Olive Tree Counseling, Inc.

1981 E Palmer-Wasilla Hwy, Suite 220, Wasilla, AK 99654
Phone: (907) 357-6513 | Fax: (907) 357-6514

Instructions

Please read the important Notice Regarding Privacy Practices and Client Rights before printing any of your Intake documents. You will have an opportunity to discuss any questions about this notice and all your intake forms during your first appointment.

Please thoroughly read, sign, and submit the following required forms to OTC's office before your first session.
*A red asterisk indicates a required field. If that field is not filled, your appointment could potentially be delayed.
Once completed, please email to Intake@olivetreecounseling.com or Fax: (907) 357-6514.

1. Electronic Communications Consent Forms
2. Acknowledgment of Receipt:
   - Notice of Privacy Practices and Client Rights
   - Intake Forms
   - Agreement Regarding Information for Court
3. Authorization for Treatment
4. Agreement to Pay for Professional Services
5. Intake: General Information Packet

As a client sharing confidential and protected information with our facility, it is in your best interest to thoroughly read and understand all the contents of this packet.

Thank you.
Sincerely,

Olive Tree Counseling, Inc.

Olive Tree Counseling, Inc.
1981 E Palmer-Wasilla Hwy, Suite 220, Wasilla, AK 99654
Phone: (907) 357-6513 | Fax: (907) 357-6514

Notice of Privacy Practices and Client Rights

This notice describes how your medical information may be used and disclosed and how you can get access to this information.
REVIEW THIS NOTICE CAREFULLY, AND KEEP IT FOR YOUR RECORDS.

*Because Olive Tree Counseling, Inc., hereafter referred to as OTC, sees clients under 18, all references to "you" include your child as the parent or guardian of the child. A parent or guardian may exercise the rights of the minor.

OTC understands that your health information is personal to you, and OTC is committed to protecting your information. This Notice of Privacy Practices and Client Rights, hereafter referred to as Notice, describes how OTC will use and disclose protected information and data OTC receives or creates related to your health care.

Our Duties

OTC is required by law to maintain the privacy of your health information and to give you this Notice describing our legal duties and privacy practices. OTC is also required to follow the terms of this Notice currently in effect.

Use and Disclosure of Health Information

OTC will not use or disclose your health information without your authorization except in the following situations:

- **Treatment**
  OTC may use and disclose your information while providing, coordinating, or managing your care. Information obtained by a member of your counseling team will be documented in your record and used to determine the course of treatment that should work best for you. OTC may also provide other healthcare providers with the minimum information that will prepare them in treating you.
- **Payment**
  OTC may use and disclose your information to obtain or offer payment for providing your care. If OTC sends you, your insurance, or health plan a bill, the information on or accompanying the bill may include information that identifies you, your diagnosis, procedures, or supplies used. OTC may be required to disclose information to your health plan to determine your eligibility for payment for certain benefits. It is your responsibility to know what personal information is required by your insurance company.
- **Health Care Operations**
  OTC may use and disclose health information for administrative aspects of your health care and manage OTC more efficiently. OTC's medical staff may use information in your record to assess the quality of care and outcomes in your case and others like it. This information will be used to improve the quality and effectiveness of the healthcare and services OTC provides.
- **Business Associates**
  OTC may disclose your information to its business associates to complete tasks OTC has requested of these associates, such as accounting or legal analysis. However, OTC requires the business associates to take precautions to protect your health information.
- **Emergencies**
  In an emergency, OTC may use or disclose information, your location, or general condition to notify or assist a family member, personal representative, or other person responsible for your care. OTC may provide hospital staff or responding officers with information relevent to your care or recovery in the event of a medical emergency, including but not limited to attempted suicide, self-harm, or assault.
- **Communication With Family**
  OTC may disclose to a family member, relative, friend—or other person with whom you identify—health information relevant to said individual's involvement in your care.
- **Manditory Reporting**
  If OTC percieves you to be a threat to others, including minors, OTC has a manditory obligation to report you to OCS or other protective human services, to which OTC will provide the required informtion for investigation.
- **Court Proceeding**
  OTC may disclose your health information in response to requests made during judicial and administrative proceedings, court orders, or subpoenas as required by law.

Confidentiality and Privacy

Confidentiality at OTC is maintained according to the AAMFT Code of Ethics, State Professional Counseling regulations and HIPAA regulations. OTC cannot guarantee that your data will be kept private where disclosing information is required by law. There are limits and exceptions to confidentiality. Understand what can and cannot be kept private:

- OTC is required by law to report physical danger by you or another person. OTC will reveal the minimum information necessary to protect you or other individuals.
- If OTC has reason to believe you are threatening harm to another person, OTC is required by law to protect said person. OTC is required to inform said person and the police, or have you hospitalized.

- If you threaten or act to harm yourself, OTC reserves the right to have you hospitalized or call family to protect you. OTC will attempt to fully discuss the situation with you before acting unless there is an exceptional reason not to.
- In an emergency of imminent threat or danger where you cannot grant consent, OTC may provide minimum information to another professional to protect your life. OTC will first attempt to get permission and discuss the situation as soon as possible.
- If OTC suspects you are abusing, neglecting, physically assaulting, or sexually molesting a child, elderly person, or disabled person, the law requires OTC to file a report with a state agency. Discuss legal aspects in detail before you disclose related information to OTC.

Other considerations regarding confidentiality and treatment:

- OTC may consult with a qualified individual about your treatment without providing your name. Likewise, when OTC is unavailable, another therapist may have access to client records at the client's request. Your information will remain protected under HIPAA guidelines.
- OTC is required to keep records and notes of your treatment. If you have specific or unusual concerns, please speak with your own attorney—OTC does not give legal advice.
- OTC sees people individually, as couples, or as families. OTC will keep information confidential except for the previously listed situations. However, if another facility requires your information for your continued progression in therapy, OTC may encourage and work with you to disclose relevant information.

Other Uses

OTC may use and disclose your personal health information for the following purposes:

- Leave messages for patients regarding upcoming appointments or other administrative matters at the contact numbers on file.
- Describe or recommend treatment alternatives to you.
- Provide information about health-related benefits or services that may be of interest.

Rarely, OTC may disclose information for Food and Drug Administration (FDA), public health, reporting abuse, neglect or domestic violence, health oversight, law enforcement, threats to public health or safety, and specialized government functions (military, national security).

Prohibition on Other Uses or Disclosures

OTC will not make any other use or disclosure of your personal health information without your written authorization. Your name and identity will only be disclosed in accordance with AS 08.29.200. Once given, you may revoke the authorization in writing. OTC is unable to reverse any disclosure that had been previously authorized.

Records Requests for Minors

While parents have legal rights to information their children share in therapy, for the mental wellbeing of the child, OTC encourages parents to not request this data. OTC may encourage and assist children in sharing information, but OTC will not share data unless necessary to protect the life and wellbeing of an individual. OTC's code of ethics prohibits harm to clients; therefore, OTC will not willingly release records unless required by law. OTC does not believe it is in a minor's best interest to release therapeutic records and reserves the right to review or reject any request for records where compliance is not lawfully required.

Other Records Requests

OTC does not release marriage and family therapeutic records to spouses without both spouses' written consent. Only your own individual records are available for you to request. However, it is not in the best interest of an individual to obtain therapeutic records. Any request for records with which OTC is legally obligated to comply will include a written statement declaring that you were informed as such.

Individual Privacy Rights

Clients have the right to confidentiality of client health information. As a client, you have the right to:

- Request restrictions on the health information OTC may use and disclose for treatment, payment, and health care operations. To request restrictions, please send a written statement to the address listed at the end of this Notice.
- Receive confidential communications regarding your health information in a certain manner or at a certain location. For instance, you may request that OTC only contact you at work or by mail. To make such a request, you must write the address listed at the end of this Notice stating how or where you wish to be contacted.
- Inspect or copy your health information in paper or digital format. You must submit your request in writing to the address listed at the end of this Notice. If you request a copy of your health information, OTC will charge a fee for the cost of copying, mailing, and other supplies. OTC reserves the right to deny your request to inspect or copy your health information. However, you may request that the denial be reviewed by a separate licensed professional to which OTC will comply with the outcome.
- Amend health information. If the health information that OTC has on record is incorrect or incomplete, you may ask to amend the information. To request an amendment, you must write to the address at the end of this Notice with the reason to support your request. OTC may deny your request to amend your health information if it is not in writing or a reason to support your request is not provided. OTC may also deny your request if:

  I. The information was not created by OTC, unless the original provider of the information is no longer available to make the amendment.

  II. The information is not part of the health information kept on record by or for OTC.

  III. The information is not part of the health information you are permitted to inspect or copy.

  IV. The information is accurate and complete.

To receive an accounting of disclosures of your health information. You must submit a request in writing to the address listed at the end of this document. Not all health information is subject to this request. Your request must state a time no longer than six years from the time of this Notice's revise date and whether you would like to receive the report in paper or electronically.

OTC may charge you the cost of providing this service. OTC will notify you of this cost, and you may choose to withdraw or modify your request before any charges are made.

To receive copy of your records—even if you have agreed to receive the records electronically—you must submit a request in writing to the address listed at the end of this Notice.

All requests to restrict use of your health information for treatment, payment, and health care operations, to inspect and copy health information, to amend your health information, or to receive an accounting of disclosures of health information must be made in writing to the contact person listed at the end of this Notice.

Other Client Rights

As a client, you have the right to:

- Be treated with respect regarding psychosocial, spiritual, and cultural variables that influence perceptions.
- Have a safe environment, free from discrimination of race, color, religion, gender, sex, handicap, national origin, or political standing. OTC treats individuals with respect and recognizes basic human rights.
- Receive information about therapist qualifications, including license, education, training experience, membership in professional groups, special areas of practice, and limits of practice.
- Have written information about fees, methods of payment, insurance coverage, and number of sessions the therapist thinks will be needed, and cancellation policies.
- Have informed consent to procedures, benefits and risks, and alternative options for your care.
- Privacy and confidentiality of your assessment and records, with exceptions listed in this Notice.
- Refuse audio or video recordings of your sessions if asked.
- Be informed of your progress.
- Report any illegal or immoral therapist behavior.

Proper and Improper Therapist Conduct

A therapist should never use threatening or coercing behavior as part of your treatment plan. If you feel threatened by your therapist, confront the behavior immediately and contact OTC's office at (907) 357-6513.

Sexual contact with any therapist is strictly prohibited and against the professional code of conduct for all professional groups of mental health workers, i.e., psychologists, psychiatrists, licensed counselors, and marriage and family counselors. You are encouraged to contact OTC's office for more information on any of OTC's therapists or to file a complaint.

No Guaranteed Outcome

OTC strives to help clients reach the goals they desire. However, therapy does not guarantee success. Unfortunate consequences, such as divorce, are a possibility. If therapy seems ineffective, OTC will explore alternative methods or resources or refer you to another provider.

Complaints

If you believe your privacy rights have been violated, you may file a complaint at (907) 357-6513 or to the address listed below. For severe violations of human or privacy rights, submit a complaint to the Secretary of the Department of Health and Human Services. OTC will never retaliate against a formal complaint.

Contact Person

Please contact the following OTC contact person for all written complaints, questions, requests, or further information related to the privacy of your health information:

Holly Hoff
Attn: Privacy Officer

1981 E. Palmer-Wasilla Hwy. Suite 220
Wasilla, AK 99654

Office: (907) 357-6513 | Fax: (907) 357-6514

Changes to This Notice

OTC reserves the right to change its privacy practices and apply revisions to previous health information. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility.

Effectiveness date: Jan. 2025. Reviewed and revised: Jan. 2026.

Olive Tree Counseling, Inc.
1981 E Palmer-Wasilla Hwy, Suite 220, Wasilla, AK 99654
Phone: (907) 357-6513 | Fax: (907) 357-6514

Consent to Electronic Communications

Any use of electronic communication must be pre-approved by Olive Tree Counseling, Inc., hereafter referred to as OTC, in agreement with the client, documented in writing, and kept in the client's records.

Telehealth & Online Services Terms and Conditions

I, the client, understand that this consent form must be filled in its entirety regardless of whether I wish to receive telehealth treatment. OTC is not liable for any claims and/or damages arising from the optional use of telehealth services. Telehealth services are entirely voluntary and will not influence the quality of care the client receives from OTC, nor condition treatment or payment on the optional use of telehealth services.

Alaska Telehealth/Telemedicine Definition, Alaska policy and regulations telemedicine references; Senate Bill 74 defines telehealth/telemedicine as the practice of health care delivery, evaluation, diagnosis, consultation, or treatment using the transfer of health care data through audio, visual, or data communications, performed over two or more locations between providers who are physically separated from the recipient or from each other, or between a provider and a recipient who are physically separated from each other.

*As a client receiving behavioral health services through online technologies, I, the client, understand that:

1. The interactive technologies used in tele-behavioral health incorporate network and software security protocols to protect the confidentiality of client information transmitted via any electronic channel. These protocols include measures to safeguard data and protect against intentional or unintentional corruption.
2. This service is provided by technology and may not involve direct, face-to-face communication. There are benefits and limitations to this service, such as the following:
    - Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.
    - There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.
    - In emergencies, disruption of services, or for routine or administrative reasons, it may be necessary to communicate by other means, i.e., through the cell phone number provided by the client.
    - In the event of disruption of services, the client must attempt to re-establish service at least twice before attempts to communicate via cell phone.
3. I, the client, will need access to, and familiarity with, the appropriate technology to participate in the service provided.
4. The exchange of information will not be direct, and any paperwork exchanged will likely be provided through electronic means or through postal delivery.
5. During my tele-behavioral health consultation, details of my medical history and personal health information may be discussed with myself or other behavioral health care professionals using interactive video, audio, or another telecommunications technology.
6. If a need for direct, in-person services arises, it is my responsibility to contact my practitioner or practitioners in my area, such as another provider in my behavioral practitioner's office, or secure an appointment with my primary care physician if my behavioral practitioner is unavailable. I understand that an opening may not be immediately available in other offices.
7. My practitioner and I will regularly reassess the appropriateness of continuing the online services agreed upon, and we will modify the treatment as needed.
8. It is my responsibility to maintain privacy on my end of communication. I understand that insurance companies, those authorized by me, the client, and those permitted by law may also have access to records or communications.
9. I may decline or discontinue any tele-behavioral health services at any time without jeopardizing my access to future care, services, and benefits.
10. Records of my communications and sessions will be stored in the same secure manner that face-to-face records are stored.
11. The laws and professional standards that apply to in-person behavioral services also apply to telehealth services. This consent does not replace other agreements, contracts, or documentation of informed consent.

12. As the client, I understand the security of online communications is a two-way responsibility. My therapist will keep my communications private and secure on my therapist's end. However, it is also my responsibility to keep online communications private and secure on my end.

Online Communications Preference

*If I, the client, authorize email or text I understand that:

- Remote and online communication be misdirected to or intercepted and disclosed by unintended third parties and, therefore, may not be a confidential medium of communication.
- Patients who have concerns should consider using another mode of communication.
- Patients understand and agree that email and text transmission is being used for the convenience of the patients. OTC does not require the use of email or text, nor does it guarantee the confidentiality and/or the security of any remote transmission of information.
- Patients, notably those patients with multi-user devices and/or accounts, are responsible for maintaining the confidentiality and security of their own devices and/or accounts. OTC is not responsible for information breaches on the end of patients' personal devices and/or accounts.
- Regardless of whether the patient wishes to communicate with OTC via email, OTC recommends that patients provide a working and up-to-date email address. Protected information will not be discussed via email without first being authorized by the patient (Please check the Junk mail inbox periodically).

*I, the client, authorize the electronic communications indicated in the following:

☐ Yes, I authorize EMAIL via the email: _____

☐ Yes, I authorize TEXTING via the #: _____

☐ Yes, I authorize FAXING via the #: _____

☐ No, I do not authorize any remote or online communications.

_____
Initials

*I, the client, acknowledge that I have thoroughly read, understood, and agree to OTC's Patient Consent to Electronic Communications terms and conditions. I understand the benefits and risks associated with online communications and consent to the conditions as indicated herein. I agree to adhere to the policies set forth above, as well as any other instructions or guidelines that OTC may impose for using electronic communications.

Optional: Text-To-Pay Service

Disregard this section if you are not interested in this service.

OTC offers an optional service as a courtesy to its clients. Text-To-Pay is utilized through Office Ally, powered via Stripe, and is certified HIPAA compliant. However, as outlined above, texting is fundamentally not a secure method of communication and is only used at the clients' convenience and discretion.

If I, the client, sign up for Text-To-Pay, I acknowledge and understand the following agreement *(please initial):*

_____
Initials

I understand that texting is not a secure form of communication and the inherent risks associated, and I agree that OTC will not be held responsible for information breaches on my end. I understand the use of Text-To-Pay is completely optional and is only offered for my own personal convenience, and it does not affect the price or quality of the service I receive. I understand that I may opt-out of Text-To-Pay at any time, with no penalty, by contacting OTC via phone, email, letter, or verbally. I acknowledged that OTC will only text the number to which I have already given authorization as outlined in the Consent to Electronic Communications form that has been provided to me.

Please note: Text-To-Pay links do not expire even if the payment has already been made.
Please check the date before making payments via previously-received Text-To-Pay links.

***Optional:** By signing below, I wish to sign up for **Text-To-Pay** and understand and agree to the above terms and statements.**

Text-To-Pay Recipient's Name	Text-To-Pay Recipient's Phone	Date

Olive Tree Counseling, Inc.
1981 E Palmer-Wasilla Hwy, Suite 220, Wasilla, AK 99654
Phone: (907) 357-6513 | Fax: (907) 357-6514

Acknowledgment of Receipt of Notice Of Privacy Practices And Client Rights

Initials

*I, the client, acknowledge that I have received OTC's Notice of Privacy Practices and Client Rights, and I understand and have had an opportunity to ask questions about the notice, my rights, therapist conduct, and other information provided within the notice.

Acknowledgment of Receipt of Intake Forms

Initials

*I, the client, acknowledge that I have read, or have had read to me, I understand, agree, and been offered copies of my Intake Forms, which include:

- Notice Of Privacy Practices & Client Rights
- Patient Consent To Electronic Communications
- Authorization For Treatment
- Court & Disclosure Statements
- Fees For Professional & Administrative Services

Court & Disclosure Statement Agreement

OTC does not make recommendations to the court concerning divorce, custody, or parenting issues—the court appoints professionals to conduct such evaluations. Request an evaluation through your attorney if necessary. The purpose of the following agreement is to avoid harming the clinical relationship between therapist and client, including couples, children, and families.

Initials

*I, the client, acknowledge and understand the following agreement:

1. I understand that the information the therapist gains from working with me, my family, and/or my child is confidential, and that OTC will not release this information without my written authorization.
2. I agree to not request any information from OTC for any court-related reason whatsoever, including but not limited to divorce or custody issues except in required cases.
3. I understand the disclosure of a minor's information it is not in the minor's best interest. OTC will only share a minor's relevant information to a parent or legal guardian with the minor's written consent. However, I agree that this information will not be used in court except in required cases.
4. I understand that it is not the role of a therapist to make recommendations to court or judge, nor to express opinions, concerning divorce or custody issues.

Olive Tree Counseling, Inc.
1981 E Palmer-Wasilla Hwy, Suite 220, Wasilla, AK 99654
Phone: (907) 357-6513 | Fax: (907) 357-6514

Authorization For Treatment

I acknowledge that I have received, read (or have had read to me), and understand the information provided to me about the therapy I am considering and have had all my questions answered fully.

Initials

*I consent to take part in the treatment with the therapist indicated below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest and will have an active role in this process. I understand that no promises have been made as to the results of treatment or of any procedures provided by this therapist. I am aware that I may stop my treatment at any time but will still be responsible for paying for the services I have already received. In the event of court-ordered treatments, I understand that the consequences of discontinuing treatment are my responsibility. I agree that I am responsible for service fees provided by OTC and that my insurance company may make payments on my account. I agree to pay for services up until the time I end the relationship. I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand if payment for services I receive is not made, OTC will stop my treatment.

Authorization to Treat a Minor

Initials

*I confirm that I am the parent or legal guardian, and have legal authority and rights to make decisions on behalf of Minor's Name: _____ hereafter referred to as Minor, and treatments Minor receives. I acknowledge and understand the information provided about the therapy I am authorizing for Minor and have had all questions answered fully. I do hereby consent to allow Minor to take part in the treatment provided by the therapist indicated below. I understand that a treatment plan will be developed with a therapist and regular review of progress toward meeting treatment goals are in Minor's best interest. I understand that no promises have been made to me as to the results of treatment or of any procedures provided at OTC. I am aware that, as the parent or legal guardian, I may stop Minor's treatment with OTC at any time. The financial obligation for the services received shall fall under the responsibility of the parent who is initially seeking Minor's treatment. I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and provider(s) of any services or treatments Minor receives.

Emergency Contact

In the event of an emergency, e.g., become ill, suicidal, or lose consciousness on the premises, I hereby give OTC, or OTC representative, authorization to contact and provide information about the emergency and location to the following contacts:

Emergency Contact 1	Emergency Contact 1's Phone#
Emergency Contact 2	Emergency Contact 2's Phone#

*My signature below shows that I understand and agree to the above terms and statements.

Client's Name	Client's Signature	Date
Parent/Legal Guardian 1	Parent/Guardian 1's Signature	Date
Parent/Legal Guardian 2	Parent/Guardian 2's Signature	Date

This therapist has discussed the terms and statements outlined within this authorization with the above party. This therapist's observations of the above party's behaviors and responses give this therapist reasonable belief that the above party is fully competent and able to give informed and willing consent.

Therapist Signature & Credentials	Date

Olive Tree Counseling, Inc.
1981 E Palmer-Wasilla Hwy, Suite 220, Wasilla, AK 99654
Phone: (907) 357-6513 | Fax: (907) 357-6514

Fees For Professional Services

Olive Tree Counseling Inc. Therapy Service Fees

Initial Assessment	$ 350.00	Crisis Therapy	$ 280.00
60-Minute Session	$ 220.00	Art Therapy	$ 240.00
45-Minute Session	$ 180.00	Play Therapy	$ 240.00
30-Minute Session	$ 110.00	No Call/No Show	Service Cost

Olive Tree Counseling Inc. Administrative Court Fees

Copies per Page	$ 00.50
Summary of Care Reports	$ 100.00
Court Appearance per Hour	$2000.00

Client Responsibilities

I agree that I am responsible for fees of service provided by OTC. My insurance company may make payments on my account; however, under HIPAA guidelines, I understand that other persons—be it friend, spouse, or family—may not make payments on my behalf without my written authorization. I also understand that OTC reserves the right to change the fee schedule and terms of payment at any time, and I will be provided with the new fee schedule and terms at the next applicable visit. I am aware that I may stop my treatment any time but will still be responsible for paying for the services I have already received. Should I not comply with my responsibility to pay for services, OTC reserves the right to provide my demographic data and financial information to a collection agency.

Primary Insurance

I understand that OTC will bill my primary insurance only out of courtesy. I understand my insurance will be provided with personal and/or protected information regarding services received at OTC, including but not limited to diagnosis codes and progress notes. I understand that I will be responsible for fees not covered by my primary insurance. By providing my insurance information, I am requesting OTC to bill my primary insurance for services I receive. I understand it is my responsibility to be informed of my own copay, degree of coverage, and annual deductible. I understand and agree that once my deductible resets, I will pay for the full cost of the services I receive.

Secondary Insurance

I understand that OTC does not bill secondary insurance companies. However, I may request OTC to provide claim forms for me to submit to secondary insurances myself.

No Shows

I understand it is my responsibility to cancel an appointment before the time of the appointment. If I do not cancel in advance and do not show up, I will be charged for that appointment. Late cancellations will be reviewed on a case-by-case basis.

Text-To-Pay and Online Payments

I understand online payment options are completely voluntary, and OTC does not require the use of online payments whatsoever. I agree to use alternative payment methods if I am concerned about security risks.

_____ *I acknowledge that I received a copy, thoroughly read, and understand the fee schedule of OTC, and agree to comply with the terms listed above, and I fully understand and agree with OTC's payment and collection terms.

Initials

Client / Parent / Guardian's Name	Signature	Date

Olive Tree Counseling, Inc.

1981 E Palmer-Wasilla Hwy, Suite 220, Wasilla, AK 99654
Phone: (907) 357-6513 | Fax: (907) 357-6514

General Information

Full Name | *DOB* | *Current Age* | *#SSN*

Spouse's Name | *DOB* | *Current Age* | *#SSN*

Home Address | *City* | *State* | *ZIP*

Mailing Address | *City* | *State* | *ZIP*

Home Phone | *Cell Phone* | *Email*

Current Employer | *Work Phone*

Insurance Carrier | *Subscriber ID* | *Group#*

Your Education / Training / Military Experience | *Your Race or Cultural Background*

Your Schedule / Best time for appointments

Please describe your most important goals and primary concerns prompting you to seek therapy.

Minors

Child's Name | *DOB* | *Current Age* | *#SSN*

Biological Parent (if different from above) | *Biological Parent's DOB* | *#SSN*

Child's Home Address | *Child's Mailing Address*

Child's Cell Phone | *Child's Email*

Referral Information

Name | *Phone* | *Relationship*

Checklist of Concerns

Family History

Describe your relationship with your mother:

Describe your relationship with your father:

Describe if you have siblings/how many, their/your relationship, or your family dynamic:

Additional childhood or family history details:

Adverse Childhood Experiences

As a minor, did an adult in your household make you afraid that you might be physically harmed?	YES	NO
Did an adult in your household physically hit, push, slap, or leave marks or bruises on your skin?	YES	NO
Did an adult touch or fondle you, or pressure you to touch them or engage in penetrative intercourse?		YES NO
Did your family make you feel unloved, unimportant, or were they distant or unsupportive?	YES	NO
Were your parents often too intoxicated to provide adequate care: food, clothes, health care, etc.?	YES	NO
Were your parents ever separated or divorced?	YES	NO
Did you see any of your caregivers be assaulted, hit, spat at, etc., or threatened with lethal weapons?	YES	NO
Was anyone in your household a problem drinker, alcoholic, or drug addict?	YES	NO
Was anyone in your household mentally ill, chronically depressed, or attempt or commit suicide?	YES	NO
Was anyone in your household arrested or sent to prison?	YES	NO

Medical History

Do you have chronic or terminal illness? Physical, medical, or allergy conditions? Are you on medications to treat them?

Are you taking medications to treat behavioral, mental, or psychiatric conditions? (Depression, bipolar, schizophrenia, etc.)

Do you have pain or ailments that affect your physical health? Have you suffered an accident or traumatic brain injury?

Controlled Substances

Do you regularly use controlled substances, such as alcohol, marijuana, tobacco, vapes, etc.? How often?

Are you bothered or are family/friends bothered or hurt by your substance use? What is the impact?

Have any of your family/friends died as a result, directly or indirectly, of addiction or substance use?

Do you regularly use prescription or over-the-counter medications, such as pain pills? How often?

Checklist of Concerns

Self & Social Support

Do you have a church, friend circle, or other trusted people you can confide in, who support, love, or value you?

How often do you go out with friends or family? Is this important to you?

Exercise Routine: i.e., How often, what type. Describe:

Self-care: Do you neglect or struggle to keep up with regular sleep, hygiene, bathing, dental, etc.?

Do you find it difficult to keep up with house chores: cleaning, cooking? Who helps with chores?

What is your de-stress or relaxation routine, i.e., meditation, safe space, alone time, etc.?

Couples

Do you have a difference in relational desires, intimacy, values, parenting, expectation of one another, etc.?

Is there conflict, poor communication, coldness, addiction, pornography, disloyalty, infidelity, etc., in your relationship?

Do you experience abuse from your partner, i.e., physical harm, emotional or verbal abuse, manipulation, etc.?

Have you experienced miscarriages, abortions, infertility, or frustrations relating to pregnancy? Or do you have/want children?

Adult Abuse

As an adult, have you been harmed emotionally, verbally, physically/domestic, etc.? By who? Describe:

Have you been touched inappropriately, raped, assaulted, groped, etc.? By who? Describe:

Have you personally survived, attempted, or witnessed a suicide or murder? Do you feel suicidal, homicidal, or violent?

Mental & Behavioral Evaluation

I have anxiety, panic attacks, hyperventilate, irrational fears, or I catastrophize.: Additional Notes:

☐ Daily ☐ Weekly ☐ Monthly ☐ Never

I'm easily angered, irritated, frustrated, lose temper or patience easily.: Additional Notes:

☐ Daily ☐ Weekly ☐ Monthly ☐ Never

I have muscular disturbances; tension, twitching, cramping, or restlessness.: Additional Notes:

☐ Daily ☐ Weekly ☐ Monthly ☐ Never

I inflict injuries on myself; cutting, hitting, punching, hair-pulling, picking, etc.: Additional Notes:

☐ Daily ☐ Weekly ☐ Monthly ☐ Never

I do or want to hit, become violent, or physical with people, animals, or objects.: Additional Notes:

☐ Daily ☐ Weekly ☐ Monthly ☐ Never

I have sleep disturbances or sleep too much, i.e., insomnia, narcolepsy, etc.: Additional Notes:

☐ Daily ☐ Weekly ☐ Monthly ☐ Never

Checklist of Concerns

Mental & Behavioral Evaluation *(continued)*

I can't tolerate people, kids, social gatherings or events; I self-isolate or withdraw.: Additional Notes:

☐ Daily ☐ Weekly ☐ Monthly ☐ Never

I feel aimless, have no goals or aspirations, or am unhappy in my current situation.: Additional Notes:

☐ Daily ☐ Weekly ☐ Monthly ☐ Never

I'm tired, drained, fatigued, unmotivated; everyday tasks take immense effort.: Additional Notes:

☐ Daily ☐ Weekly ☐ Monthly ☐ Never

I feel worthless, empty, hopeless, or I feel like dying or taking my own life.: Additional Notes:

☐ Daily ☐ Weekly ☐ Monthly ☐ Never

I'm suffering from or traumatized by sudden, recent, or past grief or loss.: Additional Notes:

☐ Daily ☐ Weekly ☐ Monthly ☐ Never

I'm sensitive to criticism, I take things personally, or fear rejection or failure.: Additional Notes:

☐ Daily ☐ Weekly ☐ Monthly ☐ Never

I have mood swings or poor emotional regulation; outbursts, crying, euphoria, etc.: Additional Notes:

☐ Daily ☐ Weekly ☐ Monthly ☐ Never

I have difficulties concentrating, making decisions, or struggle with procrastination.: Additional Notes:

☐ Daily ☐ Weekly ☐ Monthly ☐ Never

Debts, low-income, or financial concerns negatively impact my relationships.: Additional Notes:

☐ Daily ☐ Weekly ☐ Monthly ☐ Never

I become anxious or irritable if I can't pace, fidget, or move/shake parts of my body.: Additional Notes:

☐ Daily ☐ Weekly ☐ Monthly ☐ Never

I am impulsive in actions or decision-making; gambling, risk taking, spending, etc.: Additional Notes:

☐ Daily ☐ Weekly ☐ Monthly ☐ Never

I struggle with poor self-body image or food regulation; purging, binging, etc.: Additional Notes:

☐ Daily ☐ Weekly ☐ Monthly ☐ Never

I struggle with perfectionism, compulsive obsessions, or letting go of control.: Additional Notes:

☐ Daily ☐ Weekly ☐ Monthly ☐ Never

I struggle with lust, pornography, Only Fans, dysfunction, or poor self-control.: Additional Notes:

☐ Daily ☐ Weekly ☐ Monthly ☐ Never

Feel free to add any additional information in the blank space below: