ADULT CLIENT INFORMATION QUESTIONAIRE

Your cooperation in completing this questionnaire will be helpful in planning my services for you. Please answer each item carefully. Ask me for clarification after I bring you into my office if you do not understand an item. I should be able to see you shortly after you finish this questionnaire. Thanks!

Adult's Full Name(s):_____ Date(s) of Birth: _____
_____ Today's Date: _____

Address:

_____

_____

Telephone Number(s) Home (___) ____-_____ Work (___) ____-_____
Mobile(___) ____-_____Other (___) ____-_____ Other (___) ____-_____
E-mail Addresses _____

Communication Methods: There are many routine methods of communication that are not completely secure, so confidentiality cannot always be assured. Please check off the ways that you give permission for Patrick Fogle, LPC or office staff to contact you:

____ Home Phone ____ Home Phone Message (Voicemail/Machine)
____ Work Phone ____ Work Phone Message (Voicemail/Machine)
____ Mobile Phone ____ Mobile Phone Message (Voicemail)
____ Email ____ Mobile Phone Text Message ____ Postal Mail

Information on the insured person & adults/children to be seen in therapy:

Name _____ Age ____ Male___ Female ___ Relationship to insured _____ DOB_____SSN#_____

Name _____ Age ____ Male___ Female ___ Relationship to insured _____ DOB_____SSN#_____

Name _____ Age ____ Male___ Female ___ Relationship to insured _____ DOB_____SSN#_____

Name _____ Age ____ Male___ Female ___ Relationship to insured _____ DOB_____SSN#_____

Information on persons living in the home not planning to participate in therapy:

Name _____ Age ____ Male___ Female ___ Relationship to insured _____

Name _____ Age ____ Male___ Female ___ Relationship to insured _____

Name _____ Age ____ Male___ Female ___ Relationship to insured _____

Name _____ Age ____ Male___ Female ___ Relationship to insured _____

Marital Status (circle one)

● Never Married ● Married ● Separated ● Divorced ● Remarried ● Widowed ● Other

Occupation: His: _____ Hers: _____

Gross Annual Income: His: _____ Hers: _____
(Optional – Necessary if seeking financial assistance)

Circle Highest Level of Education: (Please Indicate: *His and **Hers)

● Grade School ● Middle School ● High School ● GED ● Some College
● Bachelor's Degree ● Master's Degree ● Advanced Degree (Ph.D, M.D., etc.)

Religious Preference: His: _____ Hers: _____
Where do you attend if you attend church? _____

Describe reason for seeking help:

_____

_____

Who suggested you contact us?

● Yellow Page Advertisement ● Friend ● Physician (name) _____
● Minister (name) _____ ● Other _____

Have you ever consulted a professional counselor? ● YES ● NO

If yes, his / her name _____ When? _____

City/State and/or address if known

_____

Who is your physician? _____
Do I have your permission to contact your physician about your care to coordinate services? ● YES ● NO

Are you presently taking any prescription medications? ● YES ● NO
If yes, please list:

_____

_____

List any health problems for which you currently receive treatment:

_____

_____

Have you ever considered suicide? ● YES ● NO
If yes, when? _____
Have you ever attempted suicide? ● YES ● NO
If yes, when? _____

Circle any of the following which are presently causing you (or others involved in therapy) difficulty:

Assertiveness	Health problems	Career choices	Stomach pains
Parenting	Alcohol use	Legal matters	Self-conception
Bowels	Sexual problems	Marriage	Religion
Nightmares	Loneliness	Concentration	Separation
Bed-wetting	Ulcers	My thoughts	Suicidal thoughts
Nervousness	Energy	Sleep	Decision making
Children	Parents	Insomnia	Education
Divorce	Relaxation	Ambition	Asthma
Temper	Depression	Shyness	Stress
Inferiority	Friends	Dating	Memory
Drug use	Headaches	Tiredness	Finances
Appetite	School	Unhappiness	Fears
Work	Confusion	Premarital	Food
Self-control	Sadness	In-laws	My past
Guilt	Allergies	Abuse	Other _____ _____

Now put an * by the TWO circled items that are causing you the MOST difficulty. _____ _____

If never married, circle and skip this section: • Never Married

Please give your (and your spouse's) marital history:
(Do your best in the space provided or complete on back side of page)

1st Marriage: Date began _____ Ended _____ Name of spouse _____

1st Marriage Children and ages

_____

2nd Marriage: Date began _____ Ended _____ Name of spouse _____

2nd Marriage Children and ages

_____

__ Marriage: Date began _____ Ended _____ Name of spouse _____

__ Marriage Children and ages

_____

__ Marriage: Date began _____ Ended _____ Name of spouse _____

__ Marriage Children and ages

_____

Who has custody of the minor children living in your home? _____

Is your family or anyone in your family currently involved with any of the following agencies/institutions? If yes, please give name and explanation:

Department of Human Services	• YES • NO _____
Legal Aid	• YES • NO _____
Children's Home/Ranch	• YES • NO _____
Department of Corrections	• YES • NO _____
Probation or parole	• YES • NO _____
	(parole/probation officer's name) _____
West Texas Rehabilitation	• YES • NO _____
Attorney	• YES • NO _____
Other (please specify)	_____
	_____

Are you or anyone that will be seen in therapy facing a criminal case that has not yet been adjudicated? • YES • NO
If Yes, please describe: _____

Please provide any additional information that you feel may be useful to your therapy.

_____
_____
_____
_____
_____
_____

PRIMARY INSURANCE INFORMATION

INSURED NAME______________________________________INSURED DOB____________

RELATIONSHIP TO CLIENT____________________________SSN______________________

INSURANCE COMPANY____

GROUP/PLAN#_________________________ID#______________________________________

INSURANCE PHONE #______________________INSURED EMPLOYER_______________

INSURED ADDRESS___________________CITY_______________STATE_____ZIP______

INSURED PHONE____

DOES CLIENT HAVE SECONDARY INSURANCE COVERAGE? ● YES ● NO

Insurance Info: ____

ASSIGNMENT AND RELEASE

I hereby authorize my insurance benefits be paid directly to the provider of service. I understand I am financially responsible for non-covered services. I also give my permission for release of medical records information for the filing of my insurance.

____

CLIENT SIGNATURE DATE

- -

Verification for Office Use Only

Date Verified:________By:____________Spoke with:____________Proc.Codes for Cert:____________

Coverage:___________________Co-Pay__________________Deductible___________Met__________

Network or Non-Network Pre-Certification #__________________________________

Number of visits_________________________ Dates Covered_______________To_________________

Claims Mailing Address:____

____

____

Office Use Only

Client Name(s):_____ Date:_____

First Session Notes:

Treatment Goals

Assessment/Diagnostic Impressions

Plan

S. PATRICK FOGLE, LPC
FREEDOM COUNSELING
1219 E. South 11th, Suite A, Abilene, Texas 79602
325.669.0501

PROFESSIONAL DISCLOSURE STATEMENT

Qualifications: I am a Licensed Professional Counselor in the state of Texas. In my 23+ years in the mental health field, I have received numerous hours of training and experience in the treatment of a variety of issues, including mood disorders, psychotic disorders, crisis intervention, abuse issues, trauma debriefing, stress management, addiction intervention, marital problems and others. I have been trained in numerous techniques and styles for counseling intervention with individuals, groups, families, couples, parents, and children.

Experience: I have been in a counseling practice for the last 17 years. I have performed counseling services in private practice as well as within state mental health facilities, state juvenile and criminal justice facilities, public schools, and private psychiatric hospitals. I have been a mental health consultant in several trauma centers, psychiatric and general med-surg hospitals within the state of Texas.

Nature of Counseling: I approach counseling from an eclectic position. This basically means I will find and use the approaches which I feel will best help you with your situation. The foundation of all my work is based on my belief that Jesus Christ is Lord of everything and that trusting in His power is the key to success in all areas of life. I do not require that you believe as I do in order to continue therapy with me, but I respectfully request that you be open-minded in a search for truth as you enter counseling.

INFORMED CONSENT

Counseling Relationship: Normally I will spend approximately 45-50 minutes with an individual one time weekly, with changes made based on conditions and need. During this time, I hope we can establish a trusting and honest relationship to help foster your growth and health. I will do everything in my power to provide a safe, comfortable atmosphere for your sessions, using all my energy to focus on you and your concerns. I do ask that you come prepared to work during our sessions, giving yourself the best opportunity for help. Furthermore, I ask that discussions of your issues be limited to our sessions, where I can focus my energy on you. Public contact, social gatherings, etc. are really not an appropriate time for me to do productive work for and with you. We will both be better served if we save these conversations for our sessions.

Effects of Counseling: At any time, you may initiate a discussion of possible positive or negative effects of entering, continuing, or discontinuing counseling. I am open to hearing from you at any time about concerns you have related to my services or your issues. I will work to ensure that all efforts are directed towards helping you realize your desired outcome. Unfortunately, it is nearly impossible for any provider to make a guarantee of a specific outcome or a guarantee of the effectiveness of counseling, so I make no such guarantees.

Costs and reimbursements: A fee of $165 is charged per 50-minute hour counseling session, with the exception of the first session that usually requires a diagnostic evaluation, in which the total fee is $265.00. Fees are prorated based on this hourly fee. Many times, insurance will cover part or all of the fees, and I am in- network with many insurance providers. Please ask me about your insurance or payment options and plans upon arrival. Unless previous arrangements are made, payment is expected at the time of service. If these fees are not affordable for you, please inform me, and we will talk about options that can reduce your out of pocket expenses.

Emergency Contacts: On rare occasions, emergency contact is necessary due to the nature of ongoing problems. My primary office/emergency number is (325) 669-0501, and it is a local Abilene number. This is a mobile phone and I will answer it or return your call as soon as possible. Phone contact is billed at a $165/hour, pro-rated on 15-minute intervals. Insurance companies will often not reimburse for this service. Payment will be expected at the next scheduled appointment. You also have the option of calling the mental health crisis line, which is a service of the Betty Hardwick Center, at (800) 758-3344, and you should do so if you do not hear from me within 15 minutes after leaving an emergency message. In the case of a life-threatening crisis please call 911 or go to the nearest emergency room. Please also be aware that while I do use email and text messaging to communicate with clients when I have permission to do so, these should never be considered a reliable means of communication in an emergency situation.

Court Appearance: Although it is not a specialty of mine or a preference for me to do so, I can make arrangements on a case by case basis to offer testimony in court proceedings when necessary. Please be forthcoming if the purpose of you attending therapy is solely to "be assessed" in order for me to present my written opinion or findings, or to testify on your behalf in civil or criminal court proceedings. Unless receiving treatment for a certain issue is your primary reason for attending therapy, I am typically not able to take you case, and I will make every effort to refer you to a professional who can meet your needs. Any exception to this should be agreed upon before initiating therapy. I also understand that at times you may not be aware of the necessity of me making court appearance at the initiation of therapy, but you may find out later that one is required. This will be taken into consideration, so please communicate about these situations if they exist. The fee for court appearances is $275/hour, with a 5-hour minimum. There is also a fee for report preparation of $100 per half hour if a report is required for any reason. If travel is required, mileage charges will be added at the rate of $.60/mile plus a $75 per day per Diem. Minimum payment for this service is expected at least 1 week PRIOR to the scheduled date. I cannot guarantee refunds or credits in cases of date changes due to the major scheduling conflicts involved, but every effort will be made.

Cancellations: My schedule is typically fairly full, and sometimes clients are waiting for the next available opening. When I schedule an appointment for you, it is your hour. If you will not be able to attend a session, cancellation is expected at least 24 hours in advance. This will give me the opportunity to serve someone else in your scheduled slot if you cannot attend. Failure to cancel or missing an appointment without notice will result in a billed No Show, which is 2/3 the standard hourly fee. Insurance will not reimburse this charge.

Confidentiality: In order to ensure your privacy, I will release no information regarding your attendance, treatment, progress, or any other aspect of your counseling without your written consent. I cannot completely ensure confidentiality in our waiting room, or in family or group therapy. However, I will address any matters that arise due to one of these situations. There are particular exceptions to your right of complete confidentiality: situations that give me reason to believe there is a threat to your life or the life of another, including those relating to transmittable sexual diseases; involving the physical, sexual abuse, or neglect of a child; or by court order. Another exception to confidentiality would be in communication with your insurance provider. In order to secure payment, attendance, diagnosis, treatment plans, prognosis, and progress are commonly requested. Based on recent HIPAA legislation, you are entitled to review the information being released to your insurance provider and approve/deny its transfer. Please note that in cases where the insurance provider refuses compensation, you will be responsible for payment. At times, in order to make your therapy more productive, I will consult with peers/colleagues in the mental health field and include details of your case. Personal identifying information about you will be removed in peer consultation in order to protect your confidentiality.

Teletherapy & Electronic Communications: I do provide services via teletherapy (video call) when it is convenient or necessary and agreeable to the client. I also give clients the option of communication with me via electronic means such as email & text message. Please be aware that while every effort will be made to maintain HIPAA confidentiality while using teletherapy and other electronic means, it cannot be guaranteed with these modes of communication.

Records: All sessions become part of a clinical record. This record will not be released without your expressed written consent. Copy cost for records is $4.00 per page, payable upon receipt.

By your signature below, you are indicating that you read and understood the above statement, or that any questions you had about this statement were answered to your satisfaction. I grant permission to Patrick Fogle, LPC to administer services, such as assessments and treatment, as may be indicated necessary by him for the best interest and care of myself and my family.

My signature indicates that I have read and understand all the statements above:

Signature of Client	**Date**	**Counselor**
Signature of Representative/Guardian	**Relationship to Client**	**Reason Client Unable to Sign**