

# Allen Young, LPC

2070 Buford Hwy, Suite 1B • Buford, GA 30518

706.254.8443

## **Professional Disclosure Statement and Informed Consent for Treatment**

Thank you for choosing me as your therapist. This document describes my clinical and business practices in detail so that you will fully understand our professional relationship. I ask that you print and sign a copy of this disclosure statement and bring it with you to our first session. Signing this form constitutes your acceptance of the terms of this agreement including the fees and payment structure. I look forward to working with you.

### **Education and Experience:**

I am a licensed professional counselor (LPC) in the State of Georgia (license #2431). I hold a Master of Science degree from Georgia State University in Community Counseling, with a concentration in family counseling.

Prior to becoming an LPC, I worked in hospital, community, and correctional mental health settings. Since my licensure in 1996, I have continued to work in community and correctional mental health along with a five year period of clinical and supervisory work for a managed care company.

### **Clinical Approach:**

My clinical style is collaborative, solution-focused and practical. My goal is to help my clients to recognize and build on their strengths in order to make significant changes in their lives. While we all have some experiences in common, we are ultimately unique in how we deal with life's problems and challenges. I tailor my treatment to the needs of the individual and provide a safe environment where the client can share his or her experience. In marital and family therapy, I do not keep secrets. If you give me information about a spouse or family member during a break or between sessions, I reserve the privilege of asking you to address this information in-session or of addressing it myself. I will not share information that I believe will result in physical danger to a client, however.

Therapy is a useful and helpful process, for most people. I know that therapy is most successful when the client is a full participant in therapy with an active desire to reach their goals. However, there is no guarantee that therapy will be successful or helpful, despite the best efforts of the client and therapist. Also, it is important to be aware that symptoms may worsen before they begin to improve. Moreover, changes that you make in therapy may not be appreciated by others with whom you are in professional or personal relationships. At times, this can be an added source of stress that needs to be addressed in session. These are natural aspects of the therapeutic process, and the vast majority of clients transition successfully.

### **The Therapeutic Relationship:**

Therapists and their clients enter into a helping relationship similar to that between a minister and members of his congregation or a physician and her patients. While this is most often a positive and supportive relationship, it is not a friendship. Friendship develops naturally out of mutual interests, beliefs and activities. I care for each of the people I work with and want to see them reach their goals but it is unethical for me to engage in personal activities with my clients such as going to the movies, visiting each other at home, receiving or exchanging gifts or exchanging e-mails and phone calls or a non-clinical nature. Keeping these boundaries clear enables me to maintain my focus on helping my clients, which sometimes requires expressing a point of view or asking very detailed questions that might be inappropriate in a friendship.

**Social Media:**

Facebook, LinkedIn, online dating sites and similar social media sites can be effective ways to meet new people and to stay in contact with family, friends, and colleagues. Like most of my clients, I am active on various social media sites, at times. However, I take great care to keep my personal and clinical relationships separate, including contacts on social media. If you send me a request to connect in any way on social media, be it personal or professional, I will decline. Again, this is not to be unkind but to protect client confidentiality and honor the unique counselor/client relationship I have with the people I serve.

**Faith Issues:**

I have found that concerns about religious faith and practice are often integral to the issues discussed in therapy. As a practicing Christian, I have experienced many of the joys and trials of the life of faith and I enjoy discussing them. I do not present myself as a "Christian Counselor" because I want anyone to feel comfortable working with me on any issue, whether or not they share my beliefs. Still, my understanding of the innate value of each person and my moral compass are grounded in my Christian faith. I am careful not to impose my religious beliefs, but I am very comfortable with discussing issues of faith and religious practice independently or as they relate to broader concerns.

**Fees and Payment:**

My standard fees for service are as follows:

1. \$150 for initial visit for 50 minutes of individual, couples, or family therapy
2. \$125 for 50 minutes of individual, couples, or family therapy
3. \$63 for 30 minutes of individual, couples, or family therapy
4. \$63 per half hour for written reports
5. \$63 per half hour for telephone calls exceeding 10 minutes

**There is a \$50 charge for missed appointments without 24 hours prior notice.**

Payment of fees is expected prior to service and may be paid with cash or check. Most of my work is done on a fee-for-service basis. However, I am currently a network provider for the following insurance plans:

- **Aetna**
- **Anthem BC/BS of GA**
- **Assurant**
- **Beacon Health Options**
- **Humana and HumanaX**
- **PHCS Multiplan**
- **United Health Care**

I am also on the employee assistance panels for **Anthem, Beacon Health Options, Ceridian, CorpCare, EAP Consultants, Inc., FEI, Inc., Military Onesource (MOS), Ulliance and Value Options**. If you have out-of-network benefits and wish to use them, I will provide a detailed receipt at the end of each session that you may submit to your insurance company reimbursement.

Before beginning therapy, it is important to contact your behavioral health provider to find out the following information:

1. Does your plan include out-of-network benefits?
2. Is there a limit on the number of sessions available?
3. Is preauthorization required?
4. How much does your plan reimburse per session for an LPC?

Please note that use of benefits will require a mental health diagnosis. Let me know if you do not plan to submit your receipt for insurance reimbursement, and I will not provide a diagnosis. For those who are experiencing genuine financial hardship, I have a limited number of reduced-fee slots available. The fee will be based on percentage of the federal poverty level guidelines.

**Court Appearances/Subpoenas:**

Allen Young, LPC will not appear in court or provide written statements on behalf of clients. For counseling to be effective, it must be practiced in an atmosphere of honesty and openness. When there is threat of court action (subpoenas and/or summons for separation, divorce, custody, legal actions, disability claims, etc.) the therapeutic relationship is compromised. By signing this statement, you are agreeing not to subpoena or to use Allen Young, LPC in any current and/or future court litigations or actions. If a client files a complaint or lawsuit against me, relevant information regarding the client may be disclosed as part of my legal defense. In the event that event that Allen Young, LPC is required to become involved in a legal case, there is a charge of \$500 per hour for court appearances and depositions. This payment will be billed to the client or legal counsel as appropriate. Any balances left unpaid will automatically forfeit further interaction of a therapeutic nature.

**Ethics, Confidentiality and Limitations:**

As a licensed professional counselor in Georgia, I am bound by the code of ethics as established by the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists. If you wish to file a complaint for ethical or professional reasons, please contact the Composite Board at (478)207-2440 or <http://www.sos.georgia.gov/plb/counselor/> The information provided to me by my clients is confidential and is shared only with the express, written consent of the client or their legal guardian. The only exceptions to this rule are as follows: 1) a client presents an imminent danger to himself or others 2) discovery is made of the neglect, physical or sexual abuse of children or the elderly 3) a court order is issued for client records

**Record Keeping and Storage:**

I keep notes of each session that we have together. In addition, I keep a copy of our e-mail contacts as part of the clinical record. After placing these in your record, I erase them from my e-mail. All records are kept under lock and key and no other persons are allowed access to these records. You do have the right to review your records unless I have reason to believe that parts of your record may negatively affect your clinical status. If this is the case, I may choose to withhold this part of your record. At your request, I will make copies of your records for a per page fee.

**Signature of Agreement:**

I (print name), \_\_\_\_\_, have read, or have had read to me, the information in the previous paragraphs. I understand and agree to the terms of the professional counseling relationship as detailed above. I accept the rates listed in the foregoing document and agree to pay fees in full prior to the beginning of each session.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Allen Young, LPC \*

\_\_\_\_\_  
Date

***\*My signature attests to the fact that I have discussed this document with the above-named client.***

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## Client Insurance and Billing Information Form

(Revised March 2010)

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Client Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### Primary Cardholders Insurance Information *(if different from client):*

Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name of Insured's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Relationship to Client:      Self      Spouse      Parent      Other: \_\_\_\_\_

Insurance Name: \_\_\_\_\_ Policy/ID #: \_\_\_\_\_

Group #: \_\_\_\_\_ Mental Health/Provider Phone #: \_\_\_\_\_

Authorization #: \_\_\_\_\_

### Note:

- o Insurance companies often require pre-authorization. It is your responsibility to obtain, track and provide the authorization number as well as speaking with your insurance company about any deductible, co-pays, or other benefits. Please provide us with this information and a copy of your insurance card upon your first visit.
- o I have read and understand the section about "Structure and Cost of Sessions". I understand that my insurance is being filed, however, if a claim is not paid or denied, the balance is my responsibility.
- o I have read and understand my rights under HIPAA. I authorize Allen Young, LPC to provide information to my insurance in order to properly bill claims.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Legal Guardian Signature (if applicable)

\_\_\_\_\_  
Date

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## Appointment and Cancellation Policy

Dear Client:

Welcome! My goal is to help in your path to wellness. As I sometimes have clients waiting for appointments, please be considerate of others when you are cancelling your appointment and allow at least 24-hours notice so that we may offer that time to those who may be waiting. I reserve the right to charge a \$50.00 administrative fee for cancelling with less than 24-hour notice or not showing up at all.

Your signature below shows your agreement to pay the \$50.00 fee for not showing up or cancelling with less than 24-hours notice.

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Client Signature

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Date

My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information.

---

Therapist's Signature

---

Date

**Allen Young, LPC**  
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Health Insurance Portability and Accountability Act (HIPAA)  
Notice Of Privacy Practices

*Effective 4/14/03*

**I. COMMITMENT TO YOUR PRIVACY:** Allen Young, LPC is dedicated to maintaining the privacy of your protected health information (PHI). PHI is information that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. This Notice of Privacy Practices (“Notice”) is required by law to provide you with the legal duties and the privacy practices that Allen Young, LPC maintains concerning your PHI. It also describes how medical and mental health information may be used and disclosed, as well as your rights regarding your PHI. Please read carefully and discuss any questions or concerns with your therapist.

**II. LEGAL DUTY TO SAFEGUARD YOUR PHI:** By federal and state law, Allen Young, LPC is required to ensure that your PHI is kept private. This Notice explains when, why, and how Allen Young, LPC would use and/or disclose your PHI. Use of PHI means when Allen Young, LPC shares, applies, utilizes, examines, or analyzes information within its practice; PHI is disclosed when Allen Young, LPC releases, transfers, gives, or otherwise reveals it to a third party outside of the Institute. With some exceptions, Allen Young, LPC may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, Allen Young, LPC is always legally required to follow the privacy practices described in this Notice.

**III. CHANGES TO THIS NOTICE:** The terms of this notice apply to all records containing your PHI that are created or retained by Allen Young, LPC. Please note that Allen Young, LPC reserves the right to revise or amend this Notice of Privacy Practices. Any revision or amendment will be effective for all of your records that Allen Young, LPC has created or maintained in the past and for any of your records that Allen Young, LPC may create or maintain in the future. Allen Young, LPC will have a copy of the current Notice in the office in a visible location at all times, and you may request a copy of the most current Notice at any time. The date of the latest revision will always be listed at the end of Allen Young, LPC’s Notice of Privacy Practices.

**IV. HOW Allen Young, LPC MAY USE AND DISCLOSE YOUR PHI:** Allen Young, LPC will not use or disclose your PHI without your written authorization, except as described in this Notice or as described in the “Information, Authorization and Consent to Treatment” document. Below you will find the different categories of possible uses and disclosures with some examples.

**1. For Treatment:** Allen Young, LPC may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If you are also seeing a psychiatrist for medication management, Allen Young, LPC may disclose your PHI to her/him in order to coordinate your care. Except for in an emergency, Allen Young, LPC will always ask for your authorization in writing prior to any such consultation.

**2. For Health Care Operations:** Allen Young, LPC may disclose your PHI to facilitate the efficient and correct operation of its practice. Example: Quality control - Allen Young, LPC may provide your PHI to its office personnel, accountants, practice consultants, attorneys and others to make sure that Allen Young, LPC is in compliance with applicable practices and laws. It is Allen Young, LPC’s practice to conceal all client names in such an event and maintain confidentiality. However, there is still a possibility that your PHI may be audited for such purposes.

**3. To Obtain Payment for Treatment:** Allen Young, LPC may use and disclose your PHI to bill and collect payment for the treatment and services Allen Young, LPC provided you. Example: Allen Young, LPC might send your PHI to your insurance company or managed health care plan, in order to get payment for the health care services that have been provided to you. Allen Young, LPC could also provide your PHI to billing companies, claims processing companies, and others that process health care claims for Allen Young, LPC’s office if either you or your insurance carrier are not able to stay current with your account. In this latter instance, Allen Young, LPC will always do its best to reconcile this with you first prior to involving any outside agency.

**4. Employees and Business Associates:** There may be instances where services are provided to Allen Young, LPC by an employee or through contracts with third-party “business associates.” Whenever an employee or business associate arrangement involves the use or disclosure of your PHI, Allen Young, LPC will have a written contract that requires the employee or business associate to maintain the same high standards of safeguarding your privacy that is required of Allen Young, LPC. Note: Georgia and Federal law provides additional protection for certain types of health information, including alcohol or drug abuse, mental health and AIDS/HIV, and may limit whether and how Allen Young, LPC may disclose information about you to others.

**V. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES – Allen Young, LPC may use and/or disclose your PHI without your consent or authorization for the following reasons:**

**1. Law Enforcement:** Subject to certain conditions, Allen Young, LPC may disclose your PHI when required by federal, state, or local law; judicial, board, or administrative proceedings; or, law enforcement. Example: Allen Young, LPC may make a disclosure to the appropriate officials when a law requires Allen Young, LPC to report information to government agencies, law enforcement personnel and/or in an administrative proceeding.

**2. Lawsuits and Disputes:** Allen Young, LPC may disclose information about you to respond to a court or administrative order or a search warrant. Allen Young, LPC may also disclose information if an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena duces tectum (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel. Allen Young, LPC will only do this if efforts have been made to tell you about the request and you have been provided an opportunity to object or to obtain an appropriate court order protecting the information requested.

**3. Public Health Risks:** Allen Young, LPC may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, disability, to report births and deaths, and to notify persons who may have been exposed to a disease or at risk for getting or spreading a disease or condition.

**4. Food and Drug Administration (FDA):** Allen Young, LPC may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

**5. Serious Threat to Health or Safety:** Allen Young, LPC may disclose your PHI if you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if Allen Young, LPC determines in good faith that disclosure is necessary to prevent the threatened danger. Under these circumstances, Allen Young, LPC may provide PHI to law enforcement personnel or other persons able to prevent or mitigate such a serious threat to the health or safety of a person or the public.

**6. Minors:** If you are a minor (under 18 years of age), Allen Young, LPC may be compelled to release certain types of information to your parents or guardian in accordance with applicable law.

**7. Abuse and Neglect:** Allen Young, LPC may disclose PHI if mandated by Georgia child, elder, or dependent adult abuse and neglect reporting laws. Example: If Allen Young, LPC has a reasonable suspicion of child abuse or neglect, Allen Young, LPC will report this to the Georgia Department of Child and Family Services.

**8. Coroners, Medical Examiners, and Funeral Directors:** Allen Young, LPC may release PHI about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person, determine the cause of death or other duties as authorized by law. Allen Young, LPC may also disclose PHI to funeral directors, consistent with applicable law, to carry out their duties.

**9. Communications with Family, Friends, or Others:** Allen Young, LPC may release your PHI to the person you named in your Durable Power of Attorney for Health Care (if you have one), to a friend or family member who is your personal representative (i.e., empowered under state or other law to make health-related decisions for you), or any other person you identify, relevant to that person's involvement in your care or payment related to your care. In addition, Allen Young, LPC may disclose your PHI to an entity assisting in disaster relief efforts so that your family can be notified about your condition.

**10. Military and Veterans:** If you are a member of the armed forces, Allen Young, LPC may release PHI about you as required by military command authorities. Allen Young, LPC may also release PHI about foreign military personnel to the appropriate military authority.

**11. National Security, Protective Services for the President, and Intelligence Activities:** Allen Young, LPC may release PHI about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, to conduct special investigations for intelligence, counterintelligence, and other national activities authorized by law

**12. Correctional Institutions:** If you are or become an inmate of a correctional institution, Allen Young, LPC may disclose PHI to the institution or its agents when necessary for your health or the health and safety of others.

**13. For Research Purposes:** In certain limited circumstances, Allen Young, LPC may use information you have provided for medical/psychological research, but only with your written authorization. The only circumstance where written authorization would not be required would be if the information you have provided could be completely disguised in such a manner that you could not be identified, directly or through any identifiers linked to you. The research would also need to be approved by an institutional review board that has examined the research proposal and ascertained that the established protocols have been met to ensure the privacy of your information.

**14. For Workers' Compensation Purposes:** Allen Young, LPC may provide PHI in order to comply with Workers' Compensation or similar programs established by law.

**15. Appointment Reminders:** Allen Young, LPC is permitted to contact you, without your prior authorization, to provide appointment reminders or information about alternative or other health-related benefits and services that you may need or that may be of interest to you.

**16. Health Oversight Activities:** Allen Young, LPC may disclose health information to a health oversight agency for activities such as audits, investigations, inspections, or licensure of facilities. These activities are necessary for the government to monitor the health care system, government programs and compliance with laws. Example: When compelled by U.S. Secretary of Health and Human Services to investigate or assess Allen Young, LPC's compliance with HIPAA regulations.

**17. If Disclosure is otherwise specifically required by Law.**

**VI. Other Uses and Disclosures Require Your Prior Written Authorization:** In any other situation not covered by this notice, Allen Young, LPC will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying Allen Young, LPC in writing of your decision. You understand that Allen Young, LPC is unable to take back any disclosures it has already made with your permission, Allen Young, LPC will continue to comply with laws that require certain disclosures, and Allen Young, LPC is required to retain records of the care that its therapists have provided to you.



## **VII. RIGHTS YOU HAVE REGARDING YOUR PHI:**

**1. The Right to See and Get Copies of Your PHI:** In general, you have the right to see your PHI that is in Allen Young, LPC's possession, or to get copies of it; however, you must request it in writing. If Allen Young, LPC does not have your PHI, but knows who does, you will be advised how you can get it. You will receive a response from Allen Young, LPC within 30 days of receiving your written request. Under certain circumstances, Allen Young, LPC may feel it must deny your request, but if it does, Allen Young, LPC will give you, in writing, the reasons for the denial. Allen Young, LPC will also explain your right to have its denial reviewed. If you ask for copies of your PHI, you will be charged not more than \$.25 per page and the fees associated with supplies and postage. Allen Young, LPC may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

**2. The Right to Request Limits on Uses and Disclosures of Your PHI:** You have the right to ask that Allen Young, LPC limit how it uses and discloses your PHI. While Allen Young, LPC will consider your request, it is not legally bound to agree. If Allen Young, LPC does agree to your request, it will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that Allen Young, LPC is legally required or permitted to make.

**3. The Right to Choose How Allen Young, LPC Sends Your PHI to You:** It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). Allen Young, LPC is obliged to agree to your request providing that it can give you the PHI, in the format you requested, without undue inconvenience.

**4. The Right to Get a List of the Disclosures.** You are entitled to a list of disclosures of your PHI that Allen Young, LPC has made. The list will not include uses or disclosures to which you have specifically authorized (i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, or to corrections or law enforcement personnel. The request must be in writing and state the time period desired for the accounting, which must be less than a 6-year period and starting after April 14, 2003. Allen Young, LPC will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list will include the date of the disclosure, the recipient of the disclosure (including address, if known), a description of the information disclosed, and the reason for the disclosure. Allen Young, LPC will provide the list to you at no cost, unless you make more than one request in the same year, in which case it will charge you a reasonable sum based on a set fee for each additional request.

**5. The Right to Amend Your PHI:** If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that Allen Young, LPC correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of Allen Young, LPC's receipt of your request. Allen Young, LPC may deny your request, in writing, if it finds that the PHI is: (a) correct and complete, (b) forbidden to be disclosed, (c) not part of its records, or (d) written by someone other than Allen Young, LPC denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and Allen Young, LPC's denial will be attached to any future disclosures of your PHI. If Allen Young, LPC approves your request, it will make the change(s) to your PHI. Additionally, Allen Young, LPC will tell you that the changes have been made and will advise all others who need to know about the change(s) to your PHI.

**6. The Right to Get This Notice by Email:** You have the right to get this notice by email. You have the right to request a paper copy of it as well.

**7. Submit all Written Requests:** Submit to Allen Young, LPC's Director and Privacy Officer, at the address listed on top of page one of this document.

**VIII. COMPLAINTS:** If you are concerned your privacy rights may have been violated, or if you object to a decision Allen Young, LPC made about access to your PHI, you are entitled to file a complaint. You may also send a written complaint to the Secretary of the Department of Health and Human Services Office of Civil Rights. Allen Young, LPC will provide you with the address. Under no circumstances will you be penalized or retaliated against for filing a complaint. Please discuss any questions or concerns with your therapist. Your signature below indicates that you Acknowledge receipt of this Notice:

\_\_\_\_\_  
Client Name (Please Print) \_\_\_\_\_  
Date

\_\_\_\_\_  
Client Signature

If Applicable:

\_\_\_\_\_  
Parent's or Legal Guardian's Name (Please Print) \_\_\_\_\_  
Date

\_\_\_\_\_  
Parent's or Legal Guardian's Signature

**Allen Young, LPC**

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706.254.8443

**CLIENT INFORMATION**

COMPLETION OF THIS FORM IS VOLUNTARY. YOU MAY OMIT ANY PARTS YOU WISH.

PLEASE PRINT OR WRITE LEGIBLY

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Work Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

How would you prefer that I contact you? \_\_\_\_\_

Age and date of birth: \_\_\_\_\_

Occupation: \_\_\_\_\_

Relationship Status:    Married            Single    Divorced            Separated            Widowed            Dating

Briefly describe your level of satisfaction with your current relationship: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Important information about your spouse, girlfriend/boyfriend: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list names, ages and other pertinent information of family members:

Mother:

Father:

Sisters:

Brothers:

Children:

Any other important family members:

How did you hear about me? \_\_\_\_\_

If a specific person referral you, who was it? \_\_\_\_\_

May I send this person a thank you note for the referral?            Yes    No

Briefly describe what brings you to counseling: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you seen a counselor before?            Yes    No

What was the issue you sought help for? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What medical problems, if any, are you currently being treated for?

\_\_\_\_\_

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Please list medications that you are currently taking and what you are taking them for:

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Name of prescribing physician: \_\_\_\_\_

Name of family physician: \_\_\_\_\_

Have you ever been hospitalized for a mental health reason?                      Yes      No

If yes, please describe when and for what reason:

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Please indicate who should be contacted in case of an emergency (names and phone numbers):

*NOTE: Completion of the following section indicates permission to contact these people should an emergency (as determined by the therapist) arise. If you choose not to complete this section, should an emergency arise, I will contact 911.*

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I, \_\_\_\_\_, give my permission to Allen Young, LPC, to release information, only as requested by the insurance company and its representatives, to my insurance company and its representatives. If I have asked him to prepare a “superbill” for the purpose of my attempt to have my insurance company reimburse me and I have submitted this “superbill”, I realize that my insurance company may contact him with a need for additional information in order to process my claim. My signature below indicates he has my permission to speak with my insurance company and its representatives about issues/questions related to my claim. I agree to no expiration date regarding this permission.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date