Demographic Information

Date: _____

Client Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Maiden Name (if applicable):_____

Race:_____ Religion: _____ Primary Language: _____

Home Phone: _____ Cell Phone: _____

Okay to Call Home? Yes _____ No _____ Okay to leave message? Yes _____ No _____

Okay to Call Cell? Yes _____ No _____ Okay to leave message? Yes _____ No _____

Place of Employment / Title: _____

Work Phone: _____ Work Hours: _____

Okay to Call Work? Yes _____ No _____ Okay to leave message? Yes _____ No _____

Email Address: _____ Okay to Email? Yes_____ No_____

EMERGENCY & RELATIONSHIP INFORMATION

Emergency Contact: _____ Phone: _____

Marital Status: Married: _____ Single: _____ Divorced: _____ Widowed: ____

Number of Years: Married:_____ Separated:_____ Divorced:_____ Widowed:____

Spouse's Name: _____ Date of Birth: _____

If applicable, please list all children residing in or outside the home:

Child Name: _____ Date of birth: _____
Child Name: _____ Date of birth: _____
Child Name: _____ Date of birth: _____
Child Name: _____ Date of birth: _____
Child Name: _____ Date of birth: _____

COUNSELING

Individual: _____ Marriage: _____ Family: _____ Couple: _____

Demographic Sheet Page 2

Medical History:
Family Physician: _____
Address: _____ Physician's Phone:_____

Allergies:

_____

Significant Medical Conditions:

_____

Prescription Drugs Currently Taking: (Please include dosage)

_____

_____

Mental Health History:
Current reason for seeking treatment:_____
How did you hear about us: _____
Who in your family has previously been seen for therapy: _____
Reason for seeking previous treatment: _____
With whom: _____ Any psychiatric hospitalizations: _____
List names of hospitals, mental health centers and the dates of treatment:

_____

Previous Mental Health Diagnosis: _____

Use of Alcohol:
Past: Yes ___ No ___ If Yes, Amount of Usage: _____
Present: Yes ___ No ___ If Yes, Amount of Usage: _____
Use of Street Drugs:
Past: Yes ___ No ___ If Yes, Amount of Usage: _____
Present: Yes ___ No ___ If Yes, Amount of Usage: _____
Use of Nicotine:
Past: Yes ___ No ___ If Yes, Amount of Usage: _____
Present: Yes ___ No ___ If Yes, Amount of Usage: _____

If the individual seeking treatment is a minor please answer the following questions:

Child's Name: _____
Date of Birth: _____Age: _____ Nickname: _____
Child's Address (if different than parent): _____
City: _____ State: _____ Zip: _____ County: _____
School Attending: _____ Grade Enrolled In: _____
Teacher's Name: _____ Phone: _____
Pediatrician: _____

I understand that by signing below I am giving my consent for my child to be seen and am certifying that I am the child's legal guardian and am authorized to give consent.

_____
Parent/Guardian Signature

Informed Consent to Psychotherapy

I understand that a trained therapist is providing me psychotherapy treatment within their scope of practice as defined by the Kansas Behavioral Sciences Regulatory Board.

I hereby consent for the therapist to provide me with psychotherapy treatment for the above noted purposes including such intakes, assessments and therapeutic techniques which may be recommended by the therapist to help me most appropriately.

I acknowledge that the therapist is a licensed clinician and does diagnose mental health disorders. I clearly understand that psychotherapy treatment is not a substitute for a medical examination by a medical doctor. It is recommended that I attend my personal physician medical appointments for any general medical conditions or ailments that I may be experiencing. I acknowledge that no assurance of guarantee has been provided to me as to the results of psychotherapy treatment. I acknowledge that with any treatment there can be risks. Psychotherapy treatment is an intensely personal process which can bring unpleasant memories or emotions to the surface. There are no guarantees that psychotherapy treatment will work for you. Clients can sometimes make improvements only to go backwards after a time. Progress may happen slowly. Psychotherapy treatment requires a very active effort on your part. In order to be most successful, you will have to work on things you discuss with your therapist outside of sessions.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical and mental health history form as provided by my therapist and disclosed to the therapist all of those medical conditions and/or mental health diagnosis affecting me. It is my responsibility to keep the therapist updated on my medical and mental health history. The information I have provided is true and complete to the best of my knowledge.

I have read the above noted consent, and I will discuss any questions regarding the contents and my psychotherapy with my therapist. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me by my therapist to best cope with my mental health condition and improve my quality of life. I understand that at any time I may withdraw my consent and psychotherapy treatment will be stopped.

Name of Client (printed): _____ Date_____

Signature of Client_____ Date_____

Signature of Parent/Guardian (if client is a minor)_____ Date_____

Catholic Charities Witness_____ Date_____

Updated 6/1/2020 JP

Limits of Confidentiality
Notice to Client

Confidentiality is an ethical principle that respects information obtained by a therapist as private between the therapist and the client. However, there are certain circumstances under which client confidentiality is limited by law, such as the following;

For these exceptions, your therapist will disclose information without your consent:

- When the therapist makes an assessment of an immediately foreseeable risk of suicide;
- When a client reveals intent to do physical harm to another person;
- When information is made an issue in a court action and when a subpoena is issued for the information from the therapist;
- When the therapist suspects abuse/neglect of a minor, elder, or ward and is mandated to report this to an appropriate agency;
- When a parent or legal guardian requests diagnostic or treatment information regarding a non-emancipated minor client.
- When requested by insurance companies and other third-party payers for the purpose of determining medical necessity and approving payment.

My signature here attests to the fact that I have read and understand the points presented above.

_____ _____

Client's Name (printed) Date

_____ _____

Client's Signature Date

_____ _____

Parent/Guardian Signature (if applicable) Date

Updated 6/1/2020 JP

Catholic Charities
OF NORTHERN KANSAS
Working to reduce poverty in America.

Client Rights

1. All clients have the right to be treated with respect and dignity. This shall be construed to protect and promote human dignity and respect for the individual.
2. Each client has the right to receive prompt, competent services without regard to race, religion, sex, ethnic origin, age, disability, handicapping condition, legal status, and/or ability to pay.
3. The records of each client shall be treated in a confidential manner.
   Please refer to Privacy Practices information for exceptions.
4. Each client has the right to refuse to participate in any research project, as defined by law. A refusal to participate will not affect the services available to the client.
5. For after hour's emergencies, clients have a right to contact their nearest emergency room or to call the crisis hotline at 1 (888) 887-9124 or (785) 827-4747.
6. The therapists of Catholic Charities are professionals dedicated to providing the highest quality of service. If, however, as a client you have a complaint about your service, we encourage you to discuss this matter with the therapist. If a resolution cannot be reached, you have the right to contact the Chief Executive Officer at Catholic Charities for the Diocese of Salina, within 30 days of the alleged infringement by letter stating the nature of the complaint at the following address:

   Chief Executive Officer of Catholic Charities
   P.O. Box 1366, 1500 South 9th Street
   Salina, KS 67402-1366

CATHOLIC CHARITIES ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES & CLIENT RIGHTS STATEMENT

I acknowledge that I have been offered or received a copy of Catholic Charities' Notice of Privacy Practices and Client Rights Statement.

_____

Signature of Client/Client Representative

_____

Printed name of Client/Client Representative

_____

Date

_____

Relationship of Representative to Client (if applicable)

Original to be maintained in client's permanent record.

Catholic Charities
OF NORTHERN KANSAS
Working to reduce poverty in America.

Grievance Notice

The therapists of Catholic Charities are professionals dedicated to providing the highest quality of service. If, however, as a client you have a complaint about your service, we encourage you to discuss this matter with your therapist. If a resolution cannot be reached, the Chief Executive Officer of Catholic Charities for the Diocese of Salina can be contacted by letter stating the nature of the complaint at the following address:

Chief Executive Officer of Catholic Charities
P.O. Box 1366
Salina, KS 67402-1366

_____	_____
Client Name (printed)	Date
_____	_____
Client Signature	Date
_____	_____
Parent/Guardian Signature (if applicable)	Date

Updated 6/1/2020 JP

Catholic Charities
OF NORTHERN KANSAS
Working to reduce poverty in America.

Client Fee Agreement – Sliding Fee Scale

Name of Client(s): _____

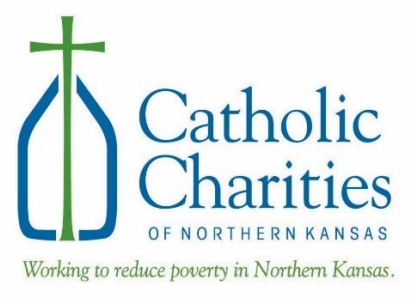
Address: _____

Catholic Charities offers a sliding fee scale for counseling clients. The fee per session will based on the client's annual household income and number of household members.

Annual Household Income: _____ # of Household Members: _____

1. I agree to pay $ _____ per session. I agree to pay my fee on the date of service. **_____ Initials**
2. I understand that conditions of employment, frequency of sessions or other factors may be considered in negotiating my fee, or re-negotiating, at a later date. **_____ Initials**
3. I understand that I may be charged a no-show fee (not to exceed $25) if I do not cancel less than 24 hours in advance or show up more than 15 minutes late for my scheduled appointment. _____ **Initials**
4. I understand that I am obligating a block of the therapist's time, which no one else may use unless adequate notification is made to cancel the appointment. **_____ Initials**
5. I understand that if I am 15+ minutes late for my scheduled session I will be counted as a no-show. **_____ Initials**
6. I understand that Catholic Charities reserves the right to reevaluate my financial status at any time, but at least every six months. **_____ Initials**

_____	_____
Client Name (printed)	Date
_____	_____
Signature	Date
_____	_____
Signature (spouse if applicable)	Date
_____	_____
Catholic Charities Representative	Date



Electronic Communication Agreement

Electronic (online) communications include e-mail, secure messaging (Google Voice, texting), and electronic file transfer to exchange information between computers, tablets, or smartphones. These can be useful ways for clients and service providers to communicate, in addition to in person visits and phone calls.

Advantages

- E-mail/online messaging is a convenient and popular way of connecting; many people use it regularly even without phone service
- Messages can be sent and received without needing both parties online at the same time
- Messages can be saved, copied and forwarded to keep a record of what was said
- Some questions/issues can be handled by online messaging without a phone call or in person visit

Disadvantages

- E-mail devices and connections can fail; messages can be lost or sent to the wrong person
- There is not always a way to verify if a message was ever received
- Messages can contain typing errors
- If the other party is away or their device is turned off, messages might not be seen promptly
- It is possible for a dishonest person to send a false message or impersonate
- Saved copies or messages sent in error cannot be erased or retracted
- Messages can contain viruses that can damage systems or misuse information
- Some questions/issues cannot be handled through online messaging

Our E-mail/Online Messaging Policies

1. **No emergencies or urgent messages**. E-mail/online messaging is not to be used for emergencies or urgent messages. We do not monitor our inbox constantly. You can send a message any time, but we may not read it until the next business day. We check messages during regular work hours and answer them at our earliest convenience. We strive to respond to messages within one business day, but circumstances could cause a delayed response. Use the telephone if you need a response right away. In a life-threatening situation always call 911.

2. **Uses.** Our agency accepts e-mail/online messages for these purposes:
   a. General messages for making or changing appointments, service inquiry, or other questions that can be answered by any appropriate staff person.
   b. Support. Our providers may give their professional e-mail address or online messaging number to you for added support/advice relating to pregnancy or case management. Although they might sometimes reply after hours, you should not expect providers to monitor their e-mail/online messaging continuously. If you have an issue that needs immediate attention, call our office directly.

3. **Part of the record**. E-mail/online messages are considered part of your client record. Our policies for record privacy and appropriate uses of confidential information apply to messages we send to each other.

4. **Security.** You need to protect the e-mail address/phone access you give us, to ensure our communications remain private. This is the only way we can trust that messages from your e-mail/phone number are really from you, and messages we send are not going to someone else. Messaging will cease if the recipient identity is uncertain and contact will be made via phone call.

5. **Availability**. If e-mail/online messaging is your preferred method of contact, we will assume that you check your inbox at reasonable intervals. We do not guarantee that we will respond to your messages and we understand that you cannot guarantee that you will respond to ours. In cases of uncertainty, we will try other ways of communicating.

6. **Sensitive client information.** We cannot always know what information you consider especially private. We take care with all patient records, but we know that some facts are more sensitive than others. Because e-mail/online messaging cannot be guaranteed 100% secure, please do not put extremely sensitive matters in messages without considering this.

7. **Voluntary.** Using e-mail/online messaging is voluntary for both of us. If we feel you are using e-mail/online messaging inappropriately (or, if we think your address/number has been hacked by an imposter), we may block your messages. If you decide you do not want to receive e-mail/ online messages from us any longer, just let us know.

8. **Changes of address.** If your e-mail address/phone number changes, you need to notify us right away to prevent any inappropriate release of information.

9. **Non-essential uses.** We will only use your e-mail address/phone number for important communications related to our agency. We will not give your e-mail address/phone number to anyone who is not part of our practice. Please do not send non-essential messages to us, because they slow down our ability to respond to important messages.

10. **Errors.** Mistakes happen. If you believe you have received or sent a message by mistake, or one that contains errors, please let us know. Please delete messages that are not intended for you.

11. **Other risks.** In addition to those above, electronic communication can have other risks and disadvantages that might cause inconvenience or harm. Everyone using e-mail/online messaging needs to use good judgment about these valuable technologies and must remember that there are alternatives that would be more appropriate for some situations.

Acknowledgement and Agreement

I acknowledge that I have read this form. I understand that electronic (online) communication has risks, including possible risks not mentioned above. I agree to abide by the policies described above. I agree to use reasonable judgment with regard to any messages I send or receive.

Client (or legal representative) Name: _____

Signature: _____ Date:_____

E-mail address/phone number to be used: _____