Anchor of Hope Counseling Services, PLLC

Welcome

Please print out these forms, complete them and bring them with you on your first visit (10 pages total):

1) Fill out the "***Client Information Form***" (for couples, please print out two copies so each can submit a separate form);

2) Read and sign the back of the "***Declaration of Practices and Procedures***" form (all family members over 18 years of age will need to sign the submitted copy);

3) Complete the "***Health Insurance Information Form***" by calling your insurance company and acquiring the necessary information listed on the form.

Please note that all of the above forms must be completed ***before*** the start of your first visit.

Thank you!

Andrea Toups, M.Ed., LPC, LMFT
Anchor of Hope Counseling Services, PLLC
(985)230-0111

Client Information Form.

Client Information:

Today's Date: ___/___/___ Client's Name: _____
Phone Numbers: (Home) _____ (Work) _____
(Cell) _____ Can we call you at work? Yes / No
Address: _____
City: _____ State: _____ Zip _____
Age: ____ Birth Date: ___/___/___
Marital Status: [ ] Single [ ] Engaged
[ ] Married – How Long? _____ - How many times? _____
[ ] Separated – How Long? [ ] Divorced – How long? _____
Education: _____ Occupation: _____
Place of Employment: _____

If you believe your insurance company may cover a portion of your visits here, please complete the following information:
Name of Insurance Company: _____ Phone: _____
Group #:_____Policy Holders S.S. #:_____ Policy#:_____

Counseling History:

Briefly describe the reason(s) you are seeking counseling: _____
_____
What is your most difficult relationship right now? _____
What is your most difficult emotion right now? _____
Who is coming for counseling? _____
Have you had any previous counseling? ____ If yes, when? _____
Where / With Whom? _____ Why? _____
Are you, or a family member, currently seeing a psychiatrist or another counselor? _____
If so, what family member? _____ Psychiatrist / Counselor Name: _____
For what reason? _____

Crisis Information:

Are you currently having suicidal thoughts, feelings, or actions? Yes / No
If yes, explain: _____
Are you currently homicidal / assaultive thoughts or feelings, or anger-control problems? Yes / No If yes, explain: _____
Have you had any past problems, hospitalizations, incarcerations for suicidal or assaultive behavior? Yes / No If yes, explain:
_____
Are you currently experiencing any current threats of significant loss or harm (illness, divorce, custody, job loss, etc.)? Yes / No
If yes, describe: _____

Emergency Contact Information (name, relationship, phone number, address):

_____

Client's Name: _____

Medical Information:
When were you last examined by a physician? _____
Name of physician: _____ Phone: _____
Address: _____
List any medical conditions you are currently being treated for: _____
_____
List any medications you are currently taking:

Name of Medication	Frequency Taken	Reason for Medication

If you enter into therapy with me, may I tell your medical doctor so that he / she can be fully informed and we can coordinate your treatment? Yes / No

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Complete this section if client is under the age of 18.
Parent / Guardian's Name: _____
Phone Numbers: (Home) _____ (Work)_____
(Cell)_____ (Beeper) _____
Can we call you at work? Yes / No
Age: ____ Birth Date: ___/___/___ Marital Status: [ ] Single [ ] Engaged
Education: _____ Place of Employment: _____

Spouse's Name: _____
Phone Numbers: (Home)_____ (Work)_____
(Cell)_____ Can we call him / her at work? Yes / No
Address: _____
Age: ____ Birth Date: ___/___/___ Social Security #: _____
Marital Status: [ ] Single [ ] Engaged
[ ]Married – How Long? _____ - How many times? _____
[ ] Separated – How Long? _____ [ ] Divorced – How long? _____
Education: _____
Occupation: _____
Place of Employment: _____

Client's Children:
List name, birth date, sex, relationship of all children, and whether they live at home with you.

Name	Birth Date	Sex	Relationship	At Home?

Client's Name: _____

Client's Family of Origin:

Father: First Name _____ Age ____ Occupation _____
State of Health _____ Resides in _____
If deceased, how and when _____
List 3 words that best describes him (ex: loving, mean, etc.) _____
_____
How do / did you get along with him? _____

Mother: First Name _____ Age ____ Occupation _____
State of Health _____ Resides in _____
If deceased, how and when _____
List 3 words that best describes her (ex: loving, mean, etc.) _____
_____
How do / did you get along with her? _____

Stepfather: First Name _____ Age ____ Occupation _____
State of Health _____ Resides in _____
If deceased, how and when _____
List 3 words that best describes him (ex: loving, mean, etc.) _____
_____
How do / did you get along with him? _____

Stepmother: First Name _____ Age ____ Occupation _____
State of Health _____ Resides in _____
If deceased, how and when _____
List 3 words that best describes her (ex: loving, mean, etc.) _____
_____
How do / did you get along with her? _____

Brothers and Sisters: Please list in birth order.

Name	Age	Sex	Where Reside	Relationship With Client (close / distant / in between)

Have you ever experienced any of the following:
[ ] Harsh physical punishment or abuse as a child
[ ] Sexual advances made toward you as a child
[ ] Sexual abuse
[ ] Incest
[ ] Rape
[ ] Physical abuse by spouse or lover
[ ] Verbal or emotional abuse as a child or adult

If so, please explain:

Substance Use/Abuse History (N/A is not applicable)

Substance	First Use	Last Use	Current Use
Depressants			
Alcohol	_____	_____	_____
Inhalants	_____	_____	_____
Barbiturates	_____	_____	_____
Hallucinogens	_____	_____	_____
Marijuana	_____	_____	_____
LSD	_____	_____	_____
Mushrooms	_____	_____	_____
PCP			
Stimulants	_____	_____	_____
Amphetamines	_____	_____	_____
Cocaine (powder)	_____	_____	_____
(crack freebase)	_____	_____	_____
Other_____	_____	_____	_____

Client's Religion / Faith:

Religious Affiliation during childhood: _____

Religious Affiliation now: _____

Level of meaningfulness of religious affiliation during childhood and adolescence:
High Medium Low

Level of meaningfulness or religious affiliation now:
High Medium Low

Attached is a Declaration of Practices and Procedures, which outlines my credentials, my approach to counseling and my Fee Policy. Please read these forms, discuss any concerns, sign, and return them to me. If you have any questions concerning my fees, qualifications, or other issues, please ask. **This is a strictly confidential client record.**

Client's Signature: _____ Date __/___/___
_____ Date __/___/___

Referral Information: Who referred you to me for counseling?

Name: _____ Phone: _____

May I have your permission to thank this person for the referral? Yes / No

Declaration of Practices and Procedures

Andrea B. Toups, M.Ed., LPC, LMFT
Anchor of Hope Counseling Services, PLLC
1004 W. Thomas St.
Hammond. LA 70401
(985) 230-0111

Qualifications: I earned a M.Ed. from Southeastern Louisiana University in 1999. Additionally, I earned a Th. M. in Psychology in Counseling from New Orleans Baptist Seminary. I am licensed as a LPC # 2998 with the Licensed Professional Counselors Board of Examiners, 8631 Summa Ave, Baton Rouge, Louisiana 70809, (225)-765-2515. I hold License # 1038 as a Licensed Marriage and Family Therapist.

Counseling Relationship: I strive to establish a counseling relationship that is person-centered and interactive and to use my skills and professional expertise to facilitate growth and development.

Area of Expertise: I work with adolescents, adults, couples and families with a wide range of problems to address issues arising in the school, social or home settings. I am a member of the American Association for Christian Counselors (AACC).

Fee Scales/Office Procedures: Counseling sessions are sixty-minutes in duration, with the last ten minutes used for rescheduling, payment, and other related business. Fees are due at the time the services are rendered. The initial evaluation cost is $150.00. The fee for each sixty-minute individual, marital, or family session is $125.00. Cash, personal checks, and third party payments are acceptable forms of payment. Please make checks payable to Anchor of Hope Counseling Services. The final obligation for payment lies with you, the client, not the insurance or managed care companies. Fees are subject to change. There will be a $30.00 NSF charge on all returned checks.

Cancellation: The time you schedule for appointments is reserved for you specifically. If you must cancel a session, the office must be notified at least 24 hours in advance, which will allow for the scheduling of another person who may benefit from this time, or you will be responsible for a cancellation fee of $50.00. If the office is not open and you need to cancel, you can leave a message on our voicemail at (985) 230-0111 and/or email the office at info@anchorofhope.info and the time of the call/email will be registered.

Services Offered and Clients Served: Counseling is often insight oriented and problem-focused and may be presented in an individual or group setting. I primarily approach counseling from a cognitive-behavioral perspective in that patterns of thoughts and actions are explored in order to better understand the clients' problems and to develop solutions. However, dependent on my professional judgment as to what is best for the client, techniques utilized will come from a wide variety of disciplines and theoretical perspectives including the use of systems theory, structural/strategic, solution focused brief therapy and spiritual disciplines. I am experienced in the working with problems of childhood and parenthood, marital difficulties, and life difficulties of adulthood that may relate to disturbances in family relationships. I am a certified PREPARE/ENRICH Counselor. While I make no systemic presentation on the subject, I am decidedly Christian in my orientation.

Code of Conduct: As a LPC, I am required to adhere to the Louisiana Codes of Conduct for Licensed Professional Counselors. I am also required by law to adhere to the Louisiana Code of Ethics for Licensed Marriage and Family Therapists. A copy of the Code of Conduct is available upon request.

Privileged Communications: Materials revealed in counseling will remain strictly confidential except under the following circumstances in accordance with state law: 1.) The client signs a written release of information indicating informed consent of such release (which is required for those who use third party insurers, HMO or PPO plans, or EAP programs; 2.) The client expresses intent to harm him/herself of someone else; 3.) There is a reasonable suspicion of abuse/neglect against a minor child, elderly person (65 or older), or a dependent adult; 4.) A court order is received directing the disclosure of information.

It is my policy to assert privileged communication on behalf of the client and the right to consult with the client if at all possible, except during an emergency, before mandated disclosure. I will endeavor to apprise clients of all mandated disclosures as conceivable.

In the event of marriage or family counseling, material obtained from an adult client individually may be shared with the client's spouse or family members only with the client's permission. Clients may refuse to sign such a waiver but should be advised that maintaining confidentiality for individual sessions during couple or family therapy could impede or even prevent a positive outcome to therapy. Any material obtained from a minor client may be shared with that client's parent or guardian.

After Hours and Emergency Situations: Should you need to contact me between appointments, call me at (985) 230-0111.You may leave a message and I will return your call as soon as possible. In an emergency situation when an immediate response is necessary, you are instructed to contact a local medical or psychiatric hospital or call 1-800-256-2970.

Client Responsibilities: You are expected to follow billing, scheduling and office procedures. If you have been seeing another mental health professional, it is expected that you get permission from them or terminate the counseling relationship. If permission is allowed I would ask for you to grant me authorization to share information with this professional so that we may coordinate our services to you.

You, the client, are a full partner in counseling. Your honesty and effort is essential to success. If as we work together you have suggestions or concerns about your counseling, I expect you to share these with me so that we can make the necessary adjustments. If it develops that you would be better served by another mental health provider, I will help you with the referral process.

Clients must make their own decisions regarding such things as deciding to marry, separate, divorce, reconcile and how to set up custody and visitation. That is, I will help you think through the possibilities and consequences of decisions, but my Code of Ethics does not allow me to advise you to make a specific decision.

Physical Health: Physical health can be an important factor in the emotional well being of an individual. If you have not had a physical examination in the last year, it is recommended that you do so. As a routine part of the initial session, you will be asked the name of your physician and to list any medications that you are now taking.

Potential Counseling Risk: The client should be aware that counseling poses potential risks. In the course of working together additional problems may surface of which the client was not initially aware. Often times the client may feel intense and unwanted feelings, including sadness, fear, anger, and guilt and/or anxiety. The experiencing of such feelings area an integral part of the therapeutic process are both natural and normal. If this occurs, the client should feel free to share these new concerns with me.

Termination: Suspension, termination, or referral may be initiated by either the counselor or the client. Treatment efforts will conclude when (1) the sought-after goals have been sufficiently achieved; (2) the client chooses to leave; or (3) it becomes evident that the client should continue therapy with another therapist due to a therapeutic impasse or a need for increased specialization. You have the right to terminate

participation in therapy at any time, for any reason, without needing to explain, and without financial obligations other than those already accrued. Termination is most often a mutual decision based upon the welfare of the counselee. Clients who wish to terminate therapy agree to meet with this counselor first, prior to making a final decision. It is my ethical duty to provide services only as reasonable progress is seen.

Professional Services Contract:

_____(Name(s) of), hereinafter referred to as the client, has this day retained Andrea B. Toups, M.Ed., LPC, LMFT of Anchor of Hope Counseling, PLLC to provide individual, marital and/or family therapy. The agreed fee per 60-minute session is _____.

It is expressly understood that Andrea B. Toups has not issued, and will not issue, any guarantee of cure or treatment effects, number of sessions necessary, or total cost of service. It is further understood that Andrea B. Toups shall be obligated to maintain a reasonable standard of care of practicing Professional Counselors. Neither Andrea B. Toups, nor Anchor of Hope Counseling, PLLC, shall be held to any special level or elevated standard of care.

The client agrees that all fees shall be due and paid at the time of service, and that payment arrears over two sessions will result in the cessation of therapy until the balance is made current.

We, the undersigned counselor and the client/s/, have read, discussed together, and fully understand this agreement and stated policies. We agree to honor these policies, including the commitment to negotiate and mediate as stated above, and will respect one another's views and differences in their outworking. This agreement is entered voluntarily by the client(s) with competency and knowledge and understanding of the consequences.

Client/s/ Signature: _____ Date: _____

_____ Date: _____

(If Client is a minor):

I, _____, give permission for Andrea B. Toups, M.Ed.,

LPC, LMFT to conduct counseling with my (relationship) _____.

Name of Minor: _____.

Counselor's Signature: _____Date: _____

Andrea B. Toups, M.Ed., LPC, LMFT

POLICY FOR CANCELLATIONS AND "NO SHOWS"

Andrea Toups, M.Ed., LPC, LMFT
Anchor of Hope Counseling Services, PLLC
1004 W Thomas St, Hammond, LA, 70403
985.230.0111 *(24 hour voice mail)*

I, _____ agree to have my/our MasterCard or Visa
(Print Name) charged the **FEE OF $50**:

1. For any session not canceled with ***at least*** 24 hour notice and/or
2. For any appointment I/we neglect to appear ("no show")
3. For any balance owed 30 days past due

I understand that any card on file, whether listed below, or encrypted in our software program, can be used.

Signature: _____ Date: _____

AOHCS's policy is that payment is due at the time of the session.

Confirmation of appointments via email is provided as a courtesy. Keeping the appointment is the responsibility of the client.

All new or returning clients will need to have a credit card number on file before scheduling their first or a new appointment.

Credit card numbers will be securely locked and kept confidentially along with other client data.

PLEASE FILL IN THE INFORMATION BELOW

CARD TYPE:

☐ MASTERCARD: ☐ VISA: ☐ DISCOVER:

CARD NUMBER: _____

CARDHOLDER NAME: _____

SIGNATURE: _____

SECURITY CODE: _____

ZIP CODE: _____

EXP DATE: _____

AMOUNT: Maximum $100.00 for missed appointments or ANY balance due past 30 days.

HEALTH INSURANCE INFORMATION

Dear Client,

We look forward to seeing you and we will gladly file your sessions with the counselor to your insurance company. However, we do not verify coverage or call to get the information concerning your coverage for you. You must call the phone number(s) on your health insurance card to get the following information PRIOR to your first session. Without ALL questions on this form answered by your Insurance Company, you will be responsible for the full session fee.

Name: _____ Date of Birth: _____
Insured's Name: _____ SS#: _____
Name of Insurance Company: _____ Effective date: _____
Insured's ID number: _____ Group Numbers: _____

You must call the number on your insurance card as ASK THESE QUESTIONS: Ask for a reference number regarding your phone call. Ref. # _____

Do I have outpatient mental health benefits? Yes_____ No_____

Is Andrea Toups (Anchor of Hope Counseling Services, PLLC) on my provider list? Yes_____ No_____

If no, do I have any "out of network" benefits? Yes_____ No_____

(Write what those benefits are on the back of this form)

Do I have a deductible to meet prior to benefit coverage? Yes_____ No_____

What is the amount of my deductible? $_____

How much of that deductible have I met? $_____

Do I have a co-payment for mental health benefits? Yes _____ No_____

If so, what is my co-payment amount per session? $_____

How many sessions are allowed per calendar year? _____

Is prior authorization needed for counseling? Yes_____ No_____

If so, authorization number? _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process claims. I authorize payment of medical benefits to the counselor who provided the service.

SIGNED: _____ DATE: _____