Higher Ground Counseling Services, LLC
Tracye L. Ditmore, MS, LMFT, LCADC
Marriage & Family Therapy and Licensed Clinical Alcohol & Drug Counseling

CLIENT INFORMATION **(Please fill out completely. We will review the information during your session, any questions will be answered at that time.)**

Last Name__________________________First____________________Middle_____________________

Address__________________________________City____________State_________Zip Code_________

It is ok to call and/or leave messages at the following numbers:

Telephone (Home) ______________________Cell_____________________Work___________________

Relationship Status_____________________ Partner's Name___________________________________

Education (highest grade completed) __________________ D.O.B.______________________________

Employer______________________________ Occupation _____________________________________

Who can I thank for referring you? ____

CLIENT INFORMATION OR PARENT/GUARDIAN IF CLIENT IS A MINOR

Last Name__________________________First____________________Middle_____________________

Address__________________________________City____________State_________Zip Code_________

Telephone (Home)_____________________Cell ____________________Work_________________

Relationship Status_________________ Partner's Name ________________________________

Education (highest grade completed) _____________________D.O.B.___________________

Employer______________________________Occupation________________________

EMERGENCY CONTACT AUTHORIZATION/INFORMATION:

Name______________________________________ Relationship ___________________________

Telephone (Home)___________________Cell ___________________Work __________________

CHILDREN'S INFORMATION

Name	D.O.B	Gender	Age	Who Has Legal Custody	Child's Residence

Have you participated in therapy in the past? Yes _ No _If yes, please explain.

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Do you or anyone in your family have a history of addictions or drug/alcohol abuse? Yes _ No _
If yes, please explain.

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____

Do you or anyone in your family have a history of abuse/violence? Yes_ No _ If yes, please explain.

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Do you have any history of or pending legal charges/cases (criminal or civil)? Yes_ No_ If yes, please explain

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Do you have any medical concerns at this time? Yes_ No_ If yes, please explain

____

____

Are you taking any medications? Yes _ No _ If yes, please explain what type and the quantity taken.

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Please check if you have ever experienced concerns about the following :

Concerns about:	**Past**	**Recently**	**Concerns about:**	**Past**	**Recently**
Depressed mood			Anxiety or tension		
Grief/loss			Feeling overwhelmed		
Suicidal ideas/behavior			Panic attacks		
Sleeping problems			Significant fear		
Appetite problems			Response to a trauma		
Energy problems			Obsessive thoughts		
Eating habits			Compulsive behavior		
Body image			Combat related stress		
Self esteem			Problems with money		
Memory problems			Impulsive behavior		
Violent behavior			Gambling		
Criminal ideas/behavior			Sexuality		
Difficulty concentrating			Sexual problems		
Communication			Paranoid thoughts		
Loneliness			Strange experiences		
Self harm behaviors			Irritability or agitation		
Relationship problems			Anger		
Parenting issues			Changes in your life		

This is a strictly confidential client health record. Redisclosure is expressly prohibited by law.

INFORMED CONSENT

My signature confirms that I consent to treatment and understand the rights listed below:

1. I have the right to refuse any or all treatment, and to leave treatment at any time.
2. I will be actively involved in the planning of my treatment, and will understand the potential consequences of treatment/ or be actively involved in the planning of my child's treatment.
3. I will be continually informed as the type of treatment I will be receiving. I will receive appropriate referrals if/ when there are concerns about any medical, academic, genetic, or other conditions that may be present and need evaluation or services.
4. I understand that my counseling, or that of my child, is confidential and protected under state and federal law: Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164. There are three instances that confidentiality is mandated by law to be broken:
   A) Where there is immediate concern that I am imminently in danger to harm myself or another person, and emergency measures must be taken for protection.
   B) When there is significant reasonable suspicion that child or elder abuse or neglect is occurring.
   C) The disclosure is made to medical personnel in a medical emergency
   D) When there is a direct order requiring a release of information through a Judicial subpoena.
   E) Each parent has a right to review their child's record unless rights have been terminated by the court
   F) Insurance companies that authorize and pay for treatment may have a right to review your records.
5. If I am participating in couples or family counseling sessions, I understand that all information shared in a joint session is open to all participants. Any information shared in an individual session is kept Confidential and separate from joint sessions. This separate information is not open to any other member of the couple/family through the counselor or case documentation in the chart.

I understand that part of the policy at this practice and in order to provide optimal therapy to clients is to have cases staffed with other therapists who maintain the same strict confidentiality.

____________________________________ __________
Client's Signature Date

____________________________________ __________
Client's/Parent/Guardian's Signature Date

____________________________________ __________
Witness' Signature Date

If you are involved in a divorce or custody litigation, you need to understand that my role as a therapist is not to make recommendations for the court concerning custody or parenting issues or to testify in court concerning opinions on issues involved in the litigation. By signing this document, you agree not to call me as a witness in any such litigation. Only court-appointed experts, investigators, or evaluators can make recommendations to the court on disputed issues concerning parental responsibilities and parenting plans.

__________________________________ ______________

Client Signature Date

__________________________________ ______________

Witness Signature Date

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PAYMENT AGREEMENT

The fees are as follows:

Individual/family/couples' session (50 minutes)	$125.00
Letters/Reports	$25.00 (per 15 min)
Less than 24 hour cancellation fee	$50.00

Please communicate with me if you have financial concerns or if there is a change in finances during your time in therapy.

I agree to pay $________per 50 minute session.

All fees must be paid at time of service. Payment is due at the time of service. Payments are accepted in the form of cash, credit card, or personal check. A $35 fee will be charged for any returned checks. If insurance does not cover all fees, it is the responsibility of the client to pay for services received. **If there is a cancellation, 24 hours notice must be given, if not, the client is responsible for the session fee.**

INSURANCE INFORMATION

Name of Insurance Company____

Address____

Telephone______________________________Fax___________________________________

Name of insured person _________________________ Relationship to client____________

Employer of person insured____

Policy Number_____________________________ Group Number_____________________

Social Security Number____

Deductible_______________ Amount paid this year___________________Co-Pay_________

I HAVE READ AND UNDERSTAND THE PAYMENT AGREEMENT

_______________________________________ ______________
Client's/Parent/Guardian's Signature Date

_______________________________________ ______________
Therapist's Signature Date

7371 W. Charleston Blvd, #110, Las Vegas, NV 89117 * (702) 525-8402 *tracyeditmore@yahoo.com
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