a v e n u e s

u n l i m i t e d

Avenues Unlimited Counseling Center, Inc.
Marriage, Family, Individual & Group Therapy
Chemical Dependency, Alcohol & Drug Counseling

Name: ______________________ Gender: ______________________

Birthdate: ______________________ Today's Date: ______________________

Address: ______________________ City: __________ State: __________ Zip: ______________

Home Phone: ______________________ Work Phone: ______________________ Ext: __________

Mobile Phone: ______________________ Fax: ______________________

Email: ______________________ Social Security Number: ______________________

In Case of Emergency Please Notify: ______________________

Emergency Contact Number: ______________________

How did you learn about Avenues Unlimited?: ______________________

EMPLOYMENT

Occupation: ______________________

Employer: ______________________

Spouse's Name: ______________________

Place of Employment: ______________________

EDUCATION

Self: ______________________

Spouse: ______________________

CHILDREN

Name(s):	Age(s):	Sex(M/F):

MEDICAL

Name/Address of Internist or General Practitioner: ______________________

Name/Address of Psychiatrist: ______________________

Previous Psychotherapist(s): ______________________

Illness Requiring Medical or Hospital Treatment in Last 12 Months: ______________________

Current Medication(s): ______________________

3701 Taylorsville Rd. #2
Louisville, Kentucky 40220

Tel. 459-9635
Fax. 459-9630

avenuesunlimited@gmail.com
www.emotionalhealth.com

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ESTIMATE YOUR DAILY USE

Alcohol:____________________ Caffiene: __________________________________Tobacco: ___________________________

CURRENT/PRIMARY ISSUES FOR WHICH YOU WISH PSYCHOTHERAPY

____

____

____

RELEASE OF INFORMATION

I hereby request that ____

at (address)____ furnish Avenues Unlimited,

with the following information____

____

____

____

Signed:____ Date:____

I hereby grant Avenues Unlimited Counseling Center, Inc. to provide the following information ________________

____

____

____

____

to: ____

Signed:____ Date:____

I have been informed of the limits of confidentiality. Initial:____

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CONSENT TO TREAT

This documents that I, ______________________________ , give my permission and consent to Avenues Unlimited

Counseling Center, Inc., to provide me psychotherapeutic treatment to _____________________(me, my child(ren)).

While I expect benefits from this treatment, I fully understand that because of factors beyond our control, such benefits and particular outcomes cannot be guaranteed. Furthermore, I understand the I/he/she/we may experience emotional strains because of the counseling or therapy, feel worse during the treatment and make life changes which could be distressing.

I understand that Avenues Unlimited is not providing emergency services, and I have been informed of whom to call upon in an emergency or during such time as he is unavailable.

I understand that regular attendance will produce the maximum benefits, but that I/we am/are free to discontinue treatment at any time. If I decide to do so i will notify Avenues Unlimited at least two weeks in advance so that effective planning for continuing care can be implemented.

Sign ____Date ______________________________

CANCELLATION POLICY

I understand that there is a 48 hour (or two working day) rescheduling policy. A rescheduling change will result if I do not give notice in this time frame.

Sign ____Date ______________________________

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LIMITS OF CONFIDENTIALITY

The contents of counseling, intake or assessment sessions are considered to be confidential. Both verbal information and written records about a client can not be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of this center not to release any information about a client without a signed release of information. Noted exceptions are as follows:

DUTY TO WARN AND PROTECT

When a client discloses intentions or a plan to harm another person, the health care professional is required to warn the intended victim and report his information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

ABUSE OF CHILDREN AND VULNERABLE ADULTS

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities.

PRENATAL EXPOSURE TO CONTROLLED SUBSTANCES

Health care professionals are require to report admitted prenatal exposure to controlled substances that are potentially harmful.

IN THE EVENT OF A CLIENT'S DEATH

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

PROFESSIONAL MISCONDUCT

Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

COURT ORDERS

Health care professionals are required to release records of clients when a court order has been placed.

MINORS/GUARDIANSHIP

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

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OTHER PROVISIONS

When fees for services are not paid in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g. diagnosis, treatment plan, case notes, test) is not disclosed. If a debt remains unpaid it may be reported to credit agencies and the client's credit report may state the amount owed, time frame and the name of the clinic.

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information which may be requested includes type of services, date/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, case notes and summaries. Please note that Avenues Unlimited Counseling Center, Inc. is not accepting insurance payments with the possible exception of certain EAP plans.

When couples, groups or families are receiving services, separate files are kept for individuals for information disclosed that is of a confidential nature. This information includes (a) testing results, (b) information given to the mental health professional not in the presence of the other person(s) utilizing services, (c) information received from other sources about the client, (d) diagnosis, (e) treatment plan, (f) individual reports/summaries and (h) information that has been requested to be separate. The material disclosed in conjoint family or couples sessions in which each part discloses such information in each other's presences, is kept in each file in the form of case notes.

In the event in which the clinic or mental health professional must telephone or e-mail the client for purposes such as appointments, cancellations or reminders or to give or receive other information, efforts are made to preserve confidentiality. Please list where we may reach you by phone and/or e-mail and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only.

If this information is not provided to us (below) we will adhere to the following procedures when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information we will say that this is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines.

PLEASE CHECK PLACES IN WHICH YOU MAY BE REACHED BY PHONE OR E-MAIL.

Include phone numbers and how you would like us to identify ourselves when phoning you.

☐ Home Phone Number ____________________ How should we identify ourselves? ______________________________

☐ Work Phone Number ____________________ How should we identify ourselves? ______________________________

☐ Other Phone Number ____________________ How should we identify ourselves? ______________________________

☐ E-mail ____

I AGREE TO THE ABOVE LIMITS OF CONFIDENTIALITY AND UNDERSTAND THEIR MEANINGS AND RAMIFICATIONS.

Client's Name (Please print) ____

Client's or Guardian's Signature ____ Date ______________

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