**Agape Counseling Services**

**Initial Assessment**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about Agape Counseling? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Method of Payment: Cash Money Order Credit Card/Debit

**Biological Assessment**

Are you currently seeing a doctor for any medical issues? Please describe. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking any medications? If yes, please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you want your counselor to coordinate with your doctor? \_\_\_\_\_\_\_ If yes, please list your primary doctor’s name and contact information \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any other health issues that you are concerned about or that would prevent you from participating in services with Agape Counseling? Please describe. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychological Assessment**

Do you have any history of dealing with a mental health issue? If yes, please describe the issue, duration, if treatment was received, type and duration of treatment. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any history of dealing with substance abuse or an addiction? If yes, please describe the addiction, duration, if treatment was received, type and duration of treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any family history of mental illness or addiction? If so, please describe.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social Assessment**

Are you currently employed? If yes, please describe nature of employment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe your educational background (ie. HS diploma, some college, BA/BS, post grad)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe your marital status (ie. married/partnered, divorced, separated, living together, in a relationship, single) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have children? Please list how many and their ages. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have people in your life you feel are supportive? Please describe their relationship to you.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have any current or past legal issues? If yes, please describe.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any special interests, strengths or abilities you would like to share with your counselor.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cultural/Spiritual Assessment**

Do you identify with any specific culture or religion? Please describe.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any cultural or religious preferences that you would like your counselor to respect during your services? Please describe. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Presenting Concern**

Issue you are seeking help for:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe what brings you to Agape Counseling Services. Are there any specific things that you would like to focus on or help with during your services at Agape?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been referred by a court or probation officer? If so, please tell us the name and phone number of who we will be corresponding with:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*INFORMATION SHEET-MINORS*

Person completing form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Minor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is the primary contact person responsible for minor?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who has legal custody/guardianship of the minor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mother’s Age:\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father’s Age:\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other adults legally or medically responsible for minor:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Minor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Message phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Minor’s school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_

List Current medical issues or medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Minor’s Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has minor ever seen another counselor? \_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_ No

Is yes, whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any additional information you want or need the counselor to know:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONSENT FOR TREATMENT OF MINOR

Note: In shared custody situations, both custodians must sign a consent form. Treatment cannot be provided beyond the first session without a signed consent form for all legal guardians/custodians of the minor.

Minor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Message Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is the primary contact person responsible for minor?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

“I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am the parent/guardian of the minor named above. I have read, understood, and had the opportunity to address any questions/concerns I have regarding treatment. I understand my child/adolescent will be treated with the best judgement possible. I hereby acknowledge that I am willing for my child/adolescent to receive coaching or counseling services.”

List any restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Signature of Father/Guardian Phone Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (printed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Signature of Mother/Guardian Phone Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (printed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Darcy Bracamonte Signature

*For Substance Abuse Counseling Clients:*

*Substance(s) Abuse History:*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Past and Current Drug(s):*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Age at First Use of Drug:*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Family History of Substance Abuse:*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Negative Consequences of Use:*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Agape Counseling Services, LLC

STATEMENT OF INTENT FOR COACHING

Counseling /therapy is different in nature than "coaching". Some issues do not necessarily require the depth or diagnostic assessment that is involved in counseling. Life coaching relies on the belief that there are numerous skills that can be learned by the client in order to impact their lives for the better.

All coaching services, educational methods, and resources delivered by Darcy Bracamonte are meant to challenge, uplift, and support you psychologically. However, coaching is not psychotherapy. If you feel psychologically stressed to the point that it is interfering with your ability to function, please have the courage to seek the help you need from a counselor who specializes in your area or difficulty. We can refer you to someone, should you request that. Life coaching may augment your therapy, but the work of coaching is meant to be done when major emotional and psychological wounds are already healing or healed.

Please read the following and sign below should you agree to each statement and wish to proceed:

• I understand that the life coaching services I will be receiving from Darcy Bracamonte are not offered as a substitute for mental health care. I also understand that my coach, Darcy Bracamonte, is not acting as a psychotherapist, and does not purport to offer mental health care in this instance.

• I understand that my coach will maintain the confidentiality of our communications only to the extent defined by the laws of the state.

• I understand and agree that I am fully responsible for my well- being during my coaching calls, and subsequently, including my choices and decisions.

• I understand that all comments and ideas offered by my coach are solely for the purpose of aiding me in achieving my defined goals. I have the ability to give my informed consent, and hereby give such consent to my coach to assist me in achieving such goals.

• I hereby release, waive, acquit and forever discharge Darcy Bracamonte and Agape Counseling Services, LLC, their agents, successors, assigns, personal representatives, executors, heirs and employees from every claim, suit action, demand or right to compensation for damages I may claim to have or that I may have arising out of actions, omissions, or commissions taken by myself as a result of the advice given or otherwise resulting from the coaching relationship contemplated hereunder. I further declare and represent that no promise, inducement or agreement not herein expressed has been made to me to enter into this release. The release made pursuant to this paragraph shall bind my heirs, executors, personal representatives, successors, assigns, and agents. I have read the statements above and I understand and agree with the points contained therein:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

**Agape Counseling Services**

**Release of Information Form**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ herby authorize my information to be shared with:

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The below information can be shared:

\_\_\_\_\_(initial) Information needed for billing purposes

\_\_\_\_\_ (initial) Information related to assessment and treatment goals

\_\_\_\_\_ (initial) Substance Abuse information (probation, courts)

\_\_\_\_\_ (initial) Emergency Contact Only

\_\_\_\_\_ (initial)Information needed for coordination of care

I understand that my records are protected under the federal and that I must give permission for my records to be released.

I understand that my records are being forwarded to the aforementioned parties and the records may contain information about sensitive information, and/or alcohol and drug use/abuse and authorize the release of these records. I understand that I may revoke this consent at any time except to the extent that action has been taken, and that in any event this consent expires automatically one year from the date of signature.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ \_\_\_\_\_\_\_\_

Printed Name Signature Date

AGAPE COUNSELING SERVICES, LLC

**INFORMED CONSENT FOR ASSESSMENT & TREATMENT**

Please initial on the lines provided to indicate that you have read each section of this document; that you understand the information provided below; and that you consent to be treated by Agape Counseling Services.

**Background and Services** \_\_\_\_\_\_\_(Initial)

Agape Counseling Services (Agape) is a Limited Liability Company (LLC). Agape Counseling Services offers professional counseling, coaching, and educational services to individuals. Each counselor and coach offers services in a variety of treatment areas based on their education, training, and experience. None of Agape Counseling Services counselors will provide treatment in any area that is beyond their ability or training. If Agape does not have a counselor that is a good fit for your treatment needs, you will be offered referrals to other treatment providers.

All Agape counselors will have, at minimum: (1) a master’s degree in their chosen field; and (2) a current license from the Arizona Board of Behavioral Health Examiners (AZBBHE). Each counselor will have a “Professional Disclosure Statement” form that will further highlight their individual credentials, background, and experience. Please note that Agape counselors are independent contractors, and clients are the clients of Agape, and not the contracted counselor.

**Purpose, limitations, and risks of treatment** \_\_\_\_\_\_(Initial)

The purpose of counseling is: (1) to identify the issues that are causing you distress; (2) to create goals and objectives that will help you resolve those issues; and (3) to achieve positive results through a process of personal change. Change is not always easy; sometimes it can be slow and even frustrating. Further, the counseling process sometimes involves working through personal issues that can result in emotional distress or psychological pain for the client. The counseling process requires a commitment of time and energy on the part of the client. While Agape certainly hopes that counseling will help you identify and achieve your goals, it is important that you understand the limitations and risks of treatment discussed above, and that there are no guarantees that the counseling process will be effective.

If you are participating in coaching, and not in counseling services, there are different goals and objectives that will be assessed and worked on. "Coaching" is usually much shorter in duration than counseling, but also requires commitment and patience with the process. There is no quick-fix, and it takes time to make the desired changes in one's life.

**Treatment process and rights** \_\_\_\_\_\_(Initial)

Your counseling will begin with one or more sessions devoted to an initial assessment, so that your counselor or coach can develop an appropriate understanding of the issues, your background, and any other factors that may be relevant. When the initial assessment process is complete, you and your counselor or coach will discuss ways to treat the problem(s) and develop a treatment plan. You have the right to participate in treatment decisions and in the development and periodic review and revision of your treatment plan. You also have the right to refuse

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any recommended treatment, or to withdraw your consent for treatment. You have the right to accept or reject any information or counsel presented by your counselor.

**Privacy, confidentiality, and records** \_\_\_\_\_\_(Initial) In general, the privacy of all communication between a client and a counselor/coach, including that of minors, is protected by law. As such, your counselor is not at liberty to release information to another professional or interested party without written permission from the client, except when such disclosure is permitted or required by law. Disclosure may be required (i.e., confidentiality may not apply) in the following circumstances:

1. When there is a reasonable suspicion of child abuse (sexual, emotional, physical, or neglect); elder abuse; or abuse of a dependent adult. In these situations, the counselor is required by law to file a report with the appropriate state agency or law enforcement. There is no limit on child abuse reporting; in the event that an adult client discloses childhood abuse, a report may be filed if there is reason to suspect that the abuser is still victimizing a minor. As mandated reporters, counselors are required to report in such situations, and are not given the latitude to determine what is or is not abuse.

2. When the counselor believes that there is the threat of harm or endangerment to the client or an identifiable other. In these cases, action may include notifying the potential victim; contacting law enforcement; contacting a client's emergency contact; seeking hospitalization for the client; or more.

3. When a court of law issues an order to provide testimony or produce documentation, and such disclosure is required by law.

There are other circumstances when confidential information may be released, including: (1) when disclosure is required by the Arizona Board of Behavioral Health Examiners; (2) if a lawsuit is filed against Agape Counseling Services; (3) to comply with worker compensation laws; (4) to comply with the USA Patriot Act; (5) to comply with any other federal, state or local laws; and more. The rules and laws regarding confidentiality, privacy, and records are complex, so please discuss any questions or concerns you have about confidentiality with your counselor and coach.

In the case of Minors (under the age of 18): please be aware that the parent(s)/guardian(s) will receive reasonable updates on the client's treatment that do not break the client's confidentiality. The client will be made aware of these updates, unless doing so poses possible harm. Confidentiality will not apply if the client presents a possible harm to self or others. Agape counselors are committed to your privacy. Your counselor will not initiate contact with you outside of the counseling setting (for example, your counselor will not initiate contact with you if you see him/her at church, in a store, etc.). Agape asks that you also maintain the privacy of other clients that you may see at Agape.

Regarding your client file and records, you may request information from your file by filling out an “Authorization to Release Information” form. Files are the property of Agape, not the client. Agape can release joint records only with the consent of all participating clients.

**Email and Electronic Communication** \_\_\_\_\_\_(Initial) Please be advised that any communication delivered and/or stored electronically (via computer or email) may not be completely secure and could result in unforeseen limits on privacy.

**Financial Agreements** \_\_\_\_\_\_(Initial) Fees for counseling services range from $90-130, dependent on specific services. Payment should be made at the beginning of each session, unless other arrangements have been made, and in cash, money order check, or credit cards only.

By signing this document, you are agreeing to pay for the counseling or coaching services provided to you, as well as any additional expenses that may be accrued in collecting fees (including a $15 fee for returned checks). In addition to the basic session and assessment fees, there may be other fees for additional services such as testing, telephone counseling, books and materials, etc. Agape Counseling Services reserves the right to change our fees with 30-days' notice. You have the right to be informed of all fees that you are required to pay and our refund and collection policies.

No-Show/Late Cancel Fees: NWCC requires 24-hours advance notice on any cancellation or rescheduled appointment. The first violation of this policy will result in a $30 no-show/late-cancel fee. The second violation will result in you being billed the full fee for the missed session and may require you to pre-pay for any additional sessions. Repeated late cancellations or missed appointments may result in termination of treatment. Clients may not be able to reschedule if they fall behind more than two payments on their account.

Refund Policy: All fees for counseling services that are delivered to you are nonrefundable. However, if you have pre-paid for multiple sessions, you can request a refund of all unused counseling fees at any time. You are also entitled to a refund on any unused overpayments (i.e., credits) on your account.

Collections Policy: If you are more than 30 days delinquent with payment(s), Agape reserves the right to turn your account over to a collections service or agency. It is the client's responsibility to keep current contact information on file.

**Insurance** \_\_\_\_\_\_ (Initial) Agape Counseling Services does not currently accept insurance. You are welcome to pursue reimbursement through your insurance company, and Agape can provide you with a receipt (including diagnostic information, if necessary) so that you can file for reimbursement. However, you (the client) are responsible for the full payment of your session fee; any reimbursement to you would need to be negotiated between you and your insurance company.

**Availability of Services and Emergency Situations** \_\_\_\_\_\_(Initial) Agape Counseling Services is a part-time, outpatient counseling center. As such, its counselors are not immediately available and may not be able to respond quickly in an emergency or crisis situation.

If you should find yourself in an emergency or crisis situation at any point during your treatment, please contact your local Emergency Services number (“911”), or go immediately to the closest emergency room. Current clients are always welcome to leave a message for their counselor via voicemail or email, but an immediate response can never be guaranteed, as phone and email messages are not immediately received, reviewed, or forwarded to the counselor.

**Consent for evaluation and treatment** \_\_\_\_\_(Initial) By signing below, I give my consent for evaluation and treatment under all of the terms described in this document. It is agreed that either client or counselor may discontinue the counseling process at any time, and that the client is free to accept or reject any treatment provided. In the case of a minor child, I affirm that I am a custodial parent or have legal guardianship rights of the child, and that I authorize services for the child under the terms of this agreement. I verify that I have read, had an opportunity to ask questions, and understand this informed consent document.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

Agape Counseling Services, LLC

PROFESSIONAL DISCLOSURE STATEMENT

We want you to be well-informed regarding your counselor’s credentials and level of experience before your first session. Please read the following information and address any questions or concerns before or during your first session.

**Darcy Bracamonte, M.A.,**

**Licensed Independent Substance Abuse Counselor (LISAC),**

**National Certified Counselor (NCC)**

Darcy earned her Master’s Degree from Northern Arizona University in 2000, and has been licensed with the Arizona Board of Behavioral Health Examiners (AZBBHE) since 2004. Darcy is also a “National Certified Counselor” through the National Board of Certified Counselors. Darcy began her counseling career as an intern with Christian Family Care Agency. She then counseled and led substance abuse groups for a private counseling agency in Peoria, AZ. Darcy also taught classes as an adjunct professor at Glendale Community College. Darcy is licensed to offer substance abuse counseling, life coaching, assessments, psycho-educational resourcing, and consulting for a variety of issues.

\*PLEASE NOTE: Darcy is not a medical physician nor a doctorate-level psychologist or psychiatrist, and is unable to prescribe medication or assess or treat individuals for psychotic disorders. Any medical or physiological symptoms should be addressed by a qualified MD or doctorate-level specialist (referrals are available).

Client 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signing indicates you have read and understood this disclosure statement.

Client 2:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signing indicates you have read and understood this disclosure statement.

Agape Counseling Services, LLC

Notice of Privacy Practices

We would like you to be aware about how your protected health information may be used and how you can get access to this information.

**You have specific rights when it comes to your health information. Let us explain the responsibilities we have to you.**

|  |  |
| --- | --- |
| Copy of Medical Record | You may ask to receive a copy of your records and a summary of your health information. Please allow 30 days to process your request. We may charge a reasonable fee in order to provide this service to you. |
| Correcting your medical records | You may want to correct some health information we have about you that is incorrect or incomplete. Please ask us. We will let you know within 60 days, if we will be able to do that for you. |
| Request confidential communication | If you'd like to be contacted in a specific way (home or office phone, email, etc) that is a reasonable request. |
| Asking limited use of what we share | You may request that certain information for treatment, payment or our operations not be shared. We are not required to agree with your request, and if it impairs your care, we may say no to your request. |
| List of those we have shared information with | You can ask for a list of the times we shared your information for six years prior to the date you asked, with who, what and why. We will include all information you asked for, once per year free of charge. Within 12 months, more requests will be charged a small fee. |
| Copy of this privacy notice | We can provide you with a copy of this notice. |
| Choose someone to act for you | If someone is your power of attorney or legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has authority to act for you. |
| File a complaint if your rights are violated | A complaint can be filed with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W. Washington, D.C. 20201, calling 1-877-696-6775 or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.  We will not retaliate against you for filing a complaint. |

**For certain health information, you can tell us your choices about what we share. We will follow your instructions.**

|  |  |
| --- | --- |
| In these instances, you have the right to tell us to: | Share information with your family, friends, or others involved in your care.  Share information in a disaster relief situation.  Include your information in a hospital directory. |
| In these cases, we never share you information unless you have given written permission | Marketing, sales of your information, sharing of therapy notes |

**Our Uses and Disclosure: How do we typically use or share your health information?**

|  |  |
| --- | --- |
| Treating you | We can use your health information and share it with other professionals who are treating you. |
| Running our organization | We can use and share your health information to run our practice, improve your care and to contact you when necessary. |
| Billing for services | We can share your information to bill and receive payment from health plans and entities. |

**How else can we use or share your health information?**

|  |  |
| --- | --- |
| Help with public health and safety issues | We can share your health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect or domestic violence, and preventing or reducing serious threat to anyone's safety or health |
| Research | We can use or share your information for health research |
| Law | If federal or state laws require it, including the Department of Health and Human Services if it wants to see that we are complying with federal privacy laws. |
| Working with medical examiner or funeral director | Sharing information with a coroner, medical examiner, or funeral director when an individual dies. |
| Addressing workers' compensation, law enforcement, and other government requests | For worker's compensation claims, law enforcement purposes, oversight agencies authorized by law, probation officers, and for special government functions such as military, national security, and presidential protective services. |
| Responding to lawsuits and legal actions | Sharing information about you in response to a court or administrative order, or in response to a subpoena. |

Our Responsibilities:

* We are required by law to maintain the privacy and security of your protected health information.
* We will let you know if a breach occurs that may have compromised the privacy and security of your information.
* We must follow the duties and privacy practices described in this notice and offer you a copy of it.
* We will not use or share your information other than as described here unless you tell us we can do so in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
* We can change the terms of this notice and the changes will apply to all information we have about you. The new notice will be available to you in our office.

If you believe your rights have been violated, you may file a complaint with the U.S. Department of Health and Human Services. For more information, see www.hhs.gov/oct/privacy/hipaa/understanding/consumers/noticepp.html

I have reviewed this Notice of Privacy Practices for Agape Counseling Services and have been offered a copy for my records.

Name (print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_

If client is a minor:

Parent/Guardian Name (print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_

*Thank you for choosing Agape Counseling Services. We look forward to serving you!*