover _____ American Express

Expiration Date _____ 3 Digit Security Code _____

Billing Address for Card: _____

_____

City State Zip

Email Address: _____

Phone Number: _____

By signing this agreement you are authorizing Theodoredis Counseling, LLC (Lehigh Valley Counselors) to charge the above listed credit card for services rendered per the disclosure statement and/or office policies you and/or the client has signed. You confirm your understanding of the following:

- The card on file can be charged for services with verbal consent from the client.
- If your account carries a balance for greater than 10 business days, the card on file may be charged for the outstanding amount without giving prior notice.

Miscellaneous Fees:

- Declined Card Fee - $25.00
- No Show or late cancellation fee will be charged ***the day of*** the missed appointment ($60.00)
- Records Request and Documentation preparation - $50.00 per request

Court Related Fee Schedule:

- $300.00 per hour
- Minimum retainer of $1200.00 for a half day (4 hours) or $2400.00 for a full day (8 hours). Additional hours are billed to the credit card on file the same day services are rendered. Retainer is nonrefundable if the case is continued or dismissed within four business days. This policy also applies to an "on call" subpoena.
- Travel time and court preparation is billed at clinician's standard hourly rate ($130.00 - $175.00)

Signature of Patient _____ Date _____

Signature of Cardholder (if not patient) _____ Date _____

If you are not the cardholder of the credit card, you agree to take full responsibility for any charges made by Theodoredis Counseling, LLC to the card you have provided. You must inform the office if there are ANY changes to your credit card information. A billing summary/receipt can be requested at any time. A written statement with a signature is required in order to terminate this contract. It must be received 48 hours prior to termination.

WE DO NOT CARRY CLIENT BALANCES. ALL FEES ARE DUE AT THE TIME OF SERVICE.

Notice of Mental Health Services

Date of Notice: _____

Dear Dr. _____ (Primary Care Physician),

_____ (Practice Name)

_____ (Practice Phone)

We are currently working with your patient,_____, in outpatient mental health counseling. Some insurance carriers require that a client's primary care physician be notified of ancillary services. This letter is to inform you that your patient is receiving mental health services at our Bethlehem, PA outpatient office.

Our mailing address is: Lehigh Valley Counselors
2045 Westgate Drive, Suite 206
Bethlehem, PA 18017

Our phone number is: 610-596-4222

Our fax number is: 610-849-2026

Our email is: StephanieB@LVCounselors.com

Listed below are the signatures of the patient / guardian granting permission for this notification.

_____ _____
Printed Name/Signature of Patient or Guardian Date

_____ _____
Printed Name/Signature of Licensed Therapist Date

Date Sent to PCP: _____

Consent and Authorization to Leave Messages, Text, or Email

Lehigh Valley Counselors may need to contact you about appointments, referrals, or billing/insurance information. To protect your privacy and to follow state and federal guidelines, unless we have your written permission to do so:

- We will NOT leave messages or discuss treatment/account information with anyone except the patient or legal guardian.
- We will NOT leave messages containing treatment/account information on voicemail/answering machines, text, or email.

I give my permission for Lehigh Valley Counselors to leave phone messages, texts, or email regarding my treatment/account information. I fully understand that this consent will remain valid until revoked by me either verbally, in writing, or after one year past the date of my last appointment.

Client Name: _____ Date of Birth: _____

Signature: _____ Date: _____

May we contact you and leave a message about appointments, insurance, and/or billing details?

	Please write your number or email address below		**Please circle one**
Cell Phone		Voice	Yes or No
		Text	Yes or No
Home Phone		Voice Only	Yes or No
Email Address		Email Only	Yes or No

May we contact you with practice information and/or invitations to provide feedback?

☐ Yes	☐ Text Cell Phone ☐ Email	☐ No

May we leave a message with anyone else on your behalf? (Please list name and phone number)

- ☐ Spouse/Partner _____
- ☐ Parent/Guardian _____
- ☐ Adult Child _____
- ☐ Other _____

  Their relationship to you? _____