Sage Recovery & Wellness Center

COUPLES REGISTRATION FORM

CLIENT INFORMATION

Legal First & Last Name:	**Preferred name:**	**Middle:**

Birth Date:	Age:	Marital Status:	Former Name:

Sex: ☐ Male ☐ Female ☐ Transgender, Gender Pronoun _____ ☐ Other, Gender Pronoun _____

Address: City: State: Zip Code:

Social Security no.:	Home phone no.:	Cell phone no.:	Ethnicity:

Occupation:	Employer:	Employer phone no.:

Who can we thank for your referral? Name:

INSURANCE INFORMATION

(Please fill in this information and then give your insurance card to the receptionist.)

If the client is NOT the person responsible for payments, a Release of Information for Financials and Attendance is required.

Please indicate primary insurance:	Subscriber's Name:	Subscriber's DOB:

Subscriber's S.S. no.:	Group #:	Policy #:

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: | Other:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Cell or Home phone #.:	Work phone #:

The above information is true to the best of my knowledge.

_____ _____

Client Signature Date

Medication Sheet

Name: _____ DOB: _____ Date: _____

Medication: Include over the counter and herbal	**Dose**	**Frequency/ time of day taken once daily-1x, twice daily-2x, as needed, etc.**	**Prescribing Physician**	***Put your initials under week if there are no changes. Put an "x" if you are no longer taking that medication.***							
				Wk1	*Wk2*	*Wk3*	*Wk4*	*Wk5*	*Wk6*	*Wk7*	*Wk8*
Ex: Wellbutrin	100	2x (or twice daily)/1AM & 1PM	Dr. Weatherby	*GR*	*GR*	*GR*	*x*	*x*			

_____ _____

Signature of Medical Director, Cole Weatherby, DO Date

Physical Health Screen

Please check any of the following symptoms you have experienced in the **past 72 hours.**

☐Muscle tension
☐Anxiety
☐Restlessness
☐Irritability
☐Insomnia
☐Headaches/Migraines
☐Poor concentration
☐Depression
☐Social isolation
☐Sweating
☐Tremor
☐Nausea
☐Vomiting
☐Diarrhea
☐Racing heart
☐Dizziness
☐Fainting
☐**Heart Palpitations**
☐**Pain/Tightness in the chest**
☐**Difficulty breathing**
☐**Confusion**
☐**Delirium tremens (DTs)**
☐**Seizures**
☐**Heart attacks**
☐**Strokes**
☐**Hallucinations-visual or auditory**
☐None

Please check the box indicating any of the following of which you have been diagnosed:

☐Tuberculosis
☐HIV/AIDS
☐STD
☐Diabetes
☐Heart disease/attack/condition
☐Liver problems
☐Seizure
☐Hepatitis B or C
☐Impaired immune system
☐Stroke
☐Cancer/Malignancy
☐Fainting
☐Blood in vomit or stool
☐Menstrual Disorders
☐High/Low BP
☐Osteopenia/Osteoporosis
☐Dental problems, specify: -
_____
☐Hypo/Hyperthyroidism
☐Polycystic Ovarian Syndrome
☐Irritable Bowel Syndrome
☐Fibromyalgia
☐Chronic Pain
☐Gastritis
☐Migraines
☐Other_____
☐None

Please indicate by checking the box if you have experienced any of the following symptoms or conditions in the **past 24 hours**:

☐Fever or chills
☐Vomiting or diarrhea
☐Non-healing wounds or abscess
☐Wet and/or bloody cough
☐Any unexplained weight gain or loss in the last 30 days
☐Any diagnosed infectious illness
☐None

Any known allergies?_____
Have you been seen by a physician in the last 12 months?☐ YES ☐ NO
If applicable: Most recent OBGYN visit: _____
Last time had labs/bloodwork done (month/year): _____ Results normal? _____ If not normal, what abnormalities? _____
Have you experienced any physical discomfort or continuous pain? ☐YES ☐NO
If so, please explain:_____

For Office Staff use only

☐Referred to medical provider ☐No referral ☐Needs medical clearance

Print & Signature of Therapist:_____Date:_____

*The chart below pertains to specific substances you have used in the past and/or present. Please **check ONE** number under the category that best describes your use pattern. Consider only drugs taken without a prescription from your doctor, unless the prescriptions were/are taken at a higher dosage than prescribed.*

	Age of first use	Date of most recent use	Never used	Tried but quit	Several times a year	Several times a month	Week-ends only	Several times a week	Daily	Several times a day
Alcohol (beer, wine, liquor)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Tobacco (chewing tobacco, dip, snuff, cigarettes, cigars, e-cig)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Cannabis (marijuana, weed, THC)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Cocaine (coke, blow, crack, rock, freebase)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Opioids (heroin, smack, horse, opium, morphine, codeine, hydrocodone, buprenorphine, oxycodone, norco)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Benzodiazepines (valium, Xanax, klonopin Ativan, ambien, Prozac)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Methamphetamine (Speed, amphetamines, methylphenidate-concerta & Ritalin, crystal)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Designer drug (MDMA, Ecstasy, bath salts, K2)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Hallucinogen (LSD, PCP, psilocybin, peyote, ACID, shrooms)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Barbiturates (Quaalude, downers, ludes, blues)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐
Inhalant (glue, gasoline, spray cans, whiteout, rush)			0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐

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Couples Counseling Intake Form

Please complete this form in its entirety on your own. At this time, please refrain from sharing your answers with your partner. Much of the information you provide will be explored further during sessions with the therapist.

Your Name: _____ **Partner's name**: _____

Personal Health History

Have you ever been diagnosed with a serious medical condition? *(Please describe and include any past or current treatment)* _____

_____

Have you ever been diagnosed with a mental health condition? *(Please describe and include any past or current treatment)* _____

_____

Have you ever struggled with substance abuse? *(Please describe and include any past or current treatment)*

_____

_____

Has your partner ever struggled with substance abuse? *(Please describe and include and past or present treatment)*

_____

_____

Do you have any family history of mental health conditions? *(Please describe)* _____

_____

Do you have any family history of substance abuse? *(Please describe)* _____

_____

Have you ever been treated or an eating disorder? *(Please describe and include any past or current treatment)*

_____

_____

General Relationship History

Do you have any cultural, religious, or spiritual beliefs and/or preferences that we should take into consideration for your treatment? ☐YES ☐NO

Explain:

How long have you and your partner been together? _____

How long have you and your partner been married *(if applicable)*? _____

How did you meet your partner? _____

_____

How many children do you have? *(Please provide genders and ages)* _____

_____

How many children live in the home? _____

Are either you or your partner a step-parent to these children? _____

If yes, what is the custody arrangement with the other biological parent? _____

_____

Does anyone else reside in the home? *(Please provide relationship and ages)* _____

_____

_____

Circle the dot below which best describes the degree of *general happiness*, everything considered, of your present relationship.

• • • • • • •

Very unhappy Happy Perfectly happy

Circle the dot below which best describes the degree of satisfaction with your *communication* with your partner.

• • • • • • •

Very dissatisfied Satisfied Perfectly satisfied

Circle the dot below which best describes the degree of satisfaction with your *emotional intimacy* with your partner.

• • • • • • •

Very dissatisfied Satisfied Perfectly satisfied

Circle the dot below which best describes the degree of satisfaction with your *physical intimacy* with your partner.

• • • • • • •

Very dissatisfied Satisfied Perfectly satisfied

How would you describe your relationship? _____

_____

What are your biggest strengths as a couple? _____

_____

What do you like most about your relationship? _____

_____

What are the biggest challenges in your relationship? _____

_____

Please mark below which stressors you and your partner have faced during your relationship:

□ Job loss	□ Death of parent	□ Birth of child/adoption	□ Suicide attempt	□ Extended absence from the home
□ Pregnancy loss	□ Death of sibling	□ Mental health issue	□ Family conflict	□ Military deployment
□ Financial strain	□ Death of child	□ Substance abuse	□ Legal problems	□ Homelessness
□ Marital separation	□ Death of other family member	□ Illness/medical issue	□ Spiritual or religious struggles	□ Career change
□ Relocation	□ Infidelity	□ Other addictions	□ Child-rearing differences	□ Other *(specify)*

Of the stressors you marked, which ones *currently contribute* to any distress in the relationship? *(If none of the above apply, please indicate what issues you believe are contributing factors to the current distress)*

_____

_____

Personal Assessment

EDUCATION/VOCATIONAL QUESTIONS

What is your highest level of education?

Any vocational training or education? ☐YES ☐NO

Any learning disabilities? ☐YES ☐NO

Are you currently employed? ☐YES ☐NO

Any current issues pertaining to employment? ☐YES ☐NO

If so, please explain:

Have you experienced any issues with maintaining employment? ☐YES ☐NO

If so, please explain:

SOCIAL/LEISURE ACTIVITIES

Please list the social/leisure activities you enjoy doing. If there is nothing currently, please list activities you enjoyed in the past.

Current:

Past:

MILITARY HISTORY

Have you served in the military? ☐YES ☐NO If yes, which branch?

Discharge was… ☐Honorable ☐Dishonorable ☐NA

Goals for Treatment

Why are you seeking counseling and what are your short term goals? _____

_____

_____

What do you hope to achieve through counseling long term? _____

_____

_____

What else have you done in an attempt to address or resolve the current issue(s)? _____

_____

_____

Client Name:_____

Client Signature: _____ Date: _____

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Release of Information

Purpose: The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Expiration: Unless sooner revoked, this authorization expires on the 60 days after my last appointment.
Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to the therapist I am working with at **Sage Recovery & Wellness Center**. I understand that I may revoke this authorization, by requesting in writing, a discontinuation of this document to **7004 Bee Caves Rd, 2-200, Austin, Texas 78746**. I also understand that the written revocation must be signed and dated with a date that is later than the date of this authorization. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.
I, _____, consent to the release of privileged information and waive the privilege of confidentiality afforded for medical and mental health care, alcohol and drug rehabilitation, and authorize Sage Recovery & Wellness Center's staff to communicate with the individuals listed below to exchange any information for the purpose of clarifying and enhancing my care and treatment.

Please check one or both of the following:
To obtain from ☐ To disclose to ☐

Name:_____ Relationship to Client:_____

Phone: _____ Fax: _____

**Ask the front desk staff for another copy of this form if you would like to or are required to release privileged information to more than one individual.*

Please check at least one of the following to indicate what information you would like released to the above individual.

☐ Assessment ☐ Treatment Plans ☐ Letter of Admission	☐ Discharge Summary ☐ Letter of Completion	☐ Urine Analysis ☐ Group Notes ☐ Individual Therapy Notes	☐ Attendance ☐ Financials ☐ Other: _____

Sage Recovery & Wellness Center, and others listed above, are hereby released from all liability arising out of, or in any way incidental to, producing records or providing information according to this authorization. A duplicate, photocopy or facsimile reproduction of this document may be used in lieu of the original.

This authorization is subject to revocation in writing by the undersigned.

Client Signature_____Date_____

Witness Signature _____

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Assessment Authorization Form

I,_____, certify that I understand and agree to the information provided in the following documentation:

- Policies and Miscellaneous Fees
- Group Rules
- Client Bills of Rights
- Client Responsibilities

Client Signature:_____ Date:_____

If the client is under the age of 18, the signature of a parent or legal guardian is required, and such person's signature will certify agreement on behalf of the client.

Printed Name of Parent or Guardian: _____

Signature of Parent or Guardian: _____Date: _____

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Confidentiality Statement

Sage Recovery & Wellness Center is required to provide you with confidentiality and consent information and to obtain you signature to acknowledge that you have read and understood this form.

Those laws require us to treat all contact with you as confidential; this includes phone calls, appointments, and written communication.

Treatment at Sage Recovery & Wellness Center is a voluntary and joint effort. Sage Recovery & Wellness Center staff members are employees of Sage Recovery & Wellness Center and are not directly affiliated with your insurance carrier.

Please note as part of the center's way of protecting your privacy we do not return calls from caller ID. If you would like a return call please leave a message on our confidential voicemail. Even if the request is initiated by you, we also cannot accept requests to be "connected" or "friends" with clients on social media sites as it could breach legally-protected confidentiality. If you see a Sage Recovery & Wellness Center staff member outside of the center, acknowledgment will be left to you in order to respect your privacy. Please note that email correspondence is not a secure method for communication and choosing to do so could result in an unintentional breach of confidentiality.

- I authorize Sage Recovery & Wellness Center to call the **phone number** provided on the **registration form** and to leave a message referencing any items that assist the center in carrying out treatment provided, such as **appointment reminders, insurance items and any calls pertaining to my clinical care**. I understand it is my choice which phone number I authorize consent for.
- I authorize Sage Recovery & Wellness Center to mail any items that assist the practice in carrying out treatment, payment, and healthcare operations (TPO), such as discharge follow up letters and patient statements, to the **address** provided on the **registration form.**

Appointments, Payment, and Insurance

Appointments: All office visits are by appointment and may be scheduled through the front desk staff or your therapist. Consistency is an important part of the counseling process; therefore the appointment time you schedule is reserved for you and is not available to anyone else. Please arrive on time, as you use up your session time when you arrive late for an appointment. The usual length of an appointment is 50 minutes. **If you are unable to keep a scheduled appointment, you must notify Sage Recovery & Wellness Center at least 24-hours in advance to avoid having to pay for the canceled or missed appointment. Please leave a message on our confidential voicemail during non-business hours.**

Cancellation Policies: Since scheduling of an appointment involves the reservation of time specifically for you**, a minimum of 24-hours notice is required for rescheduling or canceling an appointment**. Without 24-hours notice, you will be financially responsible for the full amount of the scheduled session. Most insurance companies do not reimburse for missed sessions. Your compliance in keeping appointments and actively participating in treatment is vital.

Payment: Self pay clients, including those not billing any insurance company or third party payer, are expected to pay in full at time of service unless other arrangements have been made. Except in the case of minors or when other arrangements are made, the individual receiving services is financially liable. I understand additional fees are charged for lengthy telephone communications, court attendance and report/letter writing. Insurance does not cover this.

Insurance: I understand I may be responsible for the remaining balance if the insurance or third party does not cover the full allotted amount. Sage Recovery & Wellness Center will send me an invoice with the remaining amount, which I am required to pay in full within 30 days after the rendering of services. I understand co-pays are expected at the time of service and that co-pays are non-negotiable. Failure to pay your part may jeopardize your insurance benefits. I understand should I become ineligible for insurance coverage, I agree to notify the center and I will be responsible for 100% of the remaining balance. I understand that a re-billing fee/financial charge complying with Texas State Law may be applied to any overdue balance. In the event of non-payment, I will bear the cost of collection, court costs, and/or legal fees should this be required. If services are conjoint (couples or family therapy), all clients 18 and older need to sign this contract due to confidentiality and your individual rights, regardless of who is the identified financially responsible client.