Chrysalis
CENTER FOR COUNSELING AND EATING DISORDER TREATMENT
3240 Burnt Mill Drive ▪ Suite 1 ▪ Wilmington, NC 28403 ▪ Tel: 910-790-9500 ▪ Fax: 910-796-8111

RIGHTS & CONSENT TO TREATMENT

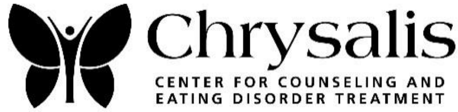
- ❑ You have the right to be respected as an individual, regardless of your gender, race, religion, sexual orientation, or disability status.
- ❑ You have the right to be treated in accordance with professional and ethical standards of conduct.
- ❑ You have the right to confidentiality. We will not disclose any information outside of the Chrysalis Center without your written consent. Personal Health Information (PHI) will be maintained in a secure, locked environment. Electronic records are maintained with a secure, dual firewall system called InSync. Please be advised that state law requires that confidentiality be broken in certain emergency situations, such as to protect you or someone else from imminent danger, to report child or elder abuse, or if mandated by a court order. We will not sell your information to anyone for any reason.
- ❑ I understand that if Chrysalis shares any information, we will adhere to the “minimum necessary” rule to protect your confidentiality and we will not share Psychotherapy Notes with any third parties.
- ❑ You have the right to discontinue therapy at any time. However, it is expected that you will confer with your therapist rather than end treatment abruptly. If you decide to discontinue treatment, you have the right to request a treatment summary and referrals to other professionals.
- ❑ I understand that sessions typically run for 38-52 minutes and will not be extended to accommodate tardy clients. In addition, if your session runs beyond the allotted time (such as in an emergency situation), your fee will be adjusted accordingly.
- ❑ I consent to take part in treatment with this clinician. I understand that it is in my best interest to actively participate in treatment and follow treatment recommendations.
- ❑ I understand and give my consent to the use of Blueprint, a HIPAA-compliant web and mobile platform that helps you and your provider measure progress throughout treatment and make adjustments to treatment as needed.
- ❑ I understand and consent to the use of Recovery Record Service, a HIPAA-compliant web and mobile platform for eating disorder education and management to record and evaluate recovery goals and progress.
- ❑ I understand that there is no guarantee that any particular outcome will result from treatment.
- ❑ I understand and give my consent for the Chrysalis Center clinical staff to consult with each other as needed in order to provide me with the most effective, ethical treatment possible. The clinicians and dietitians actively collaborate and consult about mutual cases, as well as share clinical notes.
- ❑ I understand that my therapist may consult and share clinical information with their supervisor and/or clinical board and/or university in order to provide legal and ethical treatment. They may also do so to meet the requirements set forth for licensure or certification. If I am being seen by an intern, I understand that they are not yet licensed and are practicing under the auspices of their graduate program, not Chrysalis Center.
- ❑ I understand that all communications with Chrysalis staff, including digital interactions, will be part of my clinical record. Any digital communication will be limited to that which does not compromise the clinical relationship or professional and ethical standards. I will discuss appropriate ways to use digital technology with my clinician. I understand that any communication via social media is prohibited. If I choose to communicate via digital media (cellphones, text, email, etc.), I understand that the confidentiality of these interactions cannot be guaranteed, although Chrysalis-based digital communications will utilize appropriate security measures.

I have read and understood this document and will address any concerns or questions with my therapist and/or the practice manager. Chrysalis Center reserves the right to change this agreement as necessary and in accordance with all applicable laws. Current copies of this agreement can be requested anytime and are available on our website.

Client/Representative Signature____ **Date** ______________________

I have addressed the client’s/parent’s/guardian’s concerns and/or questions. The client appears fully competent to give informed consent.

Clinician Signature____ **Date** ______________________



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ACKNOWLEDGEMENT OF RECEIPT - NOTICE OF PRIVACY PRACTICES & CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you,________________________, and Chrysalis Center. When we use the word "you" below, it can mean you, your child, a relative or other person if you have written his or her name(s) here ____.

When we examine, test, diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information to decide what treatment is best for you and to provide any treatment to you. We may also share this information with others who provide treatment to you, with others who need it to arrange payment for your treatment, or with others for other business or government functions. By signing this form you are agreeing to let us use your information and send it to others under the circumstances described in our Notice of Privacy Practices. Please read this Notice before you sign this form; it explains in more detail your rights and how we can use and share your information.

In the future we may change how we use and share your information; therefore our Notice of Privacy Practices may change. If this occurs, you can get an updated copy from our website, www.chrysaliscenter-nc.com, or by calling us at 910-790-9500. If you have any questions regarding the Notice or your privacy rights, you can also contact Kaitlyn Patterson, LPA at kaitlyn.patterson@chrysaliscenter-nc.com or at the contact information listed above.

Please note that it is your right to protect your information. If you have concerns about the use or share of your information for treatment, payment, or administrative purposes, please submit a written request to our Assistant Clinical Director at Chrysalis Center about these concerns. (Although we will try to respect your wishes, we are not required to agree to these limitations.) Furthermore, you have a right to revoke this consent after you have signed it (by submitting a letter). Any information used or shared prior to annulment of this consent cannot be changed.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to detail what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations; more information about these limitations is detailed in the Notice of Privacy Practices. If you object to any of these practices, you may discuss them with our staff and/or provide written documentation of your concerns. After you have signed this consent, you have the right to revoke it (by writing a letter to our Assistant Clinical Director telling us you no longer consent) and we will comply with your wishes as thoroughly as we are able to do so under the law.

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Chrysalis Center's Notice of Privacy Practices. My signature indicates that I have reviewed this notice, understand its content, and agree toits stipulations.

Signature:____ Date: ______________________

Printed Name:____ Date of Birth: __________________

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (relationship to the client, power of attorney, healthcare surrogate, etc.).

□ I would like to opt out of receiving any fundraising, business or marketing communications from Chrysalis.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

□ ***Client Refuses to Acknowledge Receipt****:*

Signature of authorized representative of this office or practice: ____

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INFORMED CONSENT FOR PARENTS/GUARDIANS OF MINOR CHILDREN

Divorce, Custody or Legal Issues

As a mental health treatment facility, our primary focus, responsibility, and goal is the treatment and well-being of our identified clients. In the case of a minor as the primary client, it is essential that parents and legal guardians are not in conflict and are in fact in agreement as to the decision to treat, treatment goals, appointment times and the need to maintain client confidentiality. The therapeutic process is a team approach, especially in the case of a minor child. The following informed consent states that each parent, and/or any legal guardian with authority over the health care decisions of the child, will agree to these terms and communicate effectively with each other, as well as with the provider to create a supportive environment for treatment and to assist our clinicians toward attempting to achieve the most positive outcome possible.

Although our responsibility to your child may require our involvement in conflicts between parents and guardians, we need your agreement that our involvement will be strictly limited to that which will benefit your child. This means, that you each agree as a condition of us treating your child that (please check to indicate you understanding):

- ☐ You shall treat anything that is said in any individual or group therapy session as strictly confidential;
- ☐ Our role is limited to providing treatment and you shall not attempt to gain advantage in any legal proceeding relating to the care and custody of your child from our treatment of your child;
- ☐ You shall not request or require us, through subpoena, summons or other means (except as otherwise ordered by a court of competent jurisdiction), to provide testimony in favor of one parent or guardian against the another in any legal proceeding relating to the care and custody of your child; and
- ☐ If multiple parents or guardians desire to obtain treatment information and/or testimony from any one of our clinicians relating to your child in any legal proceeding you shall each consent to the disclosure by executing one or more authorization forms we send to you and you will each share in the cost of producing such records and/or written or live testimony at our established copying charges and/or hourly rates for our clinician's time.

If there is a court appointed evaluator, and if appropriate authorization forms are signed, or a court order authorizing disclosure of treatment records is sent to us, we will disclose the requested treatment and general information about the minor. <u>We will not make any recommendations concerning the child's custody or custody arrangements, unless otherwise ordered by a court</u>.

Scheduling & Payment

I give my permission to the following people to make decisions regarding therapeutic interventions, scheduling appointments and cancelling appointments, if I am not physically present during any appointments:

Name	Relationship to Client	Contact Information (phone and/or email)

- ☐ I accept the responsibility of communicating with appropriate parties after every appointment to be updated regarding any change in the treatment plan related to the minor child's therapy.
- ☐ I understand that as the custodial parent of the minor child, I am responsible for **any and all** payments due. Any payment received from the minor child's other parent, guardian, or family member will be deducted and applied appropriately to the child's account. If the account is in default or a payment has not been made, Chrysalis Center will look to me as the sole party responsible for the financial obligations of the account.
- ☐ I understand that if my child is over the age of 16, they may make and cancel their own appointments. I will be required to put a credit card on file and complete a Third-Party Payer Agreement that will be used to pay for your child's treatment.
- ☐ I understand that if my child has their 18th birthday during the course of treatment, they may be required to fill out new paperwork to give their consent to treatment, payment responsibility, and/or if you will still be permitted to speak with the treatment team without your child present. Your child may need to complete a Release of Information to allow you to speak with **any** administrative or clinical staff about their care or appointments.

I have read and understood this document and will address any concerns or questions with the practice manager.
I have read the above consent over carefully and understand its content and hereby agree to the terms and conditions and consent to the treatment of my child under these terms and conditions set forth above by signing below.
Chrysalis Center reserves the right to change this agreement as necessary and in accordance with all applicable laws. Current copies of this agreement can be requested anytime and are available on our website. This informed consent is signed in addition to the forms regarding Client Rights and Consent to Treatment, HIPAA/Confidentiality, Financial Agreement, and any Release of Information on file.

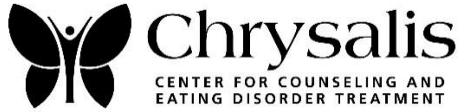
Minor Child Name **(please print)**:____

Parent/Guardian **Name (please print):** ____

Parent/Guardian **Signature:**_______________________________ **Date** __________________

I have addressed the client's/parent's/guardian's concerns and/or questions, if any. The parent/guardian appears fully competent to give informed consent.

Staff Signature_______________________________________ Date __________________



THIRD PARTY PAYER AGREEMENT

I accept full financial responsibility for the treatment of_____________________________________(client name) and agree to the provisions of the Office Procedures & Financial Agreement.

Please indicate preferred Method	Payment Options
	Credit card payment: You may provide the client with a credit card to present at the time of service or we can manually enter your credit card information (VISA/MC only) Card Number: ____ Exp Date:__________CVC Code:_________Zip code: __________
	Payment at the time of service: You may provide the client with cash or check to remit when he/she comes in for an appointment. If, for whatever reason, the client runs a balance, you will need to provide a credit card number we can maintain on file.

You may elect to have a statement sent to you at the beginning of each month. The statement will reflect all payments you made for the previous month. If you would like a statement sent to you, please indicate your preferred method and include necessary information:

____ _________________________________

Email Fax Number

____

____

Mailing Address

____ _________________________________

Signature of Third-Party Payer Date

____ _________________________________

Print Name of Third-Party Payer Contact Phone Number

Below to be filled out by client (if over

I,_________________________________(client name) authorize the above to accept full financial responsibility for any services rendered at Chrysalis. I understand that by authorizing a Third-Party Payer, that individual may obtain financial or billing information about my services at Chrysalis such as date of service, type of service, fee for service, and service provider. No clinical information will be given without a separate Release of Information.

________________________________ ___________________ ___________________

Signature of client Date Date of Birth

Communications Policy

Contacting Providers

When you need to contact your provider for in non-emergent situations, these are the most effective ways to get in touch in a reasonable amount of time:

- By phone (910-790-9500). Our clinicians do not have direct voicemails, but you can leave a message or leave a confidential voicemail with our administrative staff.
- If you wish to communicate by email, please discuss further with your clinician. Please review the Rights and Consents about the potential confidentiality risks of doing so

Please refrain from making contact with any member of your treatment team using social media messaging systems. Any communication through social media is strictly prohibited as it can create significant security risks for clients.

Please refrain from contacting you provider using SMS (normal phone text messages).

Your provider may utilize HIPAA-compliant mobile and web platforms (e.g., Blueprint, Recovery Record) to support therapeutic goals and measure treatment progress.

- These services are HIPAA-compliant to keep patient information secure even when shared with treatment teams.
- These platforms do not give medical, legal, or psychological advice, diagnoses, or treatment. These services may provide helpful Health-Related Information, but are not intended to substitute for professional advice, diagnoses, treatment, or your judgment.
- Under no circumstances should these services be used to report emergencies to your providers

Confidentiality is vital to therapy. Please speak with your provider about any concerns you have regarding preferred communication methods.

Response Time

Our office is open Monday-Thursday 8:30am-5pm and Fridays 8:30am-4pm. Our administrative and clinical staff may not be able to respond to your messages and calls immediately. For voicemails and other messages, you can expect a response within *48 hours* (weekends are excepted from this timeframe). It is likely you will receive a reply more quickly than that, but please be aware that this will not always be possible.
Be aware that there may be times when your clinician may be unable to receive or respond to messages, such as when out of cellular range or out of town.

Emergency Contact

If you are ever experiencing an emergency, including a mental health crisis, please call the local police by calling 911 or go to your nearest emergency department. Possible locations include:

New Hanover Regional Medical Center
910-343-7000
2131 17th St.
Wilmington, NC 28401

Cape Fear Hospital
910-452-8100
5301 Wrightsville Ave.
Wilmington, NC 28403

Following your call to 911 or your visit to your nearest emergency department, if you need to reach your provider, the best methods of communication are:

- By the main office line: 910-790-9500
- If you cannot reach someone by phone, please leave a voicemail

Disclosure Regarding Third-Party Access to Communications

Please know that if we use electronic communications methods, such as email, texting, online video, and possibly others, there are various technicians and administrators who maintain these services and may have access to the content of those communications. In some cases, these accesses are more likely than in others. While we take precautions whenever possible to ensure the confidentiality of communication through these methods, we cannot always guarantee your confidentiality. Use of these modes of communication implies your understanding and consent to this limitation of confidentiality. Of special consideration are work email addresses. If you use your work email to communicate with me, your employer may access our email communications. There may be similar issues involved in school email or other email accounts associated with organizations that you are affiliated with. Additionally, people with access to your computer, mobile phone, and/or other devices may also have access to your email and/or text messages. Please take a moment to contemplate the risks involved if any of these persons were to access the messages we exchange with each other.

I have read and understood this document and will address any concerns or questions with my therapist and/or the practice manager. Chrysalis Center reserves the right to change this agreement as necessary and in accordance with all applicable laws. Current copies of this agreement can be requested anytime.

Client/Representative Signature ____ Date________________

OFFICE PROCEDURES AND FINANCIAL AGREEMENT

Please read, initial, complete, and sign below. You may request a copy for your records.

Chrysalis is a business office where a number of mental health professionals, registered dietitians, and a psychiatric provider practice. Your contract for services is with our office and applies to any and all providers you may see here.

APPOINTMENTS: All office visits are by appointment and scheduled through our administrative staff. Please arrive on time, as you cut down on your appointment time when you arrive late. Appointment lengths vary depending on the type of provider seen. If you arrive more than 15 minutes late for a 50 minute appointment or 7 minutes late for a 30 minute appointment, you will be asked to reschedule your appointment, which will result in a late cancellation charge.

RECORDING DEVICES: The use of recording devices by clients, clinicians, and other persons present during a session, group or other clinical interaction, whether face-to-face or taking place by live textual, audio, or video link is strictly prohibited. Administrative calls may be monitored for quality assurance.

BLUEPRINT: Blueprint respects the privacy of all users and will never sell any personally identifiable data. You own your data at all times and can always request your data and account to be deleted by sending an email to support@blueprint-health.com with the subject of "Account Deletion." You can view Blueprint's privacy policy in detail at www.blueprint-health.com/privacy. Measuring your progress through Blueprint may be considered a billable service by your provider towards your insurance plan and as a result may result in additional co-payments, amounts applied to deductibles, and other amounts that may be deemed the responsibility of the patient as required by contract with the insurance plan and state regulations.

PAYMENT: Payment is required at the time services are rendered, whether you are a self-pay client or have insurance coverage. Acceptable methods of payment include cash, check, VISA or Master Card. *The fee for returned checks is $35. If a check is returned, you will be asked to arrange another method of payment.*

All clients are required to place a credit card on file in order to facilitate collection of payment. If estimated payment (copay, deductible, coinsurance, cash rates) is not received by the end of the date of service, the card on file will be charged. In the case that insurance reimburses different amounts than the estimated payment (copay, deductible, coinsurance, cash rates) taken, credits and debits will be applied to the card as necessary. If the card declines, you will have until one business day prior to your next appointment to provide current and valid card information or your scheduled session will be canceled and payment in full will be required before you can reschedule. A patient portal via our electronic medical records system will be provided to view and track payments.

Name (as it appears on the card): ______________________________

Card Number: ______________________________

Phone number of credit card holder: ______________________ Billing Zip code: ____________

Expiration Date: ______________________ CVV/CVC: ____________

Late cancellations/No shows: For a missed or late cancelled appointment, you will be charged up to $90 for the appointment. Please note: both clinical and nutritional appointments must be cancelled no less than one business day before the scheduled appointment. Please be advised that reminders are a courtesy, and you will be billed for late cancellations and no-shows regardless of whether or not you received the reminder message. Repeated late cancellations and/or no-shows may result in dismissal from treatment, at our discretion.

INSURANCE: As a courtesy to you, we will bill rendered services to your insurance carrier. We do not accept Medicaid. Insurance co-payments, coinsurances, and deductible payments are due at the time of service. However, verification of eligibility and/or benefit information is not a guarantee of payment by your insurer. Your benefits will be determined once a claim is processed by your insurer, which will be based upon your eligibility and the terms of your certificate of coverage applicable on the date services were rendered. In the event of non-payment from your carrier, you are responsible for payment to Chrysalis for services rendered and you will be responsible for handling any disputes with your insurance carrier. It is your responsibility to be aware of your insurance benefits and needs for pre-authorization. Any services not covered by your insurance are your responsibility.

Unless otherwise notified, the insurance policy holder will be financially responsible for any balance on the client's account. Please make one of our administrative staff aware if the billing address is different than the home address on file.

Please note: Treatment information including diagnosis, type of treatment, costs of service, dates of service, and providers may be shared with your insurance carrier for reimbursement purposes. Please be aware that any information communicated to your carrier may affect your benefits. If you decide to file through insurance, we reserve the right to share this information with your carrier upon their request.

OUTSTANDING BALANCE: You are responsible for paying any outstanding balances due on your account. Once we receive an Explanation of Benefits from your insurance carrier, your balance may be adjusted based on your carrier's allowed amount. If an account accrues two or more unpaid sessions, ongoing services may be immediately postponed until full remittance is received. Please be advised that if Chrysalis does not receive payment in full for services rendered, your treatment may be discontinued. If you are unable to pay your balance in full, a signed *payment plan agreement* will be implemented immediately. Failure to adhere to your payment plan is grounds for discontinuation of services. If you previously discontinued your care or were discharged from treatment and you desire to resume receiving services at Chrysalis, you will be expected to remit any unpaid balance prior to being seen. Payment plans may be arranged with our administrative staff. Any balance not paid in 90 days will be subject to collections.

Late Fees: A late fee of $25 will be charged to delinquent accounts that are not paid within 90 days of the issue date of the first bill and may also be referred to a third-party collection agency. You will continue to be responsible for all associated collections and fees.

ADDITIONAL SERVICES: In some circumstances, depending on the time involved and nature of task, you may be charged for additional services, such as extended sessions, scoring psychological testing, preparing a psychological report, writing letters of advocacy or documentation on your behalf, extensive clinical coordination, and extended consultations with other providers regarding your treatment. Phone calls that are extended and/or that constitute therapy may require an additional fee. These additional services will be charged up to $100/hour.

Testing Fees: Charges for psychological testing apply to all tests taken and scored. Sometimes, insurance companies do not reimburse for testing. In this event, you will be responsible for uncovered testing costs at our self-pay rate.

Conjoint Sessions (with more than one therapist): Conjoint sessions will be billed according to your benefits, which may result in a self-pay rate.

Please note: No provider at Chrysalis will fill out any disability forms (FMLA, short or long term, etc.) for clients who are not already established at Chrysalis (5+ sessions with one provider), and at the clinician's discretion. We will send records as requested to other providers or agencies with a valid Release of Information on file. If records are sent, there may be a $25 administrative fee associated with sending the records or filling out any paperwork for a third party.

Changes to the Policy: Chrysalis Center reserves the right to change this agreement as necessary and in accordance with all applicable laws. Current copies of this agreement can be requested anytime and are available on our website.

Please initial at each line and sign below to indicate that you have read, understood, and agree to the above policies. For minors, parent/guardian must sign.

_______I have read, understand, and agree to the above policies.

_______I authorize Chrysalis to release any information acquired in the course of my therapy to my insurance company as needed.

_______I understand my insurance coverage is a relationship between me and my insurance company and I agree to accept financial responsibility for payment of charges incurred.

_______I have been offered a copy of these policies to take with me if I desire.

_______I understand that the credit card on file will be charged for services rendered if I do not make alternative arrangements at time of service

_______I have discussed these policies and addressed concerns and questions with the administrative staff if needed. Initial and date by administrative staff if questions were addressed:____

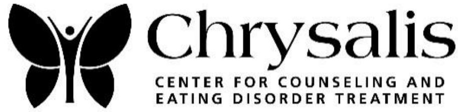
____ ____________________

Signature of Client Date

Please initial at each line and sign below to indicate that you have read, understood, and agree to the above policies. For minors, parent/guardian must sign.

____ ____________________

Signature of parent or Legal Guardian Date



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*Insurance is filed as a courtesy. All unpaid balances will be the responsibility of the client. It is the client's responsibility to notify Chrysalis of any information that has changed.

Please Note: Your insurance carrier requires us to gather this information in order to use your benefits, and the following information is not available on your insurance card. You must complete all fields on both pages of this form. If you do not provide us with accurate information, your claims may not be processed appropriately, and you will be charged the full rate for services already rendered.

______Please initial if you do not want to use your insurance benefits; you will be charged the self-pay rate for services.

INSURANCE INFORMATION

Client Information:

Full Name (Including Middle): ______________________________

Telephone: ______________________ Date of Birth: ______________________

Social Security Number: ______________________ Relationship to Policy Holder: ______________________

Primary Insurance Information (family member whose insurance you are covered by):

Policy Holder's Full Name (Including Middle): ______________________________

Policy Holder's Address: ______________________________

Policy Holder's Telephone: ______________________ Policy's Holder's Date of Birth: ______________________

Policy Holder's Social Security Number: ______________________________

Employer's Name: ______________________________

Insurance Plan Name: ______________________________

Subscriber Number of Member ID Number: ______________________________

Group Number: ______________________________

Secondary Insurance Information (If applicable):

Policy Holder's Full Name (Including Middle): ______________________________

Policy Holder's Address: ______________________________

Policy Holder's Telephone: ______________________ Policy's Holder's Date of Birth: ______________________

Policy Holder's Social Security Number: ______________________________

Employer's Name: ______________________________

Insurance Plan Name: ______________________________

Subscriber Number of Member ID Number: ______________________________

Group Number: ______________________________

I have read and completed the information above and verify that it is correct. I understand that it is my responsibility to update Chrysalis with any change in insurance information.

______________________________ ______________________

Name of Client (printed) Date

____

Signature (of parent or legal guardian)

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CONFIDENTIAL CLIENT INFORMATION

TO BE COMPLETED BY PARENT/GUARDIAN FOR CHILDREN AGE 5-17:

Welcome to Chrysalis Center. Please complete the front and back of each page to help your clinician provide appropriate services. In accordance with our professional codes of ethics and state and federal laws, any information you provide is strictly confidential. ***If you do not complete these forms in their entirety prior to your first appointment, you will not be able to see any provider at Chrysalis Center.***

Demographic Information:

Child's Name: ________________________________Child's SSN: ____________Preferred Name: _____________

Date of Birth: _________________________ Age: ___________________ Gender: ______________________

Ethnic Group: _________________________ Religious Preference: ______________________ Race: _________

Mailing Address: ____

____

City: _____________________________________ State: ___________________ Zip Code: ________________

Primary Parent/Guardian's Name: ____

Parent Email Address(es): ____

Primary Phone: _____________________________ Is it okay to leave a message? Yes No

Relationship Status: _______ Single _________Cohabitating ________Married

________Separated_________Divorced ________Widowed

If separated or divorced, what custody arrangements are in place? ___________________________________

____

*Please also provide a copy of your custody agreement.

Other Parent/Guardian Name (if relevant): ____

Email: ____Telephone: ___________________________

Address: ____

Other Emergency Contact: _________________________________Telephone: ___________________________

Relationship to child: ____

Referral/Clinical Information:

How did you find out about our services? ____

_________Individual Counseling

_________Group Counseling

_________Family Counseling

______Nutritional Counseling

_______Assessment

Mental Health History:

Has your child received counseling before? Yes No

Family/Significant Others:

If anyone in your family has a history of the following, please check all that apply and specify on the chart below: _______Mental Illness _______Substance Abuse _______Eating Disorder ______Obesity _______Dieting

Please provide the following information about your family members (include everyone who lives in the child's household, i.e. parents, stepparents, all siblings, spouse/partner, children, etc.).

Name	Relationship to You	Age	Job/ Highest Education Completed	Where they Live	Mental/Medical Conditions (mental illness, substance abuse, eating disorder, obesity, dieting)

Health Information:

Please list any chronic illnesses, injuries, physical conditions, or disabilities:________________________________

____

Allergies (including food allergies) or Adverse Reactions to Treatment:________________________________

____

Primary Care Physician Name: ____

Date of Last Physical:__________________________ Telephone: ______________________________

Have your child had any recent weight loss/gain of more/less than 10lbs? Yes No

Current Medications, Supplements, Vitamins	Daily Dose	Start Date	Name of Prescriber

In your own words, please identify the concern(s) that you want your child to address in counseling. Be as specific as you can. ____

____

____

Client Information- To Be Completed By Client (Age 11-17)

If you would like to leave separate contact information than your parent/guardian, please complete the following:
Name: ________________________ Preferred Name: ______________________ Pronouns: _______________
Email Address: ____
Primary Phone: ___________________________ Is it okay to leave a message? Yes No
Gender: _________________Ethnic Group: _____________________Religious Preference: _______________
Race: ________________________ Preferred Language: ________________________

Clinical Information:

What type of services are you seeking/expecting? (Please check all that apply to you)
________Individual Counseling
________Group Counseling
________Family Counseling
________Nutritional Counseling

Employment/Education Information:

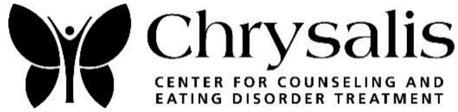
Are you currently employed? Yes No
If yes, where are you employed? ____
What is your job title? ____
Are you currently a student? Yes No
If yes, where? _____________________________Year____________________Major______________________

Mental Health History:

Have you received counseling before? Yes No

Have you ever experienced any of the following?
______Physical Abuse
______Sexual Abuse/Molestation
______Verbal/Emotional Abuse
______Sexual Assault

Are you having current difficulties with any of the following?
_____Academic Performance
_____Anger Management
_____Body Image
_____Career Planning Issues
_____Decision Making Issues
_____Divorce/Separation Issues
_____Family Relationships
_____Grief/Recent Loss
_____Financial Problems
_____Learning Disabilities
_____Legal Problems
_____Loneliness/Social Isolation
_____Peer Relationships
_____Phase of Life Issues
_____Pregnancy Issues (past, present)
_____Racial/Cultural Issues
_____Romantic Relationships
_____Self-Confidence/ Self-Esteem
_____Sexual Identity Issues
_____Spirituality
_____Unemployment



How well are you getting along psychologically at this time?

________Very well, the way I want to.
________Quite well, no important complaints.
________Fairly well, but have ups and downs.
_______So-so, can keep going with effort.
_______Quite poorly, can barely manage.
_______Very poorly, can't manage.

Have any of these symptoms -- drinking, drug use, moods, anxiety, etc. – ever interfered with school, work, your health? What concerns, if any, have family and friends expressed? Please explain. ____________________

____
____
____

Were you ever hospitalized for any of these symptoms? If yes, please explain. Please list any hospitalizations for psychological, psychiatric, eating disorder or chemical dependency treatment, including location and dates.

____
____
____

In your own words, please identify the concern(s) that you want to address in counseling. Be as specific as you can. ____

____
____
____
____

Chrysalis
CENTER FOR COUNSELING AND EATING DISORDER TREATMENT

****ONLY COMPLETE FOR EATING DISORDER TREATMENT****

Are you here for treatment for an eating disorder? Yes No *If yes, please complete the following page.*

Food History: please check all that apply

Restrictive Eating/Dieting	Past	Current		Past	Current
Skipping meals	_______	_______	Reducing calories	_______	_______
Reducing portions	_______	_______	Throwing away food	_______	_______
Chewing & spitting	_______	_______	Fasting	_______	_______
Purging/Weight Control					
Vomiting	_______	_______	Laxative use	_______	_______
Diet pill use	_______	_______	Compulsive exercise	_______	_______
Binge/Compulsive Eating					
Eating a lot in a short period of time	_______	_______	Guilt/shame after eating	_______	_______
Feeling out of control when eating	_______	_______	Eating for emotional reasons	_______	_______
Eating until uncomfortably full	_______	_______	Hiding food or eating alone	_______	_______

Have you ever deliberately lost so much weight that people expressed concern? Yes No

Have you ever been afraid of getting fat even when other people said you were thin enough or too thin? Yes No

Have you ever felt that your eating was excessive and/or not really normal? Yes No

Has anyone ever recommended weight loss? If so, who? Please explain. ____

____

Who else knows about your eating disorder? ____

Weight History:

Current Height _______ Current Weight ________ Desired Weight ______

Lowest Weight _______ Highest Weight ________

How often do you weigh yourself? Daily Weekly Monthly Rarely Never

Physical Symptoms: Which of the following are you currently experiencing?

_____Loss of period
_____Irregular period
_____Nausea
_____Dizziness
_____Light-headedness
_____Fainting spells
_____Weakness
_____Fatigue/lack of energy
_____Coldness
_____Numbness
_____Joint paint
_____Tingling
_____Acid reflux
_____Indigestion
_____Gas
_____Cramps
_____Bloating
_____Diarrhea
_____Constipation
_____Poor appetite
_____Sore throat
_____Swollen glands
_____Ulcers
_____Dental problems
_____Heart burn
_____Chest pain/tightness
_____Irregular heartbeat
_____Shortness of breath
_____Muscle cramp
_____Muscle weakness
_____Frequent urination
_____Dehydration
_____Water retention
_____Excessive thirst
_____Brittle hair
_____Hair loss
_____Dry skin
_____Yellowish skin
_____Fractures
_____Injuries

Chrysalis
CENTER FOR COUNSELING AND EATING DISORDER TREATMENT

ONLY COMPLETE FOR NUTRITIONAL COUNSELING

Are you here for or interested in nutritional services? Yes No *If yes, please complete the following page.*

Nutritional Counseling History:

Have you ever met with a nutritionist/dietician before? Yes No

Name of nutritionist(s): ____

Presenting Problem: ____

Relevant Health History

Check below if you or any family member(s) are currently experiencing or have experiences any of the following:

	Self	Family		Self	Family
Anemia	______	______	High Blood Pressure	______	______
Anorexia Nervosa	______	______	High Cholesterol	______	______
Binge Eating	______	______	Heart Disease	______	______
Bulimia Nervosa	______	______	Hypoglycemia	______	______
Cancer	______	______	Intestinal Problems	______	______
Chronic Health Problems	______	______	Laxative/Diuretic Use	______	______
Compulsive Overeating	______	______	PCOS	______	______
Diabetes	______	______	Night Eating Syndrome	______	______
Gastrointestinal issues	______	______	Thyroid Issues	______	______

Please provide any other information or relevant health history: ____

____

Current Height ________ Current Weight ________ Desired Weight _______

Lowest Weight ________ Highest Weight ________

How often do you weigh yourself? Daily Weekly Monthly Rarely Never

Food Allergies/Sensitivities: ____

Food Intolerances: ____

Foods Avoided: ____

How much caffeine do you consume each day on average? ____

How much alcohol do you consume (specify how much and how often)? ____

Current Exercise Program

Activity type: Stretching Cardio/Aerobics Strength Training Other: ___________________________

Frequency and Duration of activity: ____

Rate your level of motivation for including exercise in your life? Low Medium High

List problems that limit activity: ____

In your own words, please identify the concern(s) that you want to address in nutrition. Be as specific as you can.

____

____

____

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