A HEALING ALTERNATIVE COUNELING AND WELLNESS CENTER, LLC

8603 CROWNHILLE SUITE 29 SAN ANTONIO, TX 78233
PHONE: (210)705-2121
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INFO@FAITHGHARPER.COM

Hey there, new person!

Enclosed in this packet is all the basic forms you will need to complete before your first distance counseling. Paperwork can be either emailed of faxed to my office prior to your scheduled appointment.

In addition to the information I collect from in-office clients, I also require the following information from clients receiving distance counseling. They include a crisis-safety plan with local information in case of an emergency, a consent to release information for me to contact at least one professional care provider in your area in case of an emergency (if you are not receiving services from anyone else, it can be your local community mental health clinic), and a specific informed consent regarding distance counseling. You will notice within this informed consent that I am reiterate that you must be either be a resident of Texas or residing out of the United States for me to provide you counseling services

Copies of my HIPPA policy and my Social Media Policy are available as separate downloads and should be read before completing this packet. Additionally, I keep printed copies of them in the office and can provide them to you at your request.

Please have each person who is entering services complete a packet. (Though don't freak out by the counseling contract…if you are attending as a couple or family unit you will only pay for the service visit, not per person!).

If you have any questions, do not hesitate to contact me at info@faithgharper.com

Faith G. Harper

Faith G. Harper, PhD, LPC-S
A Healing Alternative Counseling and Wellness Center, LLC
info@faithgharper.com www.faithgharper.com
Phone: (210)705-2121

Counseling Contract

Counseling is most helpful when it takes place in a framework of trust, clarity, and understanding. This contract is intended to clarify and help this relationship. Should you have any questions concerning this covenant, please discuss them with me.

Financial Understanding

I/we understand that the fee for a 50 minute session is **$200.00;** this fee is the same for an initial visit.

I have discussed this amount with the therapist along with my ability to pay. **I agree to a fee in the amount of _____.**

If I choose to use my insurance benefits to offset the cost of my therapy, then I understand that the full fee will be charged.

I agree to be responsible for that full fee amount.

Cancellation Policy

I understand that I will be charged the full fee of **$200.00 for a missed appointment or if I fail to cancel without 24 hours notification.** This can be discussed with your therapist if special circumstances result in a missed appointment.

Limits of Confidentiality

I understand that while confidentiality is central to the process of therapy, it must be broken and a report made to the proper authorities when there is abuse or neglect of children, disabled persons, and the elderly; when there is intent to harm oneself, another, or property; or when a court order is issued.

Terminating Therapy

I understand that though I may stop therapy at any time, the ending of therapy is best if discussed with my therapist at least one session before it ends.

Consent to Counseling

I understand that there are certain risks in therapy and that there may be alternatives to therapy. I agree to counseling with Faith G. Harper. These services may also include group therapy, psychoeducation, assessment and diagnostic impressions, and referrals for other needed services.

Signed _____
Witness _____
Date _____

Signed _____
Witness _____
Date _____

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CONTACT INFORMATION

Today's Date _____ **Reverified Date** _____ **Reverified Date** _____

Legal Name_____
Last First MI

Chosen Name (if different) _____

DOB _____/_____/_____ **Gender:**_____ **Pronouns:**_____

Any relevant information about name, gender, pronouns you want me to know:

Legally Authorized Representative (if applicable)_____
Last First MI

Local Address _____
Street Apt#

_____
City, State, Zip

Preferred Form of Contact? ___Phone _____Cell Phone _____Text ____Email

Cell Phone _____
If Phone Contact checked, OK to leave message?_____

Home Phone _____
If Phone Contact checked, OK to leave message?_____

Email address: _____

If you marked that you prefer email contact or text contact, please note the following:

I understand that the confidentiality of information transmitted via email or text cannot be guaranteed.

_____ *Your Initials*

In Case of Emergency, Notify:

Name _____
First Last

Relationship _____

Contact info: _____
Street Apt#

_____
City, State, Zip

Home Phone_____

Cell Phone _____

Receipt of Notice of Privacy Practices Form
A Healing Alternative Counseling and Wellness Center, LLC
Faith G. Harper, PhD, LPC-S

I, _____, hereby acknowledge receipt of the NOTICE OF PRIVACY PRACTICES and INFORMED CONSENT FOR TECHNOLOGY ASSISTED COUNSELING from my therapist.

The NOTICE OF PRIVACY PRACTICE and INFORMED CONSENT FOR TECHNOLOGY ASSISTED COUNSELING provides detailed information about how the practice may use and disclose my confidential information.

I understand that my therapist has reserved a right to change his or her privacy practices that are described in the NOTICE.

I also understand that a copy of any Revised NOTICE will be provided to me or made available.

_____ _____

CLIENT SIGNATURE DATE

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A Healing Alternative Counseling and Wellness Center, LLC
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Phone: (210)705-2121 Fax: (210) 568-4816

Social Media Acknowledgement Form

I acknowledge that I have been provided a copy of Faith Harper's social media policy which remains in effect even when I am no longer receiving services from her.

I understand that this policy is available for download and review at any time from her website (www.faithgharper.com) and updates in this policy will be discussed with me, if I am currently receiving services from her.

I understand that if any questions about social media arise are best discussed directly with her during our sessions.

Client Name:_____

Client Signature:_____

Date:_____

Counselor Signature:_____

Date:_____

Life History Questionnaire

FAITH G. HARPER, PhD, LPC-S, ACS, ACN

The purpose of this questionnaire is to obtain some information regarding the issues that bring you in today, as well as some of your experiences and background. Completing these questions as fully and as accurately as possible will benefit you through the development of a treatment plan suited to your specific needs.

Name: _____ Date: _____

Address: _____

_____

Home Phone: ( ) _____ Cell Phone:( ) _____

Email Address: _____

DOB: __/__/__ Age: _____ Occupation: _____

SIGNIFICANT RELATIONSHIP STATUS:

☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Committed Relationship

LIST ANY MEDICATIONS YOU ARE TAKING:

Name	Dosage	Prescribed for

PLEASE STATE WHAT BRINGS YOU IN:

_____

_____

HOW LONG HAS THIS BEEN OCCURRING?

_____

ALCOHOL AND OTHER DRUG USE

Please tell me about your use of alcohol and other substances:	Never	Seldom	Once a month	2-3 times a month	Weekly	Daily
I drink 4 or more drinks in a 24-hr period.	❒	❒	❒	❒	❒	❒
I have missed work/school due to drinking.	❒	❒	❒	❒	❒	❒
After drinking, I have forgotten where I was or what I did.	❒	❒	❒	❒	❒	❒
I use other recreational drugs*.	❒	❒	❒	❒	❒	❒
I have missed work/school due to recreational drugs*.	❒	❒	❒	❒	❒	❒
After using recreational drugs*, I have forgotten where I was or what I did.	❒	❒	❒	❒	❒	❒

***RECREATIONAL DRUGS INCLUDE**, among others: marijuana; cocaine; ecstasy; heroin; meth; as well as any prescription or over-the-counter drugs taken for recreational purposes.*

PREVIOUS MENTAL HEALTH TREATMENT:

Please list any psychiatrists, therapists, hospitals, self-help groups, and residential treatment centers, and the issues for which you were seen.

_____

_____

FAMILY MENTAL HEALTH HISTORY

		If YES, please check the box for all applicable family members							Successfully Treated?	
Clinical Diagnosis	NO ONE	Mother	Father	Brothers	Sisters	Cousins	Aunts/ Uncles	Grand-parents	Yes	No
Depression	❒	❒	❒	❒	❒	❒	❒	❒	❒	❒
Bipolar Disorder	❒	❒	❒	❒	❒	❒	❒	❒	❒	❒
Anxiety/Panic Disorder	❒	❒	❒	❒	❒	❒	❒	❒	❒	❒
Eating Disorder	❒	❒	❒	❒	❒	❒	❒	❒	❒	❒
ADD/ADHD (Attention Deficit)	❒	❒	❒	❒	❒	❒	❒	❒	❒	❒
Post-traumatic Stress Disorder	❒	❒	❒	❒	❒	❒	❒	❒	❒	❒
Obsessive-Compulsive Disorder	❒	❒	❒	❒	❒	❒	❒	❒	❒	❒
Borderline Personality Disorder	❒	❒	❒	❒	❒	❒	❒	❒	❒	❒
Schizophrenia or Psychosis	❒	❒	❒	❒	❒	❒	❒	❒	❒	❒
Alcohol or Other Substance Abuse	❒	❒	❒	❒	❒	❒	❒	❒	❒	❒

Other family mental health information: _____

_____

Please describe any illness, loss, accident, or hospitalization that had a big impact on your life, and give the dates of their occurrences

_____

_____

Do you have any major health concerns?

_____

CURRENT & PREVIOUS SYMPTOMS/BEHAVIORS/EXPERIENCES

NOW	PAST		NOW	PAST	
DISTRESSING SYMPTOMS			**WORK/ACADEMIC CONCERNS**		
☐	☐	Stress	☐	☐	Procrastination
☐	☐	Anxiety/nervousness	☐	☐	Time management
☐	☐	Panic attacks	☐	☐	Poor performance evaluations/grades
☐	☐	Perfectionism	☐	☐	Test, speech, or performance anxiety
☐	☐	Fearfulness/paranoia	☐	☐	Conflict with a colleague, boss, or professor/teacher
☐	☐	Obsessive thoughts	**BODY IMAGE AND FOOD USE**		
☐	☐	Compulsions/rituals	☐	☐	Binge eating
☐	☐	Depression	☐	☐	Purging (vomiting)
☐	☐	Difficulty concentrating	☐	☐	Laxative use/abuse
☐	☐	Motivation problems	☐	☐	Diet pill use/abuse
☐	☐	Difficulty *falling* asleep	☐	☐	Restricting food intake or avoiding food/fasting
☐	☐	Difficulty *staying* asleep	☐	☐	Overeating
☐	☐	Loss of appetite	☐	☐	Dieting
☐	☐	Excessive crying	☐	☐	Being overweight or underweight
☐	☐	Irritability/anger/hostility	☐	☐	Excessive exercise
☐	☐	Mania (overly energized with unusual thoughts or behaviors)	**ADDICTION/DEPENDENCE CONCERNS**		
☐	☐	Suicidal feelings/thoughts	☐	☐	Alcohol addiction/dependence/overuse/abuse
☐	☐	Suicide attempt(s)	☐	☐	Drug addiction/dependence/overuse/abuse
ROMANTIC RELATIONSHIP CONCERNS			☐	☐	Prescription drug addiction/dependence/overuse/abuse
☐	☐	Dating concerns	☐	☐	Smoking/tobacco use
☐	☐	Concerns about sex	☐	☐	Gambling
☐	☐	Conflict with partner/spouse	☐	☐	Excessive internet use
☐	☐	Break-up/end of romantic relationship	☐	☐	Sexual addiction
SOCIAL RELATIONSHIP CONCERNS			**CONCERNS INVOLVING VIOLENCE**		
☐	☐	Difficulty making friends	☐	☐	Unwanted sex
☐	☐	Loneliness	☐	☐	Being stalked
☐	☐	Social anxiety	☐	☐	Intimate relationship violence
☐	☐	Conflict with friend(s)	☐	☐	Problems with anger control
GENDER/SEXUAL ORIENTATION CONCERNS			☐	☐	Participant in a violent incident
☐	☐	Gender identity or gender issues or questions	☐	☐	Witness of a violent incident
☐	☐	Lesbian/gay/bisexual issues or orientation questions	☐	☐	Perpetrator of abuse (physical/sexual/psychological)
☐	☐	Asexual/Demisexual/Greysexual issues or questions	☐	☐	Survivor of abuse (physical/sexual/psychological)

HOME AND FAMILY EXPERIENCES

Did the following occur in your family/home environment?	Yes	No	Not Sure
Parents divorced or permanently separated	❒	❒	❒
Frequent, hostile arguing among family members	❒	❒	❒
Death of a parent or sibling	❒	❒	❒
Parent(s) or sibling(s) with a drinking or drug problem	❒	❒	❒
Family member with an eating problem	❒	❒	❒
Family member with a debilitating illness, injury, or disability	❒	❒	❒
Family member prosecuted for criminal activity	❒	❒	❒
Family member attempted/committed suicide	❒	❒	❒
Physical abuse in your family	❒	❒	❒
Sexual abuse in your family	❒	❒	❒

Is there any other information about your mental health/emotional wellness that you believe will be pertinent to or could impact your care and treatment? Please explain below.

_____
_____
_____
_____
_____
_____

I hereby certify that all the above information is true and correct to the best of my knowledge and belief.

_____
Signature

_____
Name

_____
Date

My Personal Crisis Response Safety Plan

Should I experience a mental health crisis, I will do the following:

1. I will try to identify specifically what is upsetting me.

2. I will write down other responses I can have to this situation that do not involve harming myself.

3. I will review the thoughts and conclusions that I've come to about this situation and try to figure out if they are either accurate or helpful.

4. I will do something I enjoy that helps me feel better for at least 30 minutes. Some of these activities may include:
   _____
   _____
   _____

5. I will talk with someone whom I trust to be supportive about how I'm feeling. These people may include (list names and numbers):
   _____
   _____
   _____

6. I repeat all of the above *at least one more time.*

7. If the thoughts continue, and I find myself preparing to do something to myself, I will call my preferred local crisis line or suicide hotline (example: 1-800-273-TALK). Please list options below:
   _____
   _____
   _____

8. If I still feel in danger of harming or killing myself and don't feel I can control my behavior I will call 911 or go to the ER. My preferred ER is:
   _____

Name and Phone Numbers of Other Important Contacts for Me

Case Manager: _____
Therapist: _____
Psychiatrist: _____
Clinic Where I Get Services: _____
PCP: _____
Emergency Contact: _____

_____ _____ _____
Name Signature Date