AGAPE Counseling Center

AGAPE COUNSELING CENTER
A ministry of
AGAPE CHILD AND FAMILY SERVICES, INC.

AGAPE Child and Family Services, Inc. is a Christian based organization with a strong commitment to providing quality, professional services that are guided by Christian values.

BENEFITS AND RISKS OF THERAPY:
Research has shown that therapy can help a wide variety of problems for children, adolescents, and adults. However, because therapy is a cooperative effort between client and therapist, participation in therapy does not guarantee problem resolution or that the client necessarily will feel better. As with any treatment, whether psychological or medical, therapy should be entered into with appropriate consideration of the potential benefits and risks. If you have any questions about what to expect from therapy, please ask your therapist.

CONFIDENTIALITY:
Records and information collected about clients will be held and released in accordance with state and federal laws governing confidentiality of client records and information. Disclosure of information regarding services provided to the client is generally released to another party only with the client's written permission. Exceptions to this rule include the following cases: 1) when there is imminent danger to the client or another person, 2) when child abuse or neglect is suspected, 3) when disclosure must be made to medical personnel in a medical emergency, and 4) when the therapist is compelled by law to disclose client records or information.

Client information and records are available to agency personnel for purposes of research, report, and quality assurance review. Clients who file insurance claims consent to review of records by an agent of the insurance company.

STAFF CREDENTIALS:
All counselors at the AGAPE Counseling Center possess Master's level or higher clinical degrees and competence in individual, group, marital, and family counseling. As a commitment to standards of excellence in the area of counseling, the AGAPE Counseling Center's counselors adhere to state statutes regulating their discipline and the standards of practice mandated by their professional and regulatory agencies.

CLIENTS WITH DISABILITIES:
It is the policy of the AGAPE Counseling Center and AGAPE Child & Family Services, Inc. to accommodate clients with disabilities, pursuant to federal and state law. Any client with a disability who needs accommodation should inform AGAPE Counseling Center staff prior to receiving services. Clients with disabilities are also encouraged to inform Linda Oxford, the Clinical Director, (901) 3233600, of their need for accommodation.

NONDISCRIMINATION POLICY:
Agape Counseling Center

In accordance with Title VI of the Civil Rights Act of 1964, the AGAPE Counseling Center and AGAPE Child & Family Services, Inc., do not discriminate against participants or clients on the basis of race, color or national origin. Services are offered to all eligible persons. If you believe that the AGAPE Counseling Center or AGAPE Child & Family Services, Inc., have discriminated against you, contact your Title VI Representative, Desiree Lyles-Wallace, at (901) 323-3600.

**FEE POLICY:**
The fee for counseling services provided through AGAPE Child & Family Services, Inc. is $120.00 per 50-minute session; however this fee is negotiated on a sliding scale based on your gross monthly income. Reimbursement benefits for counseling services may be available to you through your medical insurance policy. You are expected to pay for the initial evaluation and for any deductible expenses, co-payments, and uncovered charges at the time services are rendered. If you do not have insurance benefits or the ability to pay the standard fee, payment for services can be arranged based on your family's annual gross income. Payment may be made by cash, check or credit/debit card. There is a $35.00 fee for returned checks.

**PROFESSIONAL SERVICES:**

Regular office hours are from 8:30 a.m. until 5:00 p.m. Monday through Thursday, and from 8:30 a.m. until noon on Friday. Appointments outside these hours may be arranged by mutual agreement with your therapist following your first appointment.

**CONSENT FOR TREATMENT/RESPONSIBILITIES FOR CLIENTS**

I do hereby authorize and give my consent to AGAPE Child & Family Services, Inc. to provide treatment in accordance with the customary standards of practice specified by the state and federal laws, regulatory agencies, and professional disciplines governing the professionals on staff. AGAPE Child & Family Services, Inc. does not over-book appointments. Each appointment is a reservation of resources specifically for you. Applicable charges are made for appointments not canceled within 24 hours prior to the appointment. These charges are the client's responsibility and cannot be billed to insurance companies or other third party payers.

I have read, understand and agree to the conditions of treatment described in this document.

________________________________________  ______________________________________
Client Signature / Parent or Guardian                  Date

I agree to allow a representative AGAPE Child & Family Services, Inc., to contact me regarding my experience with counseling services I have received at this agency. The phone number where I can be reached for this purpose is ________________________________

________________________________________  ______________________________________
Client/Guardian Signature                  Date
Agape Counseling Center

AGAPE CHILD AND FAMILY SERVICES, INC.

CLIENT RIGHTS & RESPONSIBILITIES

You have a right to:

- Be treated with consideration and respect for your personal dignity, autonomy, and privacy;
- Fair and equitable treatment. You have the right not to be discriminated against in the provision of service on the basis of religion, race, color, creed, sex, national origin, age, lifestyle, physical or mental handicap.
- Receive professionally competent and ethical services;
- Confidentiality except in those areas regulated by State and Federal laws;
- Consent to or refuse any service, treatment, or therapy upon explanation of the expected consequences of such consent or refusal. A parent or legal guardian may consent to or refuse any service, treatment, or therapy of behalf of a client under 16 years of age;
- Active and informed participation in the establishment, periodic review, and reassessment of the treatment
- Request restrictions on certain uses and disclosures of your protected health information to which your therapist/case manager may or may not agree; but, if he or she does, such restrictions shall apply unless our agreement is changed in writing;
- Access your records as applicable state and federal guidelines and professional ethical codes allow;
- Know the cost of services;
- Exercise any and all rights without reprisal in any form including continued uncompromised access to services;
- Revoke your authorization of your protected health information except to the extent that action has already been taken;
- File a grievance if you feel that your rights have been violated.

You have a responsibility to:

- Provide relevant information as a basis for receiving services and participating in therapy decisions;
- Seek out medical care if so requested by your therapist;
- Communicate any changes in your circumstances or any other significant matters to your therapist;
- Work toward better understanding yourself and develop additional problem solving skills.

We reserve the right to change our privacy policies and practices as needed with these current designated practices being applicable unless you receive a revision of our policies when you come for a future appointment(s).

Client/Guardian Signature: ___________________________ Date: __________
AGAPE is complying with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 by informing clients of how we use and disclose personal health information (PHI).

What is PHI?
- Name
- Address
- Telephone Number
- E-mail Address
- Social Security Number
- Medical Information (including progress notes, discharge summaries, treatment plans, etc. Any documentation relating to your care)

CLIENT RECORDS OF DISCLOSURES
In general, the HIPAA privacy gives individuals the right to request a restriction on uses and disclosures of their personal health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means such as sending correspondence to the individual’s office instead of the individual’s home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone: ____________________________
- Okay to leave message with detailed information
- Leave message with call back number only

Work Telephone: ____________________________
- Okay to leave message with detailed information
- Leave message with call back number only

Written Communication ____________________________
- Okay to mail to my home address
- Okay to mail to my work office

Other: ____________________________

I, ____________________________ hereby acknowledge that I have been notified that my personal health information is protected under the new HIPAA regulations. I have been shown the posted notification and understand my rights as a client.

Patient/Guardian Signature ____________________________ Date ____________________________
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was signed into law on August 21, 1996. This law includes important new protections for millions of working Americans and their families who have preexisting medical conditions or might suffer discrimination in health coverage based on a factor that relates to an individual’s health. HIPAA’s provisions amend Title I of the Employee Retirement Income Security Act of 1974 (ERISA) as well as the Internal Revenue Code and Public Health Service Act and place requirements on employer-sponsored group health plans, insurance companies, and health maintenance organizations (HMOs).

Your Rights Under HIPAA

You have privacy rights under a federal law that protects your health information. These rights are important for you to know. You can exercise these rights, ask questions about them, and file a complaint if you think you rights are being denied or your health information isn’t being protected. You have privacy rights under a federal law that protects your health information. These rights are important for you to know. You can exercise these rights, ask questions about the, and file a complaint if you think your rights are being denied or your health information isn’t being protected.

Details of the HIPAA Privacy Rule

The new privacy regulations ensure a national floor of privacy protections for clients by: limiting the ways that health plans, pharmacies, hospitals, and other covered entities can use clients’ personal medical information.

How to File a Health Information Privacy Compliant

If you believe that a person, agency, or organization covered under the HIPAA Privacy Rule (“a covered entity”) violated your (or someone else’s) health information privacy rights or committed another violation of the Privacy Rule, you may file a complaint with the Office for Civil Rights (OCR). OCR has authority to receive and investigate complaints against covered entities related to the Privacy Rule. A covered entity is a health plan, health care clearinghouse, and any health care provider who conducts certain health care transactions electronically.
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Client Email/Texting Informed Consent Form

Risk of Using Email/Texting

The use of email and text message has a number of risks that clients should consider prior to the use of email and/or texting. These include but are not limited to the following:

- Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Senders can easily misaddress an email or text and send the information to an undesired recipient.
- Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
- AGAPE has a right to inspect emails send through their company systems.
- Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
- Emails and texts can be used as evidence in court.
- Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party. Email messages are sent over the Internet and are not encrypted, are not secure and may be read by others. Email communications with AGAPE will NOT be encrypted and, therefore, AGAPE can NOT guarantee the confidentiality and security of any information the client sends to or that AGAPE sends to the client via email. Text messages are even less secure than e-mail, and the same conditions apply.

Conditions for the Use of Email and Texts

AGAPE cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Clients/Legal Guardians must acknowledge and consent to the following conditions:

- **In a medical emergency, do no use email or text message, call 911.**
- If you have an urgent problem during regular business hours, please call your therapist or the main office at 901-323-3600.
- Emails should not be time-sensitive. AGAPE cannot guarantee that any email and/or text will be read and responded to within any particular period of time.
- Email and text messages may be filed electronically into your medical record.
- Clinical staff will not forward client’s/parent’s/legal guardian’s identifiable emails and/or texts without the client’s/parent’s/legal guardian’s written consent, expect as authorized by law.
- Clinical staff will limit text messages and emails to brief inquiries or responses regarding scheduling.
- Client should use their best judgment when considering the use of email or text messages for communication of sensitive medical information. Clinical staff are not responsible for the content of messages.
- AGAPE is not liable for breaches of confidentiality caused by the client or any third party.
Agape Counseling Center

- It is the client’s/parent’s/legal guardian’s responsibility to follow up and/or schedule an appointment if warranted.

Withdrawal of Consent

I understand that I may revoke this consent at any time by advising AGAPE in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.

Client Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between AGAPE staff and me, and consent to the conditions and instructions outlined, as well as any other instructions that AGAPE may impose to communicate with me by email or texts.

Client Name: __________________________________________

Client Signature: _______________________________________ Date: ___________

Parent/Legal Guardian Name: ______________________________

Parent/Legal Guardian Signature: ___________________________ Date: ___________
AGAPE COUNSELING CENTER

CLIENT INFORMATION FORM-PAGE 1

DEMOGRAPHIC INFORMATION:

NAME ___________________________ PARENT/GUARDIAN ___________________________ DATE ______

ADDRESS __________________________ CITY ______ STATE ______ ZIP ______

DATE OF BIRTH _______________ AGE ___________ SOCIAL SECURITY # _______________

HIGHEST SCHOOL GRADE OR DEGREE COMPLETED: CLIENT___________ SPOUSE__________

EMPLOYER __________________________ POSITION __________________________ HOW LONG? ______

HOME PHONE _______________ OKAY TO CALL? ( ) YES ( ) NO

WORK PHONE _______________ OKAY TO CALL? ( ) YES ( ) NO

CELL PHONE _______________ OKAY TO CALL? ( ) YES ( ) NO

E-MAIL ADDRESS __________________________ OKAY TO CONTACT? ( ) YES ( ) NO

MARITAL STATUS: SINGLE___ MARRIED___ WIDOWED___ SEPARATED___ DIVORCED___ COHABITING___

SPouse’S NAME: __________________________ DOB ______ AGE ______ SOCIAL SECURITY # ______

ADDRESS: __________________________ CITY: _______________ STATE: ______ ZIP ______

EMPLOYER __________________________ POSITION: __________________________ HOW LONG? ______

DAYTIME PHONE _______________ EVENING PHONE _______________ OKAY TO CALL? ______

OTHER HOUSEHOLD MEMBERS RELATIONSHIP DATE OF BIRTH AGE

1 __________________________ 1 __________________________ 1 ______ ( )

2 __________________________ 2 __________________________ 2 ______ ( )

3 __________________________ 3 __________________________ 3 ______ ( )

4 __________________________ 4 __________________________ 4 ______ ( )

HOW DID YOU LEARN ABOUT AGAPE’S COUNSELING PROGRAM? __________________________

RELIGIOUS PREFERENCE (OPTIONAL) __________________________ CHURCH MEMBERSHIP AT __________________________

EMERGENCY CONTACT NAME __________________________ DAYTIME PHONE __________________________

EVENING PHONE __________________________ ADDRESS __________________________
AGAPE COUNSELING CENTER

CLIENT INFORMATION FORM-PAGE 2

NAME ____________________________________________

PROBLEM INFORMATION:

FOR WHOM ARE YOU REQUESTING COUNSELING? ____________________________________________

BRIEFLY DESCRIBE THE NATURE OF THE PROBLEM:

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

DESCRIBE YOUR CURRENT LIVING SITUATION:

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

PLEASE IDENTIFY WHAT YOU WOULD LIKE TO ACCOMPLISH IN THERAPY:

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

HAVE YOU (OR THE PERSON WHO WILL BE RECEIVING COUNSELING) EVER RECEIVED OUTPATIENT TREATMENT FOR A MENTAL HEALTH ISSUE? ( ) YES ( ) NO

IF YES, FROM WHOM? ____________________________________________ WHEN?

HAVE YOU (OR THE PERSON WHO WILL BE RECEIVING COUNSELING) EVER RECEIVED INPATIENT TREATMENT FOR A MENTAL HEALTH ISSUE? ( ) YES ( ) NO

IF YES, FROM WHOM? ____________________________________________ WHEN?

ARE YOU CURRENTLY BEING TREATED BY A MENTAL HEALTH PROFESSIONAL? ( ) YES ( ) NO

NAME OF TREATING PROFESSIONAL ______________________________ PHONE # __________

MEDICATION PRESCRIBED IN PAST FOR MENTAL HEALTH ISSUE

_____________________________________________________________________________________

_____________________________________________________________________________________

CURRENT PRESCRIBED MEDICATIONS AND DOSAGES

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________
FINANCIAL INFORMATION:

THE STANDARD FEE IS $100 PER SESSION. PAYMENT IS DUE AT THE TIME OF THE VISIT.

IF YOU HAVE INSURANCE BENEFITS AND CHOOSE NOT TO USE THESE BENEFITS, YOU MUST PAY THE STANDARD RATE.

IF YOU DO NOT HAVE INSURANCE OR OTHER THIRD PARTY PAYMENT BENEFITS, YOU MAY BE ELIGIBLE FOR A FEE ADJUSTMENT BASED ON FINANCIAL NEED. YOUR FEE WILL BE ADJUSTED ON A SLIDING SCALE DETERMINED BY GROSS (NOT TAKE HOME) INCOME.

IF YOU WISH TO APPLY FOR A FEE ADJUSTMENT BASED ON OUR SLIDING SCALE, PLEASE PROVIDE THE FOLLOWING INFORMATION:

1. YOUR ANNUAL GROSS INCOME .................................................. $________
2. SPOUSE’S ANNUAL GROSS INCOME ........................................... $________
3. ANNUAL INCOME FROM OTHER SOURCES (investments, stocks, bonds, etc.) $________
   TOTAL $________

INSURANCE INFORMATION:

1. PRIMARY INSURANCE COMPANY ____________________________ POLICY #: ________________
   TELEPHONE # ___________________ INSURANCE PLAN NAME ________________
   NAME OF INSURED ____________________ INSURED’S DATE OF BIRTH ________________
   INSURED’S I.D. NUMBER ___________ INSURED’S EMPLOYER ________________
   ANNUAL DEDUCTIBLE AMOUNT $________ DEDUCTIBLE PAID THIS YEAR $________

2. NAME OF OTHER INSURANCE COVERAGE ____________________ POLICY #: ________________
   TELEPHONE # ___________________ INSURANCE PLAN NAME ________________
   NAME OF INSURED ____________________ INSURED’S DATE OF BIRTH ________________
   INSURED’S I.D. NUMBER ___________ INSURED’S EMPLOYER ________________
   ANNUAL DEDUCTIBLE AMOUNT $________ DEDUCTIBLE PAID THIS YEAR $________

INSURED OR AUTHORIZED PERSON’S SIGNATURE: I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS ON THE CLIENT’S BEHALF. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO AGAPE CHILD & FAMILY SERVICES, INC. FOR SERVICES RENDERED.

SIGNED: ________________________________ DATE: __________________________
**AGAPE COUNSELING CENTER**

**CLIENT INFORMATION FORM-PAGE 4**

**NAME ___________________________**

**DATE___________________________**

**MEDICAL INFORMATION:**

**WHICH OF THE FOLLOWING ILLNESSES OR COMPLAINTS HAVE YOU (THE CLIENT) EXPERIENCED?**

- Diabetes
- Head injury
- Ulcer
- Irregular menses
- High blood pressure
- Thyroid problems
- Glaucoma
- Difficulty sleeping
- Epilepsy
- Seizures
- Dizzy Spells
- Loss of appetite
- Liver problems
- Hepatitis
- PMS
- Herpes
- Kidney problems
- Asthma
- Back pain
- Syphilis or other
- Headaches/Migraines
- Respiratory problems
- Frequent constipation
- Venereal disease(s)
- Heart Attack
- Stroke
- Loss of consciousness
- Other ________

**WHAT PRESCRIPTION MEDICATIONS ARE YOU CURRENTLY TAKING AND WHY?**

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<th>MEDICATION</th>
<th>REASON FOR TAKING IT</th>
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**PLEASE IDENTIFY ANY ALLERGIES THAT YOU HAVE:**

1. ___________________________
2. ___________________________
3. ___________________________

**WHAT OVER THE COUNTER MEDICATIONS DO YOU TAKE ON A REGULAR BASIS?**

- Diet pills/aides
- Sleeping pills
- Vitamins
- Laxatives
- Sinus medicine
- Ibuprofen
- Cough medicine
- Aspirin
- Stomach medicine

Do you have a primary care physician (PCP)? ____Yes _____No
If yes, please provide your PCP’s name, address and phone number.

**Name:** ___________________________ **Phone Number:** ___________________________

**Address:** ___________________________ **City:** ___________ **State:** ___________ **Zip:** ___________

**When did you last see your doctor? Date:** ___________ **Reason:** ___________________________
Burns Depression Checklist

Name: _______________________________ Date: ______________

1. Sadness: Have you been feeling sad or down in the dumps?
   - 0-Not at all
   - 1-Somewhat
   - 2-Moderately
   - 3-A lot

2. Discouragement: Does the future look bleak or hopeless?
   - 0-Not at all
   - 1-Somewhat
   - 2-Moderately
   - 3-A lot

3. Low self-esteem: Do you feel worthless or think of yourself as a loser?
   - 0-Not at all
   - 1-Somewhat
   - 2-Moderately
   - 3-A lot

4. Inferiority: Do you feel inadequate or inferior to others?
   - 0-Not at all
   - 1-Somewhat
   - 2-Moderately
   - 3-A lot

5. Guilt: Do you get self-critical and blame yourself?
   - 0-Not at all
   - 1-Somewhat
   - 2-Moderately
   - 3-A lot

6. Indecisiveness: Is it hard to make decisions?
   - 0-Not at all
   - 1-Somewhat
   - 2-Moderately
   - 3-A lot

7. Irritability/frustration: Have you been feeling angry or resentful?
   - 0-Not at all
   - 1-Somewhat
   - 2-Moderately
   - 3-A lot

8. Loss of interest in life: Have you lost interest in your career, hobbies, family, or friends?
   - 0-Not at all
   - 1-Somewhat
   - 2-Moderately
   - 3-A lot
(Burns Depression Checklist Continued)

9. Loss of motivation: Do you feel overwhelmed and have to push yourself hard to do things?
   - 0 - Not at all
   - 1 - Somewhat
   - 2 - Moderately
   - 3 - A lot

10. Poor self-image: Do you think you’re looking old or unattractive?
    - 0 - Not at all
    - 1 - Somewhat
    - 2 - Moderately
    - 3 - A lot

11. Appetite changes: Have you lost your appetite or do you overeat compulsively?
    - 0 - Not at all
    - 1 - Somewhat
    - 2 - Moderately
    - 3 - A lot

12. Sleep changes: Is it hard to get a good night’s sleep or are you tired and sleeping too much?
    - 0 - Not at all
    - 1 - Somewhat
    - 2 - Moderately
    - 3 - A lot

13. Loss of libido: Have you lost your interest in sex?
    - 0 - Not at all
    - 1 - Somewhat
    - 2 - Moderately
    - 3 - A lot

14. Hypochondriasis: Do you worry a lot about your health?
    - 0 - Not at all
    - 1 - Somewhat
    - 2 - Moderately
    - 3 - A lot

15. Suicidal impulses: Do you think life is not worth living or think you’d be better off dead?**
    - 0 - Not at all
    - 1 - Somewhat
    - 2 - Moderately
    - 3 - A lot

Total Points out of 45: ______

** Anyone with suicidal urges should seek immediate help from a mental health professional.

Copyright 1984 by David D. Burns, MD (from The Feeling Good Handbook, Plume, 1990.)
NAME: ___________________________ DOB: _______ SSN: ___________________________

I, ____________________________________________, authorize
(Therapist/Facility) __________________________ to
RELEASE TO/OBTAIN FROM:
The/Therapist/Facility __________________________ Telephone: __________________________
Address: __________________________ City __________________________ State __________________________ Zip: __________________________

information on the above named client pertinent to the following purpose:

________________________________________________________________________

The specific information to be released is:

___ Intake/Discharge Summaries ___ Psychological Evaluation
___ Educational Records ___ Progress Notes/Treatment Plan
___ Medical History and Evaluation(s) ___ Developmental/Social History

For the period from __________________________ to __________________________

I understand that my records are legally protected under the Federal Confidentiality Regulations and cannot be disclosed without my written authorization except as specified in the regulations. I certify that this consent to release information has been made freely, voluntarily and without coercion and that the information provided above is accurate to the best of my knowledge. I understand that I may revoke this consent at any time, except to the extent that prior action has been taken to comply with it. Disclosure of my records by the recipient of this information may not be accomplished without my further written consent. I understand that this consent will automatically expire one (1) year from the date of signature unless I express written revocation at an earlier date.

CLIENT SIGNATURE: ___________________________ DATE: ___________________________

WITNESS: ___________________________ DATE: ___________________________

PARENT OR GUARDIAN: ___________________________ DATE: ___________________________