INSTRUCTIONS:

You may fill this form out online using Adobe Acrobat Reader’s (it’s free) fill and sign function.

When completed you may return it to me via Email: info@lifesciptcounseling.com

Alternatively, you may print it out, fill it in by hand and bring it with you to our first session, or FAX: 585-787-7478.

Thank You!
INTAKE FORM

PERSONAL DATA

Date: ___________________________  Birth Place: ___________________________

Name: ___________________________  Age: ______  Birth Date: ______________

Street: ___________________________  Home Phone #: _______________________

City: _____________________________  Mobile: _____________________________

State: ________  Zip: ______________  E-Mail: _____________________________

EMPLOYMENT DATA

Employer: _________________________  Job Title: ___________________________

Street: ___________________________  Years Employed: ______________________

City: _____________________________  Work Phone #: _______________________

State: ________  Zip: ______________

EMERGENCY CONTACT INFORMATION

Name of person to contact: ___________________________  Phone #: ______________

Relationship to you: ___________________________

EDUCATIONAL DATA

Highest Grade Completed: □ 9 □ 10 □ 11 □ 12 □ AAS □ BA/BS □ MASTERS □ PhD

Degrees: _____________________________

IF YOU ARE CURRENTLY A STUDENT:

School Name: ___________________________

Street: _____________________________

City: _____________________________

State: ________  Zip: ______________

Insurance (Does not apply to Medicaid/Medicare):

Does your insurance plan have out of network coverage? □ Yes □ No □ Not Sure

If you are not certain about the coverage, please find out and let me know. If you have out of network coverage I will provide a super bill that you can submit to your insurance company so they may reimburse you.

EAP Referrals Only

Name of Health Plan: ___________________________  Provider Name: ___________________________

Provider Phone number: ___________________________
MARTIAL STATUS:

☐ Single/Not Married
☐ Never Married
☐ Married How Long:

☐ Widowed How Long: _____ Deceased Partner’s Name ________________________________

☐ Single w/Partner How Long? _____ Partner’s Name ________________________________ Age: __

☐ Separated How Long: _____ Ex-spouse’s Name ________________________________

☐ Divorced How Long: _____ Ex-spouse’s Name ________________________________

CHILDREN (First Name Only) Name: ____________ Age: ______

Name: ____________ Age: ______ Name: ____________ Age: ______

Name: ____________ Age: ______ Name: ____________ Age: ______

MEDICAL

Primary Care Physician (PCP)

Name: __________________________ Address: _____________________________

City: __________________________ State: _____ Zip: _______ Phone: ____________

Date of last physical: ________ May I contact Your PCP?  ☐ Yes  ☐ No Initials: __________

List names of any other physicians you are currently seeing, and the condition they are treating you for

Name: __________________________ Address: _____________________________

Condition: __________________________

Name: __________________________ Address: _____________________________

Condition: __________________________

Are you taking any prescription drugs at this time?  ☐ Yes  ☐ No

If YES, please list name of medication and condition prescribed for:

Medication: __________________________ Dosage: _______ Condition: __________________________

Medication: __________________________ Dosage: _______ Condition: __________________________

Medication: __________________________ Dosage: _______ Condition: __________________________

Medication: __________________________ Dosage: _______ Condition: __________________________

Do you have any food allergies?  ☐ NO  ☐ YES

Do you have hay fever, mold, or tree/grass/weed pollen allergies?  ☐ NO  ☐ YES

Do you have any other allergies?  ☐ NO  ☐ YES

Would you like to minimize or possibly eliminate these allergies?  ☐ NO  ☐ YES
FAMILY HISTORY

The following information will help me understand you and your relationship(s) to your family. Please fill out those which apply to you.

Father: ___________________________ Age:____
Year Deceased:______________________ Cause of death:________________________

Mother: ___________________________ Age:____
Year Deceased:______________________ Cause of death:________________________

Step mother:_______________________ Age:____
Year Deceased:______________________ Cause of death:________________________

Step father:_______________________ Age:____
Year Deceased:______________________ Cause of death:________________________

Describe your childhood experience of your father/step father:

Describe your childhood experience of your mother/step mother:

Number of Brothers:_______ Name:_________________________ Age:_____
Name:_________________________ Age:____ Name:_________________________ Age:_____
Name:_________________________ Age:____

Number of Sisters:________ Name:_________________________ Age:_____
Name:_________________________ Age:____ Name:_________________________ Age:_____
Name:_________________________ Age:____

What type of relationship do you have with your siblings?

Have any of your brothers or sisters attended counseling before?  □ NO  □ YES

Details
Have any of your parents or stepparents attended counseling before?  □ NO  □ YES
Details

Any history of drug or alcohol abuse in your father's family, including your father?  □ NO  □ YES
Details

Any history of drug or alcohol abuse in your mother's family, including your mother?  □ NO  □ YES
Details

Any history of drug or alcohol abuse with you?  □ NO  □ YES
Details

If yes, what made you use or continue to use?
Details

Any history of drug or alcohol abuse with your spouse/partner?  □ NO  □ YES  □ N/A
Details

Any history of traumatic events experienced by your father or his parents?  □ NO  □ YES  □ Unknown
Details

Any history of traumatic events experienced by your mother or her parents?  □ NO  □ YES  □ Unknown
Details
What Religion were you raised in? ____________________________________________

What spiritual practices do you indulge yourself in? (ex. meditation, yoga, music, art, etc.)
Details

Have you either witnessed or been the victim of any of the following: (Check All That Apply)

☐ Sexual abuse or rape? Who was the perpetrator? ____________________________
☐ Physical abuse Who was the perpetrator? ____________________________
☐ Emotional or mental abuse? Who was the perpetrator? _______________________
☐ Financial Abuse? Who was the perpetrator? ____________________________
☐ Spiritual or religious Abuse? Who was the perpetrator? _____________________
☐ Cult or Ritual Abuse? Who was the perpetrator? __________________________

Did other family members witness any of the abuses checked above? ☐ NO ☐ YES ☐ N/A
Details

Were any other family members victims of the abuses checked above? ☐ NO ☐ YES ☐ N/A
Details

Were drugs or alcohol involved in the abuse? ☐ NO ☐ YES ☐ N/A
Details

How has this experience affected your life?
Details

Any history of physical abuse to your spouse/partner? ☐ NO ☐ YES ☐ N/A
Details
Any physical problems that you feel has affected your life? □ NO □ YES
Details

Any history of sexual abuse to your spouse/partner? □ NO □ YES □ N/A
Details

Have you ever experienced any sexual difficulties? □ NO □ YES
Details

Do you ever feel like someone or something has taken over your body or mind? □ NO □ YES
If yes, what percentage of the time? ________________________________

Have you ever had counseling before? □ NO □ YES How Long:_______
When:________________ Where:_____________________________________
Facilitator(s)/Details: ____________________________________________

Has your spouse/partner ever had counseling before? □ NO □ YES How Long:_______
When:________________ Where:_____________________________________
Facilitator(s)/Details: ____________________________________________

Have you ever been a member of a self-help group? □ No □ Yes How Long:_______
When:________________ Where:_____________________________________
Facilitator(s)/Details: ____________________________________________

Have you ever suffered a significant loss, such as a:
Job □ NO □ YES ________________________________
Family member or other loved one □ NO □ YES ________________________________
Abortion □ NO □ YES ________________________________
Miscarriage □ NO □ YES ________________________________
Have you ever had major surgery? □ NO □ YES.. ________________________________
Have you ever been in the military/police/fire/EMT/First Responders?  □ NO  □ YES  Branch:______________

If YES, did you witness or were you a part of any traumatic events in the line of duty?  □ NO  □ YES

Details

Have you ever been in a serious car accident or other disaster?  □ NO  □ YES

Details

Any particular fears, phobias or anxieties I should be aware of?  □ NO  □ YES

Details

Do you:  Smoke?  □ NO  □ YES  How many packs a day?  ____________

Use Alcohol?  □ NO  □ YES  How many drinks per day?  ____________

Use Illegal drugs?  □ NO  □ YES  What type?  _____________________________

How much/often?  _____________________________

If Yes to any of the above:  Do you want to quit?  □ NO  □ YES

List three goals that you want to accomplish in your counseling & growth:

1.  __________________________________________

2.  __________________________________________

3.  __________________________________________

List your last three employers:

1.  __________________________________________ From:_________________ To:_________________

   Reason For Leaving the above Job: __________________________________________

2.  __________________________________________ From:_________________ To:_________________

   Reason For Leaving the above Job: __________________________________________

3.  __________________________________________ From:_________________ To:_________________

   Reason For Leaving the above Job: __________________________________________
### ACE Score

**Adverse Childhood Experience**

**Place an X in the Yes or No box for each question**

<table>
<thead>
<tr>
<th>QUESTION:</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did a parent or other adult in the household often or very often swear at you, insult you, humiliate you, or put you down, OR act in a way that made you afraid that you might be physically hurt?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did a parent or other adult in the household often or very often push, grab, slap, or throw something at you OR ever hit you so hard that you had marks or were injured?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way, OR attempt to have anal, oral or vaginal intercourse with you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you often or very often feel that no one in your family loved you or thought you were important or special OR that your family did not look out for each other or support each other?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you often or very often feel that you didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you, OR your parents were too drunk or too high to take care of you or take you to a doctor if you needed it?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were your parents ever separated or divorced?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was your mother or stepmother often or very often pushed, grabbed, slapped or had something thrown at her, OR, sometimes, often or very often kicked, bitten, or hit with a fist or hit with something hard, OR, ever repeatedly hit at least a few minutes or threatened with a gun or a knife?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was a household member depressed or mentally ill, OR did a household member commit suicide?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did a household member go to prison?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**For office use only:**

### Candida

If your answer to a statement is yes or true, circle the number after the statement.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you taken antibiotics (penicillin, amoxicillin, etc) short term or long term?</td>
<td>4</td>
</tr>
<tr>
<td>Do you feel &quot;sick all over,&quot; yet the cause hasn't been found?</td>
<td>3</td>
</tr>
<tr>
<td>Are you bothered by hormone disturbances, including PMS, menstrual irregularities, sexual dysfunction, sugar craving, low body temperature or fatigue?</td>
<td>2</td>
</tr>
<tr>
<td>Are you unusually sensitive to tobacco smoke, perfumes, colognes and other chemical odors?</td>
<td>2</td>
</tr>
<tr>
<td>Are you bothered by memory or concentration problems or do you sometimes feel &quot;spaced out&quot;?</td>
<td>2</td>
</tr>
<tr>
<td>Have you taken prolonged courses of Prednisone or other steroids; or have you taken &quot;the pill&quot; for more than 3 years?</td>
<td>2</td>
</tr>
<tr>
<td>Do some foods disagree with you or trigger your symptoms?</td>
<td>1</td>
</tr>
<tr>
<td>Do you suffer with constipation, diarrhea, bloating, or abdominal pain?</td>
<td>1</td>
</tr>
<tr>
<td>Does your skin itch, tingle or burn; or is it unusually dry; or are you bothered by rashes?</td>
<td>1</td>
</tr>
</tbody>
</table>

**Total Score**

Scoring for women: 9 or greater **Probably;** 12 or greater **most certainly**

Scoring for men: 7 or greater **Probably;** 10 or greater **most certainly**
**Depression Screening: PHQ-9**

*Answer each of the following questions with regard to how you have felt over the last two weeks.*

*Circle the number that represents the amount of time you experience the symptom or topic*

<table>
<thead>
<tr>
<th>Symptom or Topic</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Trouble falling or staying asleep, or sleeping to much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling bad about your self, that you are a failure</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Trouble concentrating on tasks or activities like reading or watching TV</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Moving or speaking slowly, or being fidgety &amp; restless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Thoughts that you would be better off dead or of hurting yourself or someone</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

For office use only:

- How difficult have these problems made it for you to work, take care of things at home or get along with others?
  - Not Difficult
  - Somewhat Difficult
  - Very Difficult
  - Extremely Difficult

*These questions are to ask about things you may have felt most days in the past six months.*

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most days I feel very nervous.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most days I worry about lots of things.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most days I cannot stop worrying</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most days my worry is hard to control.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel restless, keyed up or on edge.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I get tired easily.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have trouble concentrating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am easily annoyed or irritated.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My muscles are tense and tight.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have trouble sleeping.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the things you noted above affect your daily life (at home, work or leisure) or cause you a lot of distress?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Were the things you noted above bad enough that you thought about getting help for them?</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>
Post Traumatic Stress Disorder Check List

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Use the below scoring to indicate how much you have been bothered by the experience.

1 = Not at all      2 = A little bit      3 = Moderately      4 = Quite a bit      5 = Extremely

1. Repeated, disturbing memories, thoughts or images of a stressful military/life experience.
   1  2  3  4  5
   [ ] [ ] [ ] [ ] [ ]

2. Repeated, disturbing dreams of a stressful military/life experience.
   1  2  3  4  5
   [ ] [ ] [ ] [ ] [ ]

3. Suddenly acting or feeling as if a stressful military/life experience were happening again, as if you were reliving it.
   1  2  3  4  5
   [ ] [ ] [ ] [ ] [ ]

   1  2  3  4  5
   [ ] [ ] [ ] [ ] [ ]

5. Having physical reactions (e.g: heart pounding, trouble breathing, sweating) when something reminded you of a stressful military/life experience.
   1  2  3  4  5
   [ ] [ ] [ ] [ ] [ ]

6. Avoiding thinking about or talking about a stressful military/life experience or avoiding having feelings related to it.
   1  2  3  4  5
   [ ] [ ] [ ] [ ] [ ]

7. Avoiding activities or situations because they remind you of a stressful military/life experiences.
   1  2  3  4  5
   [ ] [ ] [ ] [ ] [ ]

8. Trouble remembering important parts of a stressful military/life experience.
   1  2  3  4  5
   [ ] [ ] [ ] [ ] [ ]

9. Loss of interest in activities that you used enjoy.
   1  2  3  4  5
   [ ] [ ] [ ] [ ] [ ]

10. Feeling distant or cut off from other people.
    1  2  3  4  5
    [ ] [ ] [ ] [ ] [ ]

11. Feeling emotionally numb or being unable to have loving feelings towards those close to you.
    1  2  3  4  5
    [ ] [ ] [ ] [ ] [ ]

12. Feeling as if your future will somehow be cut short
    1  2  3  4  5
    [ ] [ ] [ ] [ ] [ ]

13. Trouble falling or staying asleep
    1  2  3  4  5
    [ ] [ ] [ ] [ ] [ ]

14. Feeling irritable or having angry outbursts
    1  2  3  4  5
    [ ] [ ] [ ] [ ] [ ]

15. Having difficulty concentrating
    1  2  3  4  5
    [ ] [ ] [ ] [ ] [ ]

16. Being “super-alert” or watchful or on guard
    1  2  3  4  5
    [ ] [ ] [ ] [ ] [ ]

17. Feeling jumpy or easily startled
    1  2  3  4  5
    [ ] [ ] [ ] [ ] [ ]

For office use only:

Scoring: 17 — None: Less than 22 — Questionable; 22 – 44 Sub Clinical; Greater than 50 — Clinical

Total

202 Dickinson Road ♥ Webster, NY 14580

Revision 06.06.19
**Moral Injury Events Scale (MIES)**

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Use the below scoring to indicate how much you have been bothered by the experience.

1 = Strongly Disagree   2 = Moderately Disagree   3 = Slightly Disagree  
4 = Slightly Agree   5 = Moderately Agree   6 = Strongly Agree

1. I saw things that were morally wrong.  
   □ 1 □ 2 □ 3 □ 4 □ 5 □ 6

2. I am troubled by having witnessed others’ immoral acts  
   □ 1 □ 2 □ 3 □ 4 □ 5 □ 6

3. I acted in ways that violated my own moral code or values  
   □ 1 □ 2 □ 3 □ 4 □ 5 □ 6

4. I am troubled by having acted in ways that violated my own morals or values  
   □ 1 □ 2 □ 3 □ 4 □ 5 □ 6

5. I violated my own morals by failing to do something that I felt I should have done  
   □ 1 □ 2 □ 3 □ 4 □ 5 □ 6

6. I am troubled because I violated my morals by failing to do something I felt I should have done  
   □ 1 □ 2 □ 3 □ 4 □ 5 □ 6

7. I feel betrayed by leaders who I once trusted  
   □ 1 □ 2 □ 3 □ 4 □ 5 □ 6

8. I feel betrayed by fellow service members who I once trusted  
   □ 1 □ 2 □ 3 □ 4 □ 5 □ 6

9. I feel betrayed by others outside the U.S. military who I once trusted  
   □ 1 □ 2 □ 3 □ 4 □ 5 □ 6

**For Office Use Only:**

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
</table>

Scoring:
9 or less — None: 10 to 22 — Some; 27 to 36 — moderate; 36 or above — severe  
Total
<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Yes □</th>
<th>No □</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Are you habitually impatient?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Are you often frustrated?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Do others seem to constantly be &quot;in your way&quot;?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Are you usually on your guard against being cheated?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Do you feel a more or less constant pressure to prove yourself?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Are you habitually fearful of somehow being &quot;caught&quot;?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Does it seem (or feel) that someone is always watching you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Do you secretly resent others' success, feeling that yours is never recognized?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Are the negative things in your life more obvious to you than the positive?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Do you habitually find a lot to complain about?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Do you often feel insecure, believing that others are superior to you</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Are you afraid you will end up with less than you need?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Do you habitually expect bad things to happen?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Is it hard for you to &quot;go with the flow&quot;?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Is it often difficult for you to stand up for yourself?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Do you secretly believe that your feelings are not important?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Do you usually keep your preferences to yourself, often deferring to what others want?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Do you feel your needs are often minimized or ignored altogether?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Do you have temper tantrums?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Do you regularly tend to overreact?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Is it hard for you to accept that others care about and love you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Are you frequently afraid that somehow you are &quot;missing out&quot; on what counts?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Are you often disrespectful to those with less power than yourself?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Does the intimacy of others somehow make you uncomfortable?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For office use only:
How did you find out about me?

☐ Personal Referral

Who Referred you? ________________________________

May I send this person a thank you card? ☐ NO ☐ YES

If YES:  Their Address: _____________________________________________

City: _______________  State: _________  Zip: ________________

☐ Google Search

☐ Psychology Today Web Site

☐ HelpPro Web Site

☐ ThumbTack

☐ Good Therapy

☐ ACEP Web Site

☐ EFT Universe Web Site

☐ The Tapping Solution/Tapping International Web Site

☐ Veteran’s Stress Project

☐ Legends 102.7/WLGZ/Save Our Soldiers

Other Web Site: ________________________________

Some other method: ________________________________

Did you visit my web site before calling me? ☐ NO ☐ YES

Was my web site helpful in your decision? ☐ NO ☐ YES
INFORMATION & CONSENT

NOTE: This is a HIPPA Compliant Document. Signing this document constitutes both a receipt of my office policies, and consent to do therapy. You will receive a copy for your files.

Thank you for choosing me as your counselor/therapist. This document is designed to inform you about my background and to ensure that you understand our professional relationship. Please read the following counseling agreement conditions thoroughly and sign at the end of the document. If you have any questions, please ask them.

I use a wide variety of traditional and non-traditional tools to help you attain the healing you desire. I am only a guide. This is your work and you have the answers inside of you. It is my job to help you discover the answers.

All of the techniques I use have plenty of clinical evidence and support, are highly effective, and novel. Strong emotions may arise when clearing the energy field of allergic type disturbances, or when using any of the other psycho energetic protocols like EFT, TAT, IST9x9, Allergy Antibodies, and Energy Medicine. These techniques may involve me having safe, respectful, physical contact with safe areas of your body with your permission.

Duration of Therapy:

The duration of therapy varies, based on the individual and the presenting issues. Individual results will vary. You may terminate at any time you feel you have achieved your goals. If you are a long term client, (greater than 6 months) I ask that when the time comes to end our relationship you terminate our relationship formally and cleanly. To do so leaves the door open for the future and gives us a chance to clean up any unfinished business.

Appropriate and acceptable termination is to give two sessions (if you are a weekly client) or two weeks notice of your intent to terminate our relationship. This gives us both time to reflect on what each of us needs to say or do to bring the relationship to a close. Failure to honor this agreement will result in your receiving a bill for the remaining sessions. I reserve the right to terminate this agreement without notice in the event of abusive, dangerous, unhealthy, disrespectful or irresolvable situations.

Confidentiality/Disclosure:

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Confidentiality in therapy is a must, therefore, I will not divulge anything you tell me without written consent, except under the following circumstances:

- I am ordered by a court to disclose information.
- My need to discuss your case with my supervisor.
- You direct me to tell someone else, via signed release.
- I determine that you are a danger to yourself or others.
- You reveal that you are abusing a child (Federal Law mandates this be reported).
- You may review your PHI (Personal Health Information/Intake Form; case notes are excluded by HIPPA) by providing me a written request.
Client Agrees to:

- Arrive on time. You are responsible for showing up for your appointment. I do not call or text reminders.
- Respect my right to privacy. You only have a right to be on the premise if you have an appointment w/me.
- Have checks written on arrival.
- Be as open, honest and vulnerable as possible.
- Pay for missed or inappropriately canceled sessions.
- Pay for additional letter writing at the rate of $25/hour: Minimum Charge: $25
- Be willing to stretch and take risks when appropriate.
- Pay bounced check fees imposed by the bank plus $15.00.
- Be responsible for all fees incurred in the collection of outstanding debts (any debt 90 days past due)
- Pay for services at beginning of each session by cash or check or Credit Card
- Provide 24 hour advanced notification to cancel a scheduled appointment. Failure to do so will result in your account being charged and no further appointments until the debt is settled.
- Give two sessions or two weeks notice of intent to terminate our relationship. (See Duration of Therapy)
- Not give me gifts, invite me to social functions or expect social connection. (See Dual Relationships)
- Notify me of your inability to pay for a session at the beginning of the session.
- Let me know if you need a statement for insurance purposes.

Counselor Agrees to:

- Maintain confidentiality.
- Provide 30 day notice of fee increases.
- Provide you with a high standard of service.
- Guide you in identifying and resolving issues.
- Support you in taking healthy stretches and risks.
- Help you gain awareness and insight about yourself.
- Make referrals to other professionals where appropriate.
- Believe in you and your ability to grow, change and heal.
- Abide by the Ethical Standards of organizations I belong to.
- Be supportive, helpful, honest, respectful, compassionate & empathetic.
- Provide, upon request, copies of the Ethical Standards and Codes of Conduct by which I abide.
- Work toward a viable resolution of any complaints or concerns you have about my services or conduct.
- Provide services in 60 minute sessions, unless you are late for your appointment. Extended sessions will be billed accordingly.
- Provide, upon request, phone numbers of the organizations I belong to in the event that you feel it necessary to file a grievance.
- Send you a monthly statement, usually via Email, should you request one for insurance purposes. Otherwise, I do not send them out.
Dual Relationships:

Professional Ethics Standards prohibit Dual Relationships. This refers to a relationship that exists outside of our Counseling Relationship. This remains in affect after the termination of the therapeutic relationship. While the atmosphere will be friendly, I will not enter into any business or other social relationship with you. Should we run into each other in public, a simple acknowledgment of each other is appropriate.

Perfumes & Colognes:

Please do not wear perfumes or colognes to session as I am allergic to many of them.

Scheduling or Changing Appointments/Communicating w/Me:

Appointments may be scheduled or changed via telephone/voicemail, or email. Text messaging is an unacceptable form of communications.

Communicating with me via Facebook is not an option nor is it advised as it is not a secure form of communication. Email has limited security, so keep your data/information to a minimum.

Organizational Memberships:

- ACEP Association for Comprehensive Energy Psychology
- NYMHCA New York Mental Health Counselors Association
- VBC Veterans Business Council
- EAPA Employee Assistance Professionals Association
- Irondequoit Chamber of Commerce

Insurance:

I do not accept insurance of any type, including Medicaid, Medicare, Worker's Compensation or NYS No Fault.

This is a benefit to you since you will not be limited to the number of visits you can have during the year and preserves your confidentiality. These expenses are also a legitimate medical expense and tax deductions, as is your mileage to and from your appointments.

Currently, Licensed Mental Health Counselors can not accept Medicaid or Medicare.

Worker’s Compensation is an entirely different issue. It is against the law for you to pay for any services related to your case out of pocket. If I accepted your case w/o WCB approval I could lose my license, and I am not willing to do that. I worked to hard to get it.

Other Payment Options:

- FSAs or Flexible Spending Accounts (credit card or other type)
- HSAs or Health Savings/Spending Account (credit card or other type)
- Some insurance policies offer out-of-network coverage. I will supply you with a statement with insurance codes and procedure codes so you can submit it for reimbursement.
Video Sessions/Distance Counseling

I am a credentialed distance counselor and offer sessions over the internet for clients not in the immediate Rochester area, or during inclement weather. The program I use is VSee which offers better quality, reliability and security than Skype. It is a free program and I will send you an invitation to download and install it if you choose this option.

Your Appreciation of My Services, Time & Skills as of 08/11/16

I accept cash, checks, (payable to Tom Porpiglia) VISA, MasterCard, Discover Card, and FSA/HAS cards. You must pre-authorize the use of your credit card(s) if you wish to use it to pay for services at any time. There is a form later in this document for you to fill out. Please have checks or cash ready and available at the beginning of each session. All accounts past due 90 days will be submitted for collection.

<table>
<thead>
<tr>
<th>60 Minute Session</th>
<th>Individual</th>
<th>Couples</th>
<th>Veteran</th>
<th>Students</th>
<th>Savings</th>
<th>Veterans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Session</td>
<td>$110.00</td>
<td>$125.00</td>
<td>$105.00</td>
<td>$85.00</td>
<td>0%</td>
<td>6 Free Sessions</td>
</tr>
<tr>
<td>Pre-Pay 3 Sessions</td>
<td>$297.00</td>
<td>$337.50</td>
<td>$283.50</td>
<td>$229.50</td>
<td>10%</td>
<td>After 6 Session: See Student Rate.</td>
</tr>
<tr>
<td>Pre-Pay 6 Sessions</td>
<td>$577.50</td>
<td>$656.25</td>
<td>551.25</td>
<td>$446.25</td>
<td>12.5%</td>
<td>After 6 Session: See Student Rate.</td>
</tr>
</tbody>
</table>

Letter Writing $25/hr minimum.
Reading long emails (longer than 5 minutes) $25/quarter hour

Pre-Pay Refund Policy:

The discount is based on the usage of all sessions that you pre-paid for. If you do not use all of the sessions you have 2 options:

1. Leave the balance on account for future sessions.

2. Request a refund in writing within 30 days of your last visit. The amount of your refund will be pro-rated. You may receive discounts for blocks of 3 sessions at the 3 session discount rate, and pay full contracted price for sessions used that do not add up to a block of 3 sessions. For example, if you pay for 6 sessions and only use four, one session would be at full price and three sessions at 10% discount. Requests for refunds beyond 30 days will not be honored.

NOTE: Missed Sessions are charged at the full rate. I reserve the right to make adjustments in the fee schedule based on unusual or extraordinary circumstances. 30 day written notice of fee increases will be given. Other terms subject to change without notice.
Consent & Agreement:
I agree to honor the terms and conditions set forth in the Information & Consent document. I promise to pay the current, appropriate fee for the chosen session length at the time of service. I also agree to be responsible for all bank fees, collection agency fees or legal fees incurred in the collection of outstanding debts. In addition, I acknowledge and agree to appropriate safe, physical contact during the course of treatment w/EFT, TAT or Allergy Antidotes, when necessary.

I also authorize Tom Porpiglia of Life Script Mental Health Counseling Services PLLC, to keep my credit card number and signature on file and to charge my Visa, MasterCard or Discover card for recurring session charges in accordance with the agreed upon session length and corresponding charges determined by the table on the previous page. Missed sessions will be charged at the maximum rate defined in the table on the previous page.

If I am paying by other means (check or cash), I agree to have my card charged in the event that I fail to attend a scheduled session, return phone messages about the missed session and fail to reschedule.

I understand this form is valid until termination of services. I promise not to dispute charges ("charge back") for sessions I have received or that I have not cancelled 24 hours prior to a scheduled session. I further authorize Tom Porpiglia of Life Script Mental Health Counseling Services PLLC to disclose information about my attendance/cancellation to my credit card issuer if I dispute a charge.

Credit Card Pre-Authorization
Cardholder Name: ___________________________ Billing Address: ____________________________
City: ___________________________ State: ________ Zip: ____________________________
Card Number: ___________________________ Visa / MasterCard / Discover Exp. Date: _____________
Cardholder Signature: ___________________________ Date: _____________

Client’s Signature (if different from Cardholder)
______________________________ Date: _____________

Therapist’s Signature ___________________________ Date: _____________

If Applicable:
Partner’s Signature ___________________________ Date: _____________
Parent or Guardian ___________________________ Date: _____________