Leslie B. Whiting, LPC M.Ed. **WHITING COUNSELING** 480-962-4357
2500 S. Power Rd #120 Mesa, Arizona 85209

Client Information:

Client Name: _____ Date of Birth: _____

Partner Name: _____ Date of Birth: _____

Parents Name (for minor child only):_____

Address: _____

Home Phone: _____ Cell Phone: _____ _____
(Client) (Partner)

Email Address: _____

Employer: _____

I wish to be contacted in the following manner (check all that applies):

** Home Phone: _____** Cell Phone: _____ **Alternative Phone Number: _____

**It is ok to leave a detailed phone message: _____ **Leave phone message with call back number only: _____

** It is ok to send me emails regarding my appointments _____ ** It is ok to text me regarding my appointment _____

In Case of Emergency:

Name: _____ Relationship: _____

Home phone: _____ Work: _____ Cell: _____

Parental Consent for Treatment of Minors:

I am the legal guardian for _____ and give consent for him /her to receive
(Name of minor child)
counseling from Leslie Whiting LPC M.Ed. _____
(Legal guardian signature & relationship to minor child)

Referral Information:

Please indicate who referred you to Whiting Counseling:
Referral Type: ☐ self ☐ friend ☐ family ☐ healthcare provider ☐ Other

Referral Name _____

May we contact this person and thank them for this referral? ☐ Yes ☐ No

Signature of Responsible Party: _____

(Client/ Spouse/ Legal Guardian Signature)

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Financial Responsibility:

Name: _____
First Last Relationship

Address:_____
Street City State Zip

Phone:_____
Home Work Cell

Social Security Number:_____

I accept full responsibility for all fees due for professional services. I realize that any third party billing is out of courtesy and does not transfer any financial responsibility for unpaid services.

I understand that 24 hour notice is required to cancel or change an appointment, and that if 24 hours notice is not given, I am responsible to pay a cancellation fee of $60.00.

Signature of responsible party: _____ date: _____

Reason for Counseling:

_____

_____

Please Read the following questions and mark those to which you would respond "yes":

- ☐ Have you previously been involved in counseling?
- ☐ Do you currently use alcohol or other non-prescription drugs?
- ☐ Is there a history of mental health in your family?
- ☐ Have you ever been physically abused?
- ☐ Have you ever been emotionally abused?
- ☐ Have you ever been sexually abused?
- ☐ Have you ever been hospitalized for mental health reasons?
- ☐ Is there a family history of alcohol or drug problems?
- ☐ Have you ever attempted suicide?
- ☐ Are you presently having suicidal thoughts?

Medication:

Please list all medication, dosage, who prescribed them, and how long you have been taking this medication.

_____

_____

_____

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Please mark all of the following that apply

Feelings

- ☐ Helpless
- ☐ Depressed
- ☐ Shameful
- ☐ Angry
- ☐ Guilty
- ☐ Hopeless
- ☐ Lonely
- ☐ Sad
- ☐ Stressed
- ☐ Unhappy
- ☐ Anxious
- ☐ Out of Control
- ☐ Afraid
- ☐ Numb
- ☐ Relaxed
- ☐ Happy
- ☐ Excited
- ☐ Hopeful
- ☐ Inferiority Feeling
- ☐ Mood Shifts
- ☐ Other _____

Thoughts

- ☐ Confused
- ☐ Unintelligent
- ☐ Worthless
- ☐ Unmotivated
- ☐ Unattractive
- ☐ Unlovable
- ☐ Confident
- ☐ Worthwhile
- ☐ Homicidal
- ☐ Racing
- ☐ Obsessive
- ☐ Distracted
- ☐ Disorganized
- ☐ Paranoid
- ☐ Suicidal
- ☐ Sensitive
- ☐ Honest
- ☐ Other _____

Symptoms/Behaviors

- ☐ Eating Less
- ☐ Procrastinating
- ☐ Attempting Suicide
- ☐ Poor Concentration
- ☐ Crying
- ☐ Withdrawing Socially
- ☐ Skipping Classes
- ☐ Binge Drinking
- ☐ Injuring self
- ☐ Compulsivity
- ☐ Career/Major Choice
- ☐ Acting Out Sexually
- ☐ Acting Aggressively
- ☐ Disorganization
- ☐ Impulsivity
- ☐ Recklessness
- ☐ Irritability
- ☐ Passivity
- ☐ Drug Use
- ☐ Alcohol Use
- ☐ Being Good to Yourself
- ☐ Sexual Problems
- ☐ Socializing
- ☐ Marital Relationships
- ☐ Parent/Child Conflicts
- ☐ Lack of Ambition/Goals
- ☐ Poor Peer Relationships
- ☐ Night Mares
- ☐ Worries About Body Image
- ☐ Spiritual Problems
- ☐ Dating Concerns
- ☐ Finances
- ☐ Other _____

Physical Symptoms

- ☐ Insomnia
- ☐ Tired
- ☐ Weight Gain or Loss
- ☐ Pain
- ☐ Headaches
- ☐ Tightness In Chest
- ☐ Dizziness or Light-headedness
- ☐ Numbness or Tingling
- ☐ Vomiting
- ☐ Rapid Heart Beat
- ☐ Dry Mouth
- ☐ Excessive Sleep
- ☐ Loss of Memory
- ☐ Eating Problems
- ☐ Other _____

Please describe any medical conditions you have:

Anything else you would like us to know about you:

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Please READ and SIGN

Confidentiality:

All sessions are completely confidential in accordance with law and recognized professional standards. If I, as your counselor, need to communicate to another about your case, you must give me written permission to do so. The only exception to this is, if in accordance with law and reasonable professional judgment, such communication appears needed to protect you or others from harm or in response to legal process, or in other proper circumstances, the privileged nature of your communication ceased in these circumstances. Possible exceptions include, but not limited to, the following situations: child abuse, abuse of the elderly or disabled, threats of suicide, and threats of homicide.

Informed Consent:

Therapy is an interactive process between client and therapist and the results of therapy depend on your cooperation. It is meant to promote change and understanding. Sometimes this process can be emotionally painful, and at other times very fulfilling. You will be expected to contribute to all decisions regarding therapeutic intervention devised for you, including out of session assignments. You have the right to refuse or alter any service and intervention. While I will use my best effort to assist you the nature of psychological services is that there can be no assurances of results and no promises can be made regarding the outcome of any services provided. You should question the rationale of any services, intervention and discussion if these seem unclear to you.

Fee Rate:

Fee for service is $150.00 for a 45-50 minute counseling session. A 90 minute session is billed at the rate of $300.00. Longer or shorter sessions may be prorated at the rate of $40.00 per each 15 minutes. After hour/emergency appointments will be billed at the rate of $200.00 per 45-50 minute session.

Payment Method:

Payment is expected at the time services are rendered, by cash, check, or credit cards. If there is a third party payer, prior arrangements must be made with written clarification of payment on file with this office. All reports, for individuals or court will not be issued until full payment for services is received.

Missed Appointments:

If you are unable to keep an appointment, please notify the office immediately. If an appointment is canceled or missed without 24 hours prior notice, you will be billed for the missed session at the rate of $150.00. A credit card will be kept on file to make payment and will be charged at the scheduled appointment time, unless prior arrangements have been made. Third party payer will not be charged for missed appointments.

Responsibility:

The client (or responsible party) is considered responsible for payment of professional services. When you request to bill a third party and that third party fails to make payment within 30 days from date of service, payment is expected from client or responsible party within 10 days of receipt of statement. Bills not paid in full within 45 days from the billing date will be subject to an interest charge of 10% added to the balance due.

Consent:

I, voluntarily, agree to receive mental health assessment, care, treatment or services and authorize Leslie B Whiting M.Ed. LPC, to provide such care. I understand and agree that I will participate in the planning of these services and that I may stop such care at any time. By signing this consent form I acknowledge that I have read and understand all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification on anything unclear to me.

_____ _____

Client/Spouse or Partner Signature Date

_____ _____

Therapist Signature Date