

**PATIENT ADMISSION and INFORMED CONSENT DOCUMENT**

Patient Name: \_\_\_\_\_  
*(Last) (First) (Middle Initial)*

If Minor, Name of Parent/Guardian: \_\_\_\_\_  
*(Last) (First)*

Patient Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient Age: \_\_\_\_\_ Patient Gender: [ ]Male [ ]Female

Patient Marital Status: [ ]Never Married [ ]Partnered [ ]Married [ ]Separated [ ]Divorced [ ]Widowed

Address: \_\_\_\_\_  
*(Street and Number) (City) (State) (Zip)*

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ May we leave a message? [ ]Yes [ ]No

Cell or Other Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ May we leave a message? [ ]Yes [ ]No

Emergency Contact Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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

**BILLING INFORMATION**

Primary Insured Name: \_\_\_\_\_

Primary Insured Address: \_\_\_\_\_

Primary Insured Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Primary Insured Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Primary Insured Relationship to Patient: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Mental Health Therapy Co-Pay: \$\_\_\_\_\_ Mental Health Therapy Deductible: \$\_\_\_\_\_

Group/Member/ID #: \_\_\_\_\_ Policy/Plan #: \_\_\_\_\_

**OFFICE USE ONLY**

DSM Axis I Codes: #1: \_\_\_\_\_ #2: \_\_\_\_\_ #3: \_\_\_\_\_ GAF: \_\_\_\_\_

Counselor Assignment: \_\_\_\_\_ Date: \_\_\_\_\_

Director Approval: \_\_\_\_\_ Date: \_\_\_\_\_

Primary Payment Source: [ ]Self [ ]Insurance [ ]Ecclesiastical Leader [ ]Vocational Rehabilitation  
[ ]Utah County Substance Abuse [ ]DCFS [ ]DJJS [ ]DWS [ ]Medicaid [ ]6<sup>th</sup> District Juvenile Court

Secondary Payment Source: [ ]Self [ ]Insurance [ ]Ecclesiastical Leader [ ]Vocational Rehabilitation  
[ ]Utah County Substance Abuse [ ]DCFS [ ]DJJS [ ]DWS [ ]Medicaid [ ]6<sup>th</sup> District Juvenile Court

[ ]In Network [ ]Out of Network [ ]Bill Under Counselor Name [ ]Bill Under Director Name

Primary Location: [ ]Provo [ ]Salem [ ]Eagle Mountain [ ]6<sup>th</sup> District Juvenile Court

### CLIENT RIGHTS' STATEMENT

You have the right:

1. To expect quality service provided by concerned, trained, professional and competent staff.
2. To expect complete confidentiality within the limits of the law, and to be informed about the legal exceptions to confidentiality; and to expect that no information will be released without your knowledge and written consent.
3. To a clear working contract in which business items, such as time of sessions, payment plans/fees, absences, access, emergency procedures, third-party reimbursement procedures, termination and referral procedures, and advanced notice of the use of collection agencies, are discussed.
4. To a clear statement of the purposes, goals, techniques, rules limitations, and all other pertinent information that may affect the ongoing mental health counseling relationship.
5. To appropriate information regarding your mental health counselor's education, training, skills, license and practice limitations and to request and receive referrals to other clinicians when appropriate.
6. To full, knowledgeable, and responsible participation in the ongoing treatment plan to the maximum extent feasible.
7. To obtain information about your case record and to have this information explained clearly and directly.
8. To request information and/or consultation regarding the conduct and progress of your therapy.
9. To refuse any recommended services and to be advised of the consequences of this action.
10. To a safe environment for counseling free of emotional, physical, or sexual abuse.
11. To a client grievance procedure, including requests for consultation and/or mediation; and to file a complaint with the mental health counselor's supervisor (where relevant), and/or the I to a clearly defined ending process, and to discontinue therapy at any time.
12. To know your diagnosis and the implications of reporting this diagnosis to third parties.

I have read and understand the Center's *client right's statement*. (Initials) \_\_\_\_\_

### FEES AND BILLING

| Session Type   | Master's Counselor | Doctoral Psychologist | Important Notes  |
|--|--------------------|-----------------------|--|
| 25-30 minute individual, couple, or family therapy                             | \$50.00            | \$65.00               | 1. Payment/co-payment is due in full at the beginning of each session<br>2. There is a \$10.00 fee per month for unpaid balances requiring sending of a billing statement<br>3. Included in fees are brief phone calls (5 min) and routine documentation/paperwork (10-15 min)<br>4. There is a \$25 fee for any cancelled check or declined credit card transaction |
| 45-50 minute individual, couple, or family therapy                             | \$95.00            | \$110.00              |  |
| 75-80 minute individual, couple, or family therapy/intake admission evaluation | \$140.00           | \$170.00              |  |
| 60 minute group therapy  | \$30.00            | \$30.00               |  |
| 60 minute psychological testing  | N/A                | \$145.00              |  |

I have read and understand the Center's *fees and billing*. (Initials) \_\_\_\_\_

### Counseling Policies

Life Enhancement Center, Inc. (LEC) offers a variety of individual, couple, family, and group counseling services provided by licensed mental health counselors and supervised graduate student interns. Counseling can have both risks and benefits. The counseling process may include discussions of your personal challenges and difficulties which can elicit uncomfortable feelings such as sadness, guilt, anger and frustration. However, counseling has also been shown to have many benefits. It can often lead to better interpersonal relationships, improved academic performance, solutions to specific problems and reductions in your feelings of distress. But there is no assurance of these benefits. As a good consumer it is important for you to be active in your work in counseling, i.e., ask questions, frankly discuss issues of concern with your counselor, etc.

Counseling at LEC is intended to enhance your personal life. If, during your work with your counselor, you have questions or concerns about what is happening and why, please ask your counselor. The more you understand the counseling process, the greater the benefit. If, at any time during your counseling experience, you have concerns that you feel you cannot share with your counselor, please speak with the Clinical Director. If you consider your situation an emergency that will not allow a delay, please inform our staff. For after-hours emergency services, go to the nearest hospital emergency room or contact local emergency medical care by dialing 9-1-1.

Many issues you may typically encounter can be addressed with short-term counseling services we provide. Your initial session is an assessment session, devoted to defining your concerns, developing a treatment plan, and determining whether LEC can meet your needs. If at any point it is determined that other services are more suitable, we will help you obtain assistance from appropriate providers. Non-compliance with the plan we develop to assist you could result in the termination of services.

**I have read and understand the Center's *counseling policies*. (Initials) \_\_\_\_\_**

### Appointments

We appreciate your assistance in the efficient management of your appointments. Consistent attendance at counseling sessions is extremely important to the progress you will make in therapy. Although we recognize that not every scheduling conflict can be anticipated, if for any reason you find that you are unable to keep an appointment (either individual or group), please call the center at least 24 hours prior to your appointment. The office staff will assist you in rescheduling a session (please be aware that the next available appointment with your individual counselor may be the next week at your regularly scheduled time) or leave a message for your counselor(s). If you decide to discontinue services, we would like you to discuss this with your counselor in session. If for any reason you are unable to do so, please call and let us know of your intention so that services will not be delayed for other clients. Please be aware that if you do not keep a scheduled counseling appointment and do not call to reschedule within 48 hours after the appointment, your file will be closed and LEC's services to you will be considered completed. If you subsequently wish to reconnect with your counselor, see a different counselor, or request another LEC service, please contact your original counselor. If your counselor needs to reschedule an appointment, we will call you according to your preference for being contacted. In the unfortunate event of counselor transfer, incapacitation, or death, the Clinical Director will assign you to a replacement counselor after consultation regarding your treatment needs.

**I have read and understand the Center's policy on *appointments*. (Initials) \_\_\_\_\_**

**Confidentiality**

In keeping with ethical standards and state and federal law, all services provided by the staff of LEC are kept confidential except as noted below and in the accompanying *Notice of Privacy Practices*. We consult as needed within the staff of LEC about the best way to provide the assistance that you might need. As required by psychological practice guidelines and current standards of care, we keep records of your counseling. LEC professional staff have a legal responsibility to disclose client information without prior consent when a client is likely to harm himself, herself or others unless protective measures are taken, when there is reasonable suspicion of abuse of children, dependent adults or the elderly, when the client lacks the capacity to care for him or herself and when there is a valid court order for the disclosure of client files. Fortunately these situations are infrequent. By signing this form you also give LEC permission to communicate with the Emergency Contact that you have designated if we believe that you are at risk. Please consult with your counselor if you have any questions about confidentiality.

**I have read and understand the Center's policy on confidentiality. (Initials) \_\_\_\_\_**

**Training and Research**

LEC is an approved training site. The counseling you receive may be from a master's-level student intern or a post-masters associate professional counselor. All counselors in training will inform you of their status as well as the name of their clinical supervisor who can be contacted through our central office. In order to adequately supervise trainees, a supervisor may require that your therapy session be audio or video recorded. By signing this form you agree to have your sessions recorded if your counselor is in training. Staff counselors may also wish to record counseling sessions for the purpose of training others, but will ask your permission to do so. You may choose not to be recorded if your counselor is not a trainee. All recordings are kept confidential in the same manner as your treatment records and will be destroyed after supervisory review. Please talk with your counselor if you have questions about audio and video recording.

**I have read and understand the Center's policy on training and research. (Initials) \_\_\_\_\_**

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**PARENTAL CONSENT FOR MENTAL HEALTH TREATMENT OF A MINOR**

As the parent or legal guardian with the authority to consent on behalf of the minor named herein, I hereby give my consent for the minor to seek counseling, psychotherapy, and/or psychiatric care as deemed advisable and/or necessary by the professional staff of LEC. The mental health provider responsible for the care has explained to me the proposed treatment plan, the general nature and extent of the risks involved in the treatment, and alternative treatment options, if any. However, treatment will not be delayed if any emergency exists. This consent will be valid until the minor reaches the age of 18, but can be revoked at any time by written notification. Any questions relating to this form or the proposed treatment can be presented to the Clinical Director.

**Please sign below to indicate that you understand and agree to participate in counseling in accord with the above policies.**

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**LIFE FUNCTIONING INVENTORY**

Are you currently receiving psychiatric, counseling, or psychotherapy elsewhere?  Yes  No

Have you had previous psychological counseling?  Yes  No

**PROBLEM ANALYSIS**

1. PROBLEM DESCRIPTION: Briefly **describe the problem** you most wish help with right now:

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2. PROBLEM INTENSITY: How would you **rate the intensity** of the problem or concern that brought you in?

(Circle the appropriate number):      1      2      3      4      5      6  
    Not Intense      Moderately Intense      Extremely Intense

3. PROBLEM DURATION: Approximately **how long** have you had the current problem? \_\_\_\_\_

4. COPING ATTEMPTS: In what ways have you attempted to cope with this problem?

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**FAMILY BACKGROUND**

1. Please check any past, present, or impending special problems in your family:

- deaths                       divorce                       frequent relocations                       debilitating injuries/disabilities  
 alcohol/drug abuse    serious illness                       psychiatric disorder                       physical/sexual abuse  
 financial crisis/unemployment                       legal problems                       attempted/completed suicide  
 eating disorders       other \_\_\_\_\_

Please specify family member(s), which special problem, and approximate year of occurrence (e.g. mother-serious illness, 1998 etc.)

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2. Have you personally experienced any **family abuse**? (Circle one):

None      Unsure      Emotional      Physical      Sexual

3. Have you personally experienced **legal problems**? No      Yes

4. Did you experience **learning problems** in elementary or high school? (Circle one):

None      Some      Substantial      Constant struggle

5. In general, how **happy or adjusted** were you growing up? (Circle one):

Poor      Unsatisfactory      About average      Substantial      Completely

6. How much is your immediate family a source of **emotional support** for you? (Circle one):

None      Little      Somewhat      Substantial      Very Strong

7. How much **conflict in values** do you currently experience with your parents? (Circle one):

Very little or none      Some      Moderate      Strong      Extreme

8. Who in your family do you currently **feel closest** to? \_\_\_\_\_  
 Most **distant** from? \_\_\_\_\_ In most **conflict** with? \_\_\_\_\_

**HEALTH AND SOCIAL ISSUES**

1. How is your current **physical health**? Poor Unsatisfactory Satisfactory Good Very good

2. Please list any **persistent physical symptoms** or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): \_\_\_\_\_

3. Are you presently taking any **prescribed medication**? No Yes please indicate: \_\_\_\_\_

4. Are you having any problems with your **sleep habits**? No Yes (If yes, check where applicable):  
 Sleeping too little  Sleeping too much  Poor quality sleep  Disturbing dreams  Other

5. Do you have any problems or worries about **sexual functioning**? No Yes (If yes, check where applicable):  
 Lack of desire  Performance Problem  Sexual Impulsiveness  Difficulties maintaining arousal  
 Worried about sexually transmitted disease  Other

6. Have you ever experienced **sexual assault, unwanted sex, or uncomfortable touching**?  
 Frequently A few times Once Never Unsure

7. Have you had **suicidal thoughts** recently (*within 30 days*)? Frequently Sometimes Rarely Never  
 Have you had them in the **past** (30+ days)? Frequently Sometimes Rarely Never

8. Have you ever intentionally **inflicted any harm or tissue damage upon yourself**? Yes No Unsure

9. In the past, how would you rate the quality of your **peer relationships**?  
 Very Poor Unsatisfactory About Average Good Excellent

10. Approximately how many **significant intimate relationships** (e.g. lasting 6 months or more) have you been involved in? \_\_\_\_\_ Are you in one now? Yes No Unsure

11. Besides family members, approximately how many people can you really count on right now for **friendship or emotional support**? \_\_\_\_\_

12. Do you have physical disabilities?  Yes  No Describe: \_\_\_\_\_

**WELLNESS SELF CHECK**

**Physical Symptoms:**

Have you had any of the following symptoms on a regular basis? (Check all that apply)

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> irritability  | <input type="checkbox"/> phobias             | <input type="checkbox"/> racing heart rate     | <input type="checkbox"/> headaches          |
| <input type="checkbox"/> shortness of breath                                 | <input type="checkbox"/> teeth clenching     | <input type="checkbox"/> feeling overworked    | <input type="checkbox"/> stomach discomfort |
| <input type="checkbox"/> cold hands and feet (pain, butterflies, queasiness) | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> diarrhea/constipation |   |
| <input type="checkbox"/> insomnia  | <input type="checkbox"/> nausea              | <input type="checkbox"/> muscle tension        | <input type="checkbox"/> other _____        |

**Smoking**

Do you smoke? Yes No Would you like to quit? Yes No

**Eating Behaviors:**

Have you ever participated in these behaviors? (Check all that apply)

- I have regularly consumed unusually large amounts of food in a short period of time.  
 I have attempted to control weight by forcing myself to vomit or spit out food.  
 I have used laxatives excessively to control weight.  
 I have exercised more than 1 hour a day five or more times a week to control weight.  
 I have restricted my food intake in a way that I have and/or others have been concerned about my health

**Substance Use**

|  |   |   |        |        |        |      |
|--|---|---|--------|--------|--------|------|
| Number of days per week you typically drink alcohol?                           | 0 | 1 | 2 or 3 | 4 or 5 | 6 or 7 | More |
| Number of days per week you typically use drugs?                               | 0 | 1 | 2 or 3 | 4 or 5 | 6 or 7 | More |
| Number of alcoholic drinks you typically consume when socializing or partying? | 0 | 1 | 2 or 3 | 4 or 5 | 6 or 7 | More |

Within the last 30 days, on how many days did you use?

| Substance | Amount | Frequency |
|-----------|--------|-----------|
| _____     | _____  | _____     |
| _____     | _____  | _____     |
| _____     | _____  | _____     |

Do you have any family member that has experienced alcohol or other drug addiction? Yes                      No                      Not Sure

Have you experienced the following DUE TO ALCOHOL OR OTHER DRUG USE in the past 12 months? (Check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Poor academic performance and/or attendance                  | <input type="checkbox"/> Blackout (alcohol amnesia) or poor memory       |
| <input type="checkbox"/> Guilt, remorse or depression after drinking/using            | <input type="checkbox"/> Legal or judicial trouble                       |
| <input type="checkbox"/> Thought about or attempted to stop drinking/using            | <input type="checkbox"/> Inability to stop drinking/using after starting |
| <input type="checkbox"/> Changed levels of energy, mental clarity, or motivation      | <input type="checkbox"/> Significant personality change when using       |
| <input type="checkbox"/> Relationships affected by drinking/using                     |  |
| <input type="checkbox"/> High tolerance to the effects of alcohol or other substances |  |

**Exercise:**

Do you exercise on a regular basis?                      Yes                      No

**Significant Events:** (Check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Thought about harming yourself                    | <input type="checkbox"/> The ending of a significant relationship |
| <input type="checkbox"/> Sexual abuse/ sexual assault/ rape                | <input type="checkbox"/> Physical abuse                           |
| <input type="checkbox"/> Been a victim of or a witness to a violent crime  | <input type="checkbox"/> The death of a loved one                 |
| <input type="checkbox"/> Any other traumatic event (Please specify: _____) |   |