Solace Center

1470 West Herndon Avenue, Suite 100
Fresno, CA 93711

CLIENT (ADULT) DATA SHEET

Date_____

CLIENT CONTACT INFORMATION

Client Name: _____ Social Security #: _____
Age_____ Sex _____ Ethnicity (optional) _____ Birth date_____ Place of Birth_____
Parent/Legal Guardian Contact: _____ Phone # ( ) _____
Address_____Apt#:_____ City_____ Zip_____
Phone (Cell/Home): ( ) _____ Alternative Phone: ( ) _____
Special instructions_____
Referred to Solace Center by: _____
Payment: □ Cash Pay
Health Insurance Information for mental health services?
Provider? (Health Net/Blue Cross/etc): _____
ID #_____
Emergency Contact: _____ Relation: _____Phone # :( )_____

CLIENT PERSONAL DATA

1. Date of last physical exam? _____

   Physician Name_____

   Phone Number/Address _____

2. Do you suffer from any serious or chronic medical conditions? If yes, please provide details_____

   _____

3. Please list all current medications, including over-the-counter and herbal.

Name of medication	Dosage	Prescribed for	Prescribed by whom?	Helpful? (Y) (N)

4. Please identify any medication allergies below:

   _____

INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

Client Name (print): _____ Date of Birth _____

I understand that I am entering into a therapeutic relationship with a licensed mental health clinician at *The Solace Center*. The type and extent of mental health services offered by the treating mental health clinician will depend upon the needs reported by me during the course of treatment. Therapeutic goals and services will be discussed and reviewed with me during the course of treatment.

I understand that all information shared with the clinicians and staff at *The Solace Center* is confidential and no information will be released without my consent. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
B. When there is suspicion that a child or elder (65+) is being sexually, physically or emotionally abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities. (See Penal Code 11166.05).
C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

I understand that *The Solace Center* services are provided by a range of mental health professionals. These professionals are licensed in the State of California to offer therapy and related services.

I understand that while psychotherapy may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings. Psychotherapy may also involve the recall of troubling events and memories. I understand that my symptoms may get worse before they get better and that psychotherapy is not guaranteed to improve mental health functioning.

I consent to participate in the evaluation and treatment offered to me by *The Solace Center*. I understand that I may stop treatment at any time.

I have received a copy of Solace Centers Privacy Procedures. I understand I may receive a copy at my request.

SIGNED: _____ Date: _____

Solace Center

Clinician-Patient Agreement and Financial Responsibility
Please read and *sign two copies*. Keep one for your records

Solace Center is a business facility where a number of mental health professionals practice. **Each therapist is an independent practitioner.** The name **Solace Center** is for the purpose of shared office expenses. **Your contract for services is with your therapist only and does not include a contract with any of the other therapists at this site.**

Rights and Risks:

- You may ask questions about any aspect of the counseling process.
- If you have been referred by a court or state agency, you have the right to divulge only what you want to be included in a report.
- Therapy is most effective when you are open and can speak honestly about your emotions and experiences.
- Therapy may include talking about emotionally provoking subjects and scenarios.

Confidentiality:

- Information shared by you in session will be kept confidential.
- Information will not be released without your written consent, except for professional consultation if needed and unless required by law.
- I am required by law to disclose information pertaining to suspected child abuse, the inability to care for one's basic needs for food, clothing or shelter, and threatened harm to oneself or others.
- The court may subpoena counseling records.
- It is understood that information regarding treatment and diagnosis may be provided to an insurance company.
- You may want to discuss further limits or exceptions of confidentiality.
- Please see *Informed Consent for Assessment and Treatment* for more details

Appointments:

- All office visits are by appointment and may be scheduled through the office manager or your counselor directly.
- Please arrive on time, as you use up your own time when you arrive late for an appointment. The usual length of an appointment is between 45-50 minutes.
- Late cancellation (less than 24 hours before) *and/or* no-show appointments are billed to the client for the full amount. In the case of illness, please notify us no later than 8:00 a.m. the day of the appointment. Please leave a message if you get voice mail. If your appointment is cancelled or missed, contact the office for a new appointment time. Insurance companies will not pay for no-show charges or late cancellation charges or for telephone consultations.

Fees:

- The client portion of fees, is expected to be paid *at the time of service. (Cash pay is expected in full, Co-payment for insurances)*
- Your health insurance may help you recover some of your counseling costs. Most group policies, but few individual policies cover outpatient psychotherapy. Please verify with your company the amounts of coverage for outpatient psychotherapy by licensed professionals. If your policy requires preauthorization to receive services, it is your responsibility and needs to be handled prior to your first visit.
- Insured clients are expected to take care of their fees as services are rendered. Our office will bill your insurance company for services provided. You will receive a statement each month

reflecting any balance due on your account. This office cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim. You are responsible for payment (and insurance claims) on your account. ***Failure to pay your part may jeopardize your benefits. Copays are not negotiable***.

- Clients paying on a cash basis, and not billing any insurance company are expected to pay in full at time of service unless a payment plan has been previously arranged.
- Except in the case of minors or when other arrangements are made, the person receiving the counseling service is financially liable.
- Accounts become delinquent after thirty (30) days. ***Accounts 90 days in arrears will be terminated***.
- Any change in my financial situation I will discuss with my therapist. In the event, you find it necessary to change mental health providers and require records to be sent from **Solace Center** your account will need to be paid in full.

I have read, understand and agree to the above policies. I have been offered a copy of these policies to take with me if desired. I hereby authorize **Solace Center** and my therapist to release any information acquired in the course of my therapy to my insurance company (if client is a minor, parent or guardian sign). I understand my insurance coverage is a relationship between me and my insurance company, and I agree to accept financial responsibility for payment of charges incurred. I understand that a re-billing fee/financial charge complying with California State Law will be applied to any overdue balance, and in the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. I have read and/or received a copy of **Solace Center**'s Privacy Policy

Individual Session Fee-$65

Couples - $85

Letters- $35

Insufficient Funds Check Fee-$25

No Show/Cancelations made less than 24 hours in advance - $25

Emergencies:

The phone number for Solace Center is **559-256-0985** If you receive the voice mail, please leave a message for your personal counselor. Your counselor may be on the phone, in therapy with someone else, or out of the office. In a crisis situation please **call 911, *or* go immediately to your local hospital emergency room.**

Client Signature: _____ **Date:**_____

Parent/Guardian Signature: _____ **Date:**_____

Health Check Protocol

To protect your health as well as the health of other children attending the program, the following guidelines have been established:

Consider Canceling your Appointment at Solace Center If:

1. You have a fever of **100 degrees** or above. Before returning to Solace Center your temperature should be normal for 24 hours without the use of fever reducing medication.
2. You have **diarrhea**. This means abnormally loose bowel movements. Before returning to Solace Center, you should be free of diarrhea for 16 hours
3. You have **discharge (green in color) from the nose or congestion** which causes difficulty in breathing.
4. You have been **vomiting**.
5. You have a **rash** that covers the body (not diaper rash). Please obtain a written release form from your doctor when you return to Solace Center.
6. You are is constantly **scratching his/her head**, has lice, nits, or head sores.
7. You have **a headache** and **stiff neck**.
8. You have red or **pink** eyes with a discharge.
9. You have a known **infectious disease**.
10. Current **immunizations** including are not on file.

If you have any of the symptoms listed, contacting your physician is recommended.