Please complete this form and give it to your counselor.

Name_________________________________________Date_____________________________________

Reason for seeking services:________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

The following is a symptom checklist. Please check any and all that apply.

 Changes in sleep pattern
 Changes in eating pattern
 Sexual problems
 Performance at work
 Satisfaction in primary relationships
 Coping with recent losses
 Difficulty with daily routine
 Letting others take advantage of you
 Hyperactivity
 Repeating certain acts
 Using alcohol to cope
 Using drugs to cope
 Worrying about your health
 Depression or sadness
 Euphoria or feeling high
 Confusion
 Feeling angry or hostile
 Anxiety or nervousness
 Lack of energy
 Sudden changes in mood
 Difficulty concentrating
 Feeling guilty
 Thoughts of hurting others
 Thoughts of hurting self
 Feeling worthless
 Withdrawal from others
 Memory problems
 Functioning at home
Client Agreement and Consent Form

Client Information: PLEASE PRINT

First Name: ___________________________________________ Last Name: ___________________________________________

DOB: __________________________ Gender: __________________________ Marital Status: __________________________

Address: ___________________________________________ City: __________________________ State: __________ Zip: __________

Phone Number 1: ___________________________________________ (circle one) Home  Cell (Phone & Text)  Work

Phone Number 2: ___________________________________________ (circle one) Home  Cell (Phone & Text)  Work

Please read the following carefully and initial/sign where indicated.

Check one: I authorize appointment and payment communications via:  ☐ Phone # 1  ☐ Phone # 2

Email Address: _____________________________________________________________________________________

I authorize LIPC to communicate appointment and payment information via above email address. ___________Initial

Parent(s)/Guardian if client is under 18 years old: __________________________________________

Emergency Contact Name: __________________________ Relation: __________ Phone Number: __________

Your Employer: __________________________________________

Primary Care Physician: __________________________ Phone#: __________________________

Psychiatrist (if seeing one): __________________________ Phone#: __________________________

How did you hear about us?: __________________________________________

Thank you for selecting Life in Progress Counseling, LLC (LIPC). This document is designed to ensure that you understand our professional relationship. If at any time or for any reason you are dissatisfied with our services, please inform me so that your concerns can be addressed.

All therapists at LIPC are licensed, professionally trained and experienced. The relationship with your therapist is a professional one. The contents of treatment are confidential with the following exceptions: a) your authorized disclosure to another party; b) if you are a danger to yourself or others; c) a judge’s order to disclose information; or d) mandated child abuse reporting. As mandated reporters, we are required to report if a child is or has been abused, even if we do not see the child in a professional capacity. We are also mandated to report disclosure by a client admitting to abusing a child, even if that child is no longer in danger. By signing this form, you consent to have your therapist consult with LIPC clinical staff if the clinical need arises and you also acknowledge that LIPC support staff has access to all files. If you are referred to another professional within this practice, the clinical staff will consult regarding your case.

Our mission is to help you feel better and manage your life more effectively. With your written consent, we will share treatment information with other healthcare providers who are also treating you. We will NOT provide any information regarding your treatment to non-healthcare professionals who seek your treatment information for non-treatment purposes. This means, for example, that we will not release information for the purpose of any legal proceeding, child custody determination, disability, etc. Although we do not involve ourselves in legal proceedings, if court ordered we will do so as an expert witness and bill you directly for such services.
Emergencies: In case of emergency and/or you fear you may harm yourself or another, call 911, go to the nearest emergency room or call your local crisis center. Crisis centers by county:

Chester- 877-918-2100  
Montgomery- 855-634-4673  
Delaware- 855-889-7827  
Lancaster- 717-394-2631  
Philadelphia- 215-686-4420

Electronic Communication: Should you choose to communicate with your treating professional or our administrative support staff via text or email, please understand that such communications are not HIPAA compliant (and therefore not ultimately secure). Therefore, we recommend that if you choose to communicate with your clinician via these methods, please limit the communication to scheduling and do not share treatment-related information. You may discuss this further with your therapist.

Practice Policies: LIPC recommends a Credit Card on File (CCOF) to receive services from our providers. Our CCOF Policy allows LIPC to easily process time of service payments, deductibles (if applicable) and coinsurance amounts which may remain as your out of pocket expenses after your insurance company reimburses LIPC for services provided, as well as other service fees related to late cancellations, missed appointments and emergency medication refills. Our CCOF Policy, Financial Procedures and Payment Policy and Appointment Cancellation Policy are available for your review at your request. By signing below, you acknowledge that you have been made aware of these policies and agree to the information contained in these policies.

Assignment and Release: I, the undersigned, agree to assign directly to LIPC, all insurance benefits, if any, otherwise payable to me or insurance policy holder for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that if I don't pay at the time of service, my CCOF will be billed for my portion of the fee. I hereby authorize LIPC to release all information necessary to secure the payment of benefits, including relevant clinical information pertaining to the services provided, which may include any or all of the following: diagnosis, treatment plans, summaries of treatment, or copies of the clinical chart. I authorize the use of my signature on all my insurance submissions. If I am not the insurance policy holder, I agree to allow LIPC to release whatever billing information is necessary for payment to be made to LIPC.

Only if under age 14, please indicate with whom we can discuss information concerning the scheduling of your appointments at LIPC:

____________________________________________________________________________________________

I have read and understand the information outlined above as well as the Policies and Practices to Protect the Privacy of your Health and the Member’s Rights and Responsibilities Statement (copies may be requested).

____________________________________________    ______________  
Client Signature (age 14 and above)       Date

____________________________________________    ______________  
Parent /Guardian signature if client is under 18      Date

Revised 5/15/18
Credit Card on File (CCOF) Policy
Effective: January 1, 2018

Life in Progress Counseling will implement a policy requiring all clients to provide a credit card on file, effective January 1, 2018. As you may be aware the current healthcare market has resulted in insurance policies increasingly transferring costs to you, the insured. Some insurance plans require high deductibles and copayments in amounts not known to you or us at the time of your visit.

Similar to many other businesses, including healthcare practices, you are required to provide your credit card number at the time of making a reservation or an appointment. In some cases, companies will apply late cancellation fees should your reservation or appointment be cancelled outside of a specified timeframe. Our CCOF Policy allows Life in Progress Counseling to easily process time of service payments, deductibles (if applicable) and co-insurance amounts which may remain as your out of pocket expenses after your insurance company reimburses Life in Progress Counseling for services provided. This will eliminate the need to send you paper statements for outstanding balances.

Additionally, your credit card will be charged if your appointment is cancelled outside of our specified timeframes as outlined in our Appointment Cancellation Policy. You will be advised of this charge and a receipt will be sent to you electronically.

Life in Progress Counseling will store CCOF information in a secure form.

Our CCOF Policy in no way will compromise your ability to dispute a charge or question your insurance company’s determination of payment.

Type of Card____________________________________________
Credit/Debit/HSA/FSA____________________________________
Card#_________________________________________________
Expiration Date__________________________________________
CVV/CVC number ________________________________________
Name as it Appears on Card________________________________
Zip Code for Card________________________________________
Signature________________________________________________
Today’s Date____________________________________________
## Patient Stress Questionnaire

Name: ________________________________

Date: _______________  Birthdate _______________

Over the **last two weeks**, how often have you been bothered by any of the following problems? (please circle your answer & check the boxes that apply to you)

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly Every day</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>3. □ Trouble falling or staying asleep, or □ sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>5. □ Poor appetite or □ overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>6. Feeling bad about yourself or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>8. □ Moving or speaking so slowly that other people could have noticed, or □ the opposite - being so fidgety or restless that you've been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>9. □ Thoughts that you would be better off dead, or □ hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

**Total** add columns: ________________________

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly Every day</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling nervous, anxious or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>2. Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>3. Worrying too much about different things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4. Trouble relaxing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>5. Being so restless that it is hard to sit still</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>6. Becoming easily annoyed or irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>7. Feeling afraid as if something awful might happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

**Total** add columns: ________________________

*adapted from PHQ 8, GAD7, PC-PTSD and AUDIT 1/24/11

Provider: ________________________________