Strive Counseling Services, LLC 2024 3rd Avenue N. Suite 312-Birmingham, AL 35203

Teen/Child Intake Form

Date: ________________

Client Name: ________________________________ DOB: ____________

Person completing form (e.g., parent/guardian): ________________________ Relationship: __________

If you are unable to answer any of the questions below, please write DK (Don't Know) in the blank provided.

ETHNICITY (*optional*):

___ Caucasian
___ Hispanic
___ African American
___ Native American
___ Asian
Other: ____________

HOUSEHOLD *Intimate Relationship*

___ never been in a serious relationship
___ not currently in serious relationship
___ currently in a serious relationship
___ not currently looking for serious relationship

Relationship Satisfaction

___ very satisfied
___ satisfied
___ somewhat satisfied
___ very dissatisfied
___ dissatisfied

List all persons currently living in child's household

Name	Age	Sex	Relationship to child

List children and stepchildren not living with child

Name	Age	Sex	Freq of visit/Relationship

Describe any past or current significant issues intimate relationships

____

____

____

____

____

HISTORY

FAMILY OF ORIGIN

Present during Childhood:

Mother [ ]
Father [ ]
Stepmother [ ]
Stepfather [ ]
Brother(s) [ ]
Sister(s) [ ] Other: __ [ ]

Parent's current marital status:

[ ] Married to each other for ___ years
[ ] Separated for ___ years
[ ] Divorced for ___ years
[ ] Mother remarried ___ times
[ ] Father remarried ___ times
[ ] Mother involved with someone

[ ] Father involved with someone

[ ] Mother deceased for ___ years

(your age at mother's death: ___)

[ ] Father deceased for ___ years

(your age at father's death: _

Describe parents:

Describe child's family experience:

[ ] outstanding home environment

[ ] normal home environment

[ ] chaotic home environment

[ ] alcoholic/addicted parent(s)

[ ] poverty (serious financial problems)

[ ] witnessed or was aware of physical/verbal/sexual abuse (circle all that apply)

[ ] experienced physical/verbal/sexual abuse from others (circle all that apply)

Father: [ ] biological [ ] adoptive [ ] step [ ] other

Full name: ____________________________

Occupation: ____________________________ Education: ____________________________

General health: ____________________________

Mother: [ ] biological [ ] adoptive [ ] step [ ] other

Full name: ____________________________

Occupation: ____________________________ Education: ____________________________

General health: ____________________________

Describe any abuse the child has experienced: ____________________________

____

____

Other difficult experiences the child has had: ____________________________

____

____

Age of emancipation from home: ____________ *Circumstances*: ____________________________

Describe any past or current significant issues In other intimate relationships : ____________________________

____

____

DEVELOPMENTAL HISTORY *(check all that apply to child's development)*

Problems during mother's pregnancy:

[ ] none

[ ] high blood pressure

[ ] bed rest

[ ] alcohol use

[ ] drug use

[ ] cigarette use

[ ] other _______

Birth:

[ ] normal delivery

[ ] difficult delivery

[ ] cesarean delivery

[ ] complications: ____________

Birth weight: ________

Infancy:

[ ] feeding problems

[ ] sleep problems

[ ] toilet training problems

[ ] colic

Childhood health:

[ ] lead poisoning (age:)

[ ] ear infections

[ ] head injury (list age and describe: ______________________)

[ ] other significant injury (list age and describe: ______________________)

[ ] asthma (age diagnosed) [ ] seizures (type and ages: ______________________)

[ ] hearing loss (age diagnosed and severity: ______________________)

[ ] impaired vision not corrected by lenses (age diagnosed: ______________________)

[ ] surgeries (ages and type: ______________________)

[ ] chronic, serious health problems: ______________________

Delayed developmental milestones (check only those that were not reached at expected age):

[ ] sitting [ ] engaging peers [ ] walking
[ ] rolling over [ ] tolerating separation [ ] speaking
[ ] standing [ ] toilet training [ ] riding bicycle

Social interaction (check all that apply to child):

[ ] normal social interaction
[ ] very shy
[ ] inappropriate sex play
[ ] isolated self
[ ] dominated others
[ ] had acting out friends
[ ] other: ______________

Emotional/behavior problems (check all that apply to child):

[ ] drug use
[ ] alcohol abuse
[ ] stealing
[ ] often sad
[ ] violent temper
[ ] disobedient
[ ] distrustful
[ ] hostile/angry
[ ] impulsive
[ ] indecisive
[ ] immature
[ ] hyperactive
[ ] extreme worrier
[ ] self-injurious acts
[ ] fire-setting
[ ] anxious
[ ] easily distracted
[ ] frequently daydreamed

Intellectual/academic functioning (check all that apply to child):

[ ] normal intelligence
[ ] high intelligence
[ ] mild retardation
[ ] moderate retardation
[ ] authority conflicts
[ ] attention problems
[ ] special education from ____ to ____ for ______________________________

Current or highest education level: ______________________________

SOCIO-ECONOMIC HISTORY *(check all that apply)*

Living situation:
[ ] housing adequate
[ ] homeless
[ ] housing overcrowded
[ ] dependent on others for housing
[ ] housing dangerous/ deteriorating

Employment:
[ ] employed and satisfied
[ ] employed but dissatisfied
[ ] unemployed
[ ] coworker conflicts
[ ] change jobs a lot
[ ] disabled: ____________

Financial situation:
[ ] no current financial problems
[ ] large indebtedness
[ ] poverty
[ ] impulsive spending
[ ] relationship conflicts over finances

Social support system:
[ ] supportive network
[ ] few friends
[ ] substance-use-based friends
[ ] no friends
[ ] distant from family of origin
[ ] living companions dysfunctional

Legal history
[ ] no legal problems

Sexual history:
[ ] heterosexual orientation

Cultural/Spiritual/Recreational history:
Cultural identity (e.g. ethnicity, religion):

Internal Use

[ ] now on parole/probation
[ ] arrest(s) not substance-related
[ ] arrest(s) substance-related
[ ] court ordered this treatment
[ ] jail/prison ___ time(s); total time served: _

____

____
[ ] describe last legal difficulty:

____

[ ] homosexual orientation
[ ] bisexual orientation
[ ] currently sexually active
[ ] not currently sexually active
[ ] currently sexually dissatisfied
[ ] history of unsafe sex: ages __ to __
[ ] age first sexual experience: ___
[ ] age first pregnancy or

____

____

Describe any cultural issues that contribute to current problem: ______________________________

____

	Yes	No
Active in community/recreational activities?	[ ]	[ ]
Was active in community/recreational activities?	[ ]	[ ]
Currently engage in hobbies?	[ ]	[ ]
Currently participate in spiritual activities	[ ]	[ ]

____

Name and city of church attended: ______________

____

Describe any other developmental problems or issues: ______________________________

If answered "yes" to any of the above, describe:

____
____
____

MEDICAL AND PSYCHOLOGICAL HISTORY

Primary Care Physician: ____________________________________ ` ______________ Phone:____________________

Psychiatrist (*if any*): ____
Phone: ________________

Describe current physical health: [ ] Good [ ] Fair [ ] Poor

List any current medical conditions: ____
____
____

List any known allergies: ____

Describe any serious hospitalization or accidents. Include Date, Age, and Reason
____
____
____

Has child previously taken medication to treat psychological problems? [ ] no [ ] yes (include below)
List any medications currently taken:

Internal Use

Medication	Reason	Dosage	Freq	Start/End Date	Physician	Side Effects	Beneficial?

Which of the following areas of functioning have been impaired by psychological problems? (*Check all that apply*)

[ ] Occupational [ ] Academic [ ] Social [ ] Affective (Emotional) [ ] Physical

Is there a history of any of the following in the family?

___ tuberculosis
___ birth defects
___ emotional problems
___ behavior problems
___ thyroid problems
___ cancer
___ mental retardation
___ heart disease
___ high blood pressure
___ alcoholism
___ drug abuse
___ diabetes
___ Alzheimer's disease or dementia
___ stroke
___ other chronic or serious health problems: ____________

Has any family member ever received a psychiatric diagnosis or psychological treatment (inpatient or outpatient)? [ ] No [ ] Yes (describe below)

Has any family member ever taken medication for a psychological problem ? [ ] No [ ] Yes (describe below)

SUBSTANCE USE HISTORY *(check all that apply)*

Family alcohol/ drug abuse history:

[ ] father
[ ] mother
[ ] stepparent/live-in
[ ] uncle(s)/aunt(s)
[ ] grandparent(s)
[ ] sibling(s)
[ ] spouse/significant other
[ ] children
[ ] other ____________

Substance use status:

[ ] no history of abuse
[ ] active abuse
[ ] early full remission
[ ] sustained full remission [ ] sustained partial remission

Issues related to substance abuse:

[ ] hangovers
[ ] seizures
[ ] blackouts
[ ] overdose
[ ] assaults
[ ] binges
[ ] job loss
[ ] arrests
[ ] suicidal impulse
[ ] sleep disturbance
[ ] withdrawal symptoms
[ ] medical conditions
[ ] tolerance changes
[ ] loss of control of amount used
[ ] relationship conflicts

Substances used:

	First use age:	Current use? (Yes/No)	Last use age:	Frequency	Amount
[ ] Alcohol					

	______	______	______	______	______
[ ] amphetamines/speed	______	______	______	______	______
[ ] barbiturates/owners	______	______	______	______	______
[ ] caffeine	______	______	______	______	______
[ ] cocaine	______	______	______	______	______
[ ] crack cocaine	______	______	______	______	______
[ ] hallucinogens (e.g, LSD)	______	______	______	______	______
[ ] heroin	______	______	______	______	______
[ ] inhalants (e.g., glue, gas)	______	______	______	______	______
[ ] marijuana or hashish	______	______	______	______	______
[ ] nicotine/cigarettes	______	______	______	______	______
[ ] PCP	______	______	______	______	______
[ ] prescription: ________	______	______	______	______	______
[ ] other:	______			______	______

PREVIOUS TREATMENT

PSYCHIATRIC HOSPITALIZATIONS AND TREATMENT (INCLUDING CD TREATMENT)

Prior outpatient psychotherapy or counseling? [ ] No [ ] Yes *If yes, complete the following:*

Age at time	Psychotherapist/Counselor (Agency, City)	Duration	Circumstances for treatment
__________	____________________	__________	____________________
__________	____________________	__________	____________________
__________	____________________	__________	____________________
__________	____________________	__________	____________________
	____________________		____________________

____

Is child currently seeing any of the above? [ ] No [ ] Yes *If yes, please include name here:*

Internal Use

Prior hospitalizations or <u>inpatient</u> treatment for psychological or CD issues? [ ] No [ ] Yes *If yes, complete the following*:

Age at time	Hospital/Treatment Center	Duration	Circumstances for treatment
___	___	___	___
___	___	___	___
___	___	___	___
___	___	___	___
	___		___

PREVIOUS DIAGNOSES

Has child ever been diagnosed with a psychiatric, substance abuse, learning, emotional, or behavioral disorder??

[ ] No [ ] Yes *If yes, complete the following*:

Diagnosis	Age	Diagnosis made by	Agree?
___	___	___	___
___	___	___	___
___	___	___	___
___	___	___	___
	___		

CURRENT SYMPTOM CHECKLIST (*Rate the intensity of the symptoms present in the <u>last two weeks</u>*)

None = This symptom is not present at this time **Mild** = This symptom is currently impacting my quality of life, but not significantly impairing my day-to-day functioning **Moderate** = This symptom is significantly impacting my quality of life and/or day-to-day functioning **Severe** = This symptom is profoundly impacting my quality of life and/or day-to-day functioning

Symptom	None	Mild	Moderate	Severe
Depressed mood				
Low energy				
Sleep disturbances				
Dissociation				
Hyperactivity				
Bingeing				
Decreased sex drive				
Unresolved guilt				
Irritability				
Nausea/acid indigestion				
Social anxiety				
Self-mutilation/cutting				
Impulsive actions/speech				
Nightmares				
Elevated mood				
Losing train of thought				
Mood swings				
Disorganized				
Anorexia				
Social isolation				

Symptom	None	Mild	Moderate	Severe
Increased or decreased appetite				
Unplanned weight gain				
Unplanned weight loss				
Paranoid thoughts				
Poor concentration/indecisive				
Purging/over-exercising				
Excessive worrying				
Low self-worth				
Anger management problems				
Tension				
Hallucinations				
Racing thoughts				
Restlessness				
Loss of interest in normal activity				
Decreased creativity/productivity				
Unresolved anger				
Easily distracted				
Memories of trauma				
Hopelessness				
Marital problems				

Internal Use

Grief						Panic attacks				
Phobias						Suicidal thoughts				
Headaches						Feel panicky/anxious				
Loneliness						Work problems				
Problems at Home						Has attempted suicide in the past				

Briefly describe how the above symptoms impair the child's ability to function: ______________________________

____

____

[ ] Death of a family member
[ ] Health problems in family
[ ] Disruption of family by separation
[ ] Disruption of family by divorce
[ ] Disruption of family by estrangement
[ ] Marriage stress
[ ] Removal from the home
[ ] Remarriage of parent
[ ] Sexual abuse
[ ] Physical abuse
[ ] Parental overprotection
[ ] Neglect of a child
[ ] Inadequate discipline
[ ] Discord with siblings
[ ] Birth of a sibling
[ ] Birth of a child

[ ] Death or loss of a friend
[ ] Inadequate social support
[ ] Living alone
[ ] Difficulty with acculturation
[ ] Discrimination
[ ] Adjustment to life cycle transition
[ ] Illiteracy
[ ] Academic problems
[ ] Discord with teachers or classmates
[ ] Unemployment
[ ] Threat of job loss
[ ] Stressful work schedule
[ ] Job dissatisfaction
[ ] Job change
[ ] Discord with boss or coworkers
[ ] Homelessness

[ ] Inadequate housing
[ ] Unsafe neighborhood
[ ] Discord with neighbors or landlord
[ ] Extreme poverty
[ ] Inadequate finances
[ ] Insufficient welfare support
[ ] Inadequate healthcare
[ ] Inadequate health insurance
[ ] Recent arrest or incarceration
[ ] Involved in litigation
[ ] Victim of a recent crime
[ ] Exposure to war, disasters, or other hostilities
[ ] Discord with counselor, social worker, physician or other caregiver
[ ] Other ____________________

PRESENTING PROBLEMS

Please state any reasons for seeking therapy. For each problem please include any additional relevant information including the length of time this has been a problem.

1. ____

____ 2. ____

____ 3. ____

____

Therapist use only

Internal Use

Privacy of Information Shared in Counseling/Therapy: Your Rights and My Policies

What to expect:

The purpose of meeting with a counselor or therapist is to get help with problems in your life that are bothering you or that are keeping you from being successful in important areas of your life. You may be here because you wanted to talk to a counselor or therapist about these problems. Or, you may be here because your parent, guardian, doctor or teacher had concerns about you. When we meet, we will discuss these problems. I will ask questions, listen to you and suggest a plan for improving these problems. It is important that you feel comfortable talking to me about the issues that are bothering you. Sometimes these issues will include things you don't want your parents or guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their counselor or therapist. Privacy, also called confidentiality, is an important and necessary part of good counseling.

As a general rule, I will keep the information you share with me in our sessions confidential, unless I have your written consent to disclose certain information. There are, however, important exceptions to this rule that are important for you to understand before you share personal information with me in a therapy session. In some situations, I am required by law or by the guidelines of my profession to disclose information whether or not I have your permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

>You tell me you plan to cause serious harm or death to yourself, and I believe you have the intent and ability to carry out this threat in the very near future. I must take steps to inform a parent or guardian of what you have told me and how serious I believe this threat to be. I must make sure that you are protected from harming yourself.

> You tell me you plan to cause serious harm or death to someone else who can be identified, and I believe you have the intent and ability to carry out this threat in the very near future. In this situation, I must inform your parent or guardian, and I must inform the person who you intend to harm.

>You are doing things that could cause serious harm to you or someone else, even if you do not*intend* to harm yourself or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.

>You tell me you are being abused-physically, sexually or emotionally-or that you have been abused in the past. In this situation, I am required by law to report the abuse to the of Social Services.

>You are involved in a court case and a request is made for information about your counseling or therapy. If this happens, I will not disclose information without your written agreement *unless* the court requires me to. I will do all I can within the law to protect your confidentiality, and if I am required to disclose information to the court, I will inform you that this is happening.

Communicating with your parent(s) or guardian(s):

Except for situations such as those mentioned above, I will not tell your parent or guardian specific things you share with me in our private therapy sessions. This includes activities and behavior that your parent/guardian would not approve of — or would be upset by — but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. If I feel that you are in such danger, I will communicate this information to your parent or guardian.

Example: If you tell me that you have tried alcohol at a few parties, I would keep this information confidential. If you tell me that you are drinking and driving or that you are a passenger in a car with a driver who is drunk, I would not keep this information confidential from your parent/guardian. If you tell me, or if I believe based on things you've told me, that you are addicted to alcohol, I would not keep this information confidential.

Example: If you tell me that you are having protected sex with a boyfriend or girlfriend, I would keep this information confidential. If you tell me that, on several occasions, you have engaged in unprotected sex with people you do not know or in unsafe situations, I will not keep this information confidential. You can always ask me questions about the types of information I would disclose. You can ask in the form of "hypothetical situations," in other words: "If someone told you that they were doing _________, would you tell their parents?"

Even if I have agreed to keep information confidential – to not tell your parent or guardian – I may believe that it is important for them to know what is going on in your life. In these situations, I will encourage you to tell your parent/guardian and will help you find the best way to tell them. Also, when meeting with your parents, I may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you.

[You should also know that, by law in Virginia, your parent/guardian has the right to see any written records I keep about our sessions. It is extremely rare that a parent/guardian would ever request to look at these records.]

Communicating with other adults:

School: I will not share any information with your school unless I have your permission and permission from your parent or guardian. Sometimes I may request to speak to someone at your school to find out how things are going for you. Also, it may be helpful in some situations for me to give suggestions to your teacher or counselor at school. If I want to contact your school, or if someone at your school wants to contact me, I will discuss it with you and ask for your written permission. A very unlikely situation might come up in which I do not have your permission but both I and your parent or guardian believe that it is very important for me to be able to share certain information with someone at your school. In this situation, I will use my professional judgment to decide whether to share any information.

Doctors: Sometimes your doctor and I may need to work together; for example, if you need to take medication in addition to seeing a counselor or therapist. I will get your written permission and permission from your parent/guardian in advance to share information with your doctor. The only time I will share information with your doctor even if I don't have your permission is if you are doing something that puts you at risk for serious and immediate physical/medical harm.

STRIVE COUNSELING SERVICES L.L.C.

FEE AGREEMENT

The purpose of this form is to provide you an efficient way of payment, if you so choose. It is also set up for the purpose of payment toward missed appointments. I welcome any questions you may have before signing.

● By completing and signing this Payment Agreement, you are indicating that you understand and agree to provide a valid credit card number, with expiration date, for payment of future therapy sessions, appointments, or other fees.

● Your signature indicates you understand that if you do not attend a scheduled appointment, your credit card will be charged the **100% of the regular amount** of the session you reserved unless you canceled at least **24 hours** in advance, business days Monday through Friday; for cancellations with less than **24 hours** notice, the full service fee will be charged. For missed appointments with no notice given, the full fee will be charged.

● Your signature indicates you understand that you, not an insurance company or any other 3rd party payer, will be paying for any missed or late cancelled appointments.

● Payments or copayments are expected at the time of service or in advance of service, unless otherwise agreed upon. Your signature indicates you understand that if you do not pay with cash or check at the time of service, your credit card will be charged for your payment due.

● Please note that we welcome Visa or Master Card; when using credit or debit card payments, a **$2.00** surcharge will be added to each card transaction. Current Fees for Services:

Initial Assessment –60 Minutes $140.00

Individual Therapy -50 minutes (regular session) $125.00

Individual Therapy –90 minutes $175.00

Marital and Family Therapy – 50 minutes $140.00

Marital and Family Therapy – 90 minutes $180.00

Requested letters, records or subpoenaed paperwork $100.00/hr.

No show or late cancellations **(50% of the amount for the regular session you reserved according to my fee schedule.**

I understand and agree to comply with this Payment Agreement. I authorize the use of my credit card information for payment of services rendered.

Client/Guardian:_________________________________ Sign:____________________________Date:__________
Print Name Signature Client Name:____________________________________ SS# (or Insurance ID#):___________________________ If Different Than Above Day Phone: ____________________ Evening Phone: ____________________ Cell Phone: _____________________ Please enter the following information exactly as it appears on your credit card statement: Please Circle: VISA / MASTERCARD Card Number:____ Expiration:______________ Card Verification Number:_____________ Billing Zip Code:__________________
Address:____
*Your credit card information will be held confidential and this information will be secured in your client file.

STRIVE COUNSELING SERVICES, L.L.C.

PAYMENT AGREEMENT

1. I agree to pay my co-payment, deductible or my fee-for-service charge for each 45-60 minute session before each appointment begins. In order to make it possible for you to pay on the day of service we have a sliding fee available.

2. I understand that if I incur an outstanding co-pay or fee-for-service balance of more than $200.00 and/or two (2) sessions go by without any payment that therapy may be temporarily suspended or terminated until sufficient payment is received to place my outstanding balance below this amount.

3. I agree to make arrangements in advance, if another person/business is guaranteeing. If we have to send a statement or insurance claim, it will be at the full rate.

4. I understand that a 5% past due fee will be assessed for accounts that are 60 days past due and will continue to be assessed each month that payment has not been received (unless other arrangements have been made with Strive Counseling Services). I understand that a collection agency may be employed after my account becomes 90 days past due with the express purpose of collecting any past-due debts that I might owe Strive Counseling Services, L.L.C.

5. I understand that payment for any mental health legal report prepared is due in full before it will be released to another party or me.

6. I understand that I am personally responsible to know my insurance limits, exclusions, deductibles, and co-payment structures, even though support staff does a preliminary check. I do not hold Strive Counseling Services responsible for insurance company errors or refusals for reimbursements for services rendered. I understand I am responsible for all services for which my insurance company will not pay.

7. I agree to reimburse Strive Counseling Services for any session that I cancel or reschedule without 24 hours notice or for which I fail to arrive based on the fees listed on the fee sheet. I understand that my insurance company will not pay for late cancellations or missed appointments. Exceptions are illness and inclement weather conditions.

8. I understand that if I miss two or more sessions without giving 24 hours notice, Strive Counseling Services, L.L.C. and my therapist reserves the right to terminate our therapy relationship by letter or phone call. I also understand that if I am 20 or more minutes late to my counseling sessions two (2) or more times, my therapist and/or Strive Counseling Services, L.L.C. reserves the right to terminate our therapy relationship by letter or phone call.

9. I agree that all communication regarding my treatment will take place during the therapeutic hour. I understand that communication via telephone is preferred. I agree not to email or mobile to mobile text my therapist or Strive Counseling Services, L.L.C. unless authorized in advance by my therapist, and to do so for therapeutic purposes only.

10. I understand that my case may be discussed in group supervision for assessment, diagnosis, and evaluation of treatment and progress.

11. As defined in “Client’s Rights and Responsibilities” Strive Counseling Services, L.L.C. has a duty to warn and protect any individuals who may be or have been harmed by you as a client, including yourself (threat of self-harm or suicide).

12. I agree that I will not attempt to subpoena or require any counselor to appear in any legal proceeding related to any matters discussed during counseling; nor will I attempt to subpoena any notes or records related to this counseling.

13. I have read the above and understand its contents. I agree to abide by the provisions set forth above. I have been given a copy of "Client's Rights and Responsibilities" information, and I agree to read this information before my next counseling session, if I have not already done so.

___________________________________ _________________________________ ____________
Signature of Patient or Responsible Party Signature of Co-Responsible Party Date

Strive Counseling Services, L.L.C. Social Media Policy

Crystal Mullen-Johnson, LICSW, PIP, RPT

Owner

Friending:

In respect of your privacy and confidentiality I do not accept friend or contact requests from current or former clients on any of my PERSONAL pages on social networking sites (Facebook, Twitter, LinkedIn, etc.). It may also blur the boundaries of our therapeutic relationship. Please discuss your concerns about social media during our intake if you have questions.

Fanning/ Following:

If I decide to maintain a Facebook Page for my professional practice, I will not accept clients as Fans or Followers. As FB is a public forum, any articles of interest posted are for educational purposes only and not intended to diagnose or treat. Please do not share, @, repost, or like any post if you are an active or former client. Client confidentiality is considered paramount and is upheld at all times.

Interacting

To protect your privacy and confidentiality, please do not use private messaging on sites such as Twitter, Facebook, or LinkedIn to contact me. These sites are not secure and I will not exchange any information with client about appointments, sessions, or anything pertaining to your therapy, mental or emotional state. If you are ever in a crisis please contact the Crisis Center hotline, (205) 323-7782 or check yourself into the emergency room. Please do not reference Strive Counseling Services, L.L.C. when you are posting, @replies, or other means of engaging with us online. Engaging with me in this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart.

If you need to contact me between sessions, please contact me during business hours at my office. ALL voicemails and emails will be returned during BUSINESS HOURS ONLY. I do not communicate with clients on a cell phone. Please read below for more information regarding email interactions.

Use of Search Engines

I will not search for clients on Google, social media or any other search Engine as it violates your privacy. It's NOT a regular part of my practice. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone, or email) there might be an instance in which I will contact the emergency contact person/number your listed on your intake form. These are unusual situations and if I ever resort to such means, I will fully document it

and discuss it with you when we next meet.

Strive Counseling Services, L.L.C. Social Media Policy

Crystal Mullen-Johnson, LICSW, PIP, RPT

Owner

Business Review Sites

You may find my mental health counseling practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find our listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client.

I highly recommend you not to violate your privacy but of course, you have a right to express yourself on any site you wish. But due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. We urge you to take your own privacy as seriously as I take my commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with me about your feelings about our work, there is a good possibility that we may never see it. If we are working together, I hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. None of this is meant to keep you from sharing that you are in therapy with me wherever and with whomever you like.

Confidentiality means that I cannot tell people that you are our client, but you are more than welcome to tell anyone you wish who your therapist is or how you feel about the treatment I provided to you, in any forum of your choosing. If you do choose to write something on a business review site, I hope you will keep in mind that you may be sharing personally revealing information in a public forum.

Location-Based Services

If you used location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. If you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at my office on a weekly basis. Please be aware of this risk if you are intentionally “checking in,” from my office or if you have a passive LBS app enabled on your phone.

Email

I prefer using email for the sole purpose of arranging or modifying appointments. Please do not email me content related to your therapy sessions, as email is not completely secure or confidential. If you choose to communicate with me by email, be aware that all emails are retained in the logs of your and my Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be

read by the system administrator(s) of the Internet service provider. You should also

know that any emails I receive from you and any responses that I send to you become a part of your legal record.

Conclusion

Thank you for taking the time to review my Social Media Policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the Internet, do bring them to my attention so that we can discuss them.

Office Phone: 205/721-9893
Email: cmullenj@strivebhm.com

STRIVE Counseling Services, L.L.C.

2024 3rd Avenue North, Suite 312
Birmingham, AL 35203
(205) 721-9893
cmullenj@strivebhm.com

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to the Counseling Center by other individuals or agencies. Such requests should be referred to the original individual or agency.

I, ____, authorize the Counseling Center
to: _____ release to:
_____ obtain from:
_____ exchange with:

____
____
____
____

the following information pertaining to myself:
_____ treatment summary
_____ history/intake
_____ diagnosis
_____ psychological test results
_____ psychiatric evaluation/medication history
_____ dates of treatment attendance
_____ other (specify) ______________________________

for the purpose of:
_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) ______________________________

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event __________________
_______________________________________. (See back for authorization extension).

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

____ Social Security #:________________
Signature of Client Date OR
Date of Birth:___________________

____
Signature of Witness Date
(7/98)

STRIVE Counseling Services, L.L.C.

RECORD OF AUTHORIZATION EXTENSIONS

I hereby confirm that I have reviewed this consent form and agree to its extension for an additional:

Check One:

_____ 6 months OR

_____ other (specify) ___________________________

_______________________________________ _________________________________

Client Date Witness Date

Check One:

_____ 6 months OR

_____ other (specify) ___________________________

_______________________________________ _________________________________

Client Date Witness Date

Check One:

_____ 6 months OR

_____ other (specify) ___________________________

_______________________________________ _________________________________

Client Date Witness Date