Resolution Counseling PLLC Charles Young MA, LLPC
5840 Lorac Suite S, Clarkston, Mi 48346 (248)-249-0989

Consent to Treatment – Resolution Counseling Services

Charles Young – MA, LLPC and Director

I acknowledge that prior to beginning my counseling experience I was fully informed of the services I am receiving and, I realize that at any time I can go to www.timeforaresolution.com for additional information about the therapy I am considering. In addition, I have had all my questions answered to my satisfaction.
I do hereby seek and consent to take part in the treatment by my Counselor, Charles Young. I understand that developing a treatment plan with him and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist. I understand that payment for the services I receive is due on the day of my session and if it is not made within a reasonable time, the therapist may stop my treatment and if needed can seek collections.
Confidentiality is upheld in all instances. If I want my therapist to communicate with family or medical professionals, I have to sign a consent form to allow this, except if I should become a risk to myself or another. Also, I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive.
I am aware that I may stop my treatment with this therapist at any time. If I do not schedule or attend an appointment within 30 days, my treatment will no longer be active and I may lose my status as an active patient. I understand that I will still be responsible for payment of services I have already received and any outstanding co-pays or missed appointment fees. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.) In addition, I understand it is my responsibility to keep my therapist informed of my treatment status or my therapy will be automatically terminated after 30 days of non-involvement.
I know that I must call to cancel an appointment preferably 72 hours (3 days) before the time of the appointment, minimally 24 hours before. If I do not cancel within 24 hours and do not show up, I will be charged a $35 fee for that appointment, unless it is deemed an emergency, as determined by my therapist.
My signature below shows that I understand and agree with all of these statements.

____ __________
Signature of client (or person acting for client) Date

___________________________________ _______________________________
Printed name Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

____ __________
Signature of therapist- Charles Young, MA, LLPC Date

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Adult Checklist of Concerns

Name: ____ Date: ________________

Please mark all of the items below that apply. You may add a note or details in the space next to the concerns checked.

BRING COMPLETED FORM TO YOUR FIRST SESSION.

- ❑ I have no problem or concerns bringing me here
- ❑ Abuse–physical, sexual, emotional, neglect, cruelty to children or animals
- ❑ Aggression, violence
- ❑ Alcohol use
- ❑ Anger, hostility, arguing, irritability
- ❑ Anxiety, nervousness
- ❑ Attention, concentration, distractibility
- ❑ Career concerns, goals, and choices
- ❑ Childhood issues (your own childhood)
- ❑ Codependence
- ❑ Confusion
- ❑ Compulsions
- ❑ Custody of children
- ❑ Decision making, indecision, mixed feelings, putting off decisions
- ❑ Delusions (false ideas)
- ❑ Dependence
- ❑ Depression, low mood, sadness, crying
- ❑ Divorce, separation
- ❑ Drug use–prescription medications, over-the-counter medications, street drugs
- ❑ Eating problems–overeating, under-eating, appetite, vomiting (see also Weight)
- ❑ Emptiness
- ❑ Failure
- ❑ Fatigue, tiredness, low energy
- ❑ Fears, phobias
- ❑ Financial or money troubles, debt, impulsive spending, low income
- ❑ Friendships
- ❑ Gambling
- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Guilt
- ❑ Headaches, other kinds of pains
- ❑ Health, illness, medical concerns, physical problems
- ❑ Housework/chores–quality, schedules, sharing duties
- ❑ Inferiority feelings ❑ Interpersonal conflicts

- ❑ Irresponsibility
- ❑ Judgment problems, risk taking
- ❑ Legal matters, charges, suits
- ❑ Loneliness
- ❑ Marital conflict, distance, infidelity, remarriage, differences, disappointments
- ❑ Memory problems
- ❑ Menstrual problems, PMS, menopause
- ❑ Mood swings
- ❑ Motivation, laziness
- ❑ Nervousness, tension
- ❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ❑ Oversensitivity to rejection
- ❑ Pain, chronic
- ❑ Panic or anxiety attacks
- ❑ Parenting, child management, single parenthood
- ❑ Perfectionism
- ❑ Pessimism
- ❑ Procrastination, work inhibitions, laziness
- ❑ Relationship problems (with friends, with relatives, or at work)
- ❑ School problems (see also “Career concerns ...”)
- ❑ Self-centeredness
- ❑ Self-esteem
- ❑ Self-neglect, poor self-care
- ❑ Sexual issues, dysfunctions, conflicts, desire differences, (see Abuse)
- ❑ Shyness, oversensitivity to criticism
- ❑ Sleep problems–too much, too little, insomnia, nightmares
- ❑ Smoking and tobacco use
- ❑ Spiritual, religious, moral, ethical issues
- ❑ Stress, relaxation, stress management, stress disorders, tension
- ❑ Suspiciousness, distrust
- ❑ Suicidal thoughts
- ❑ Temper problems, self-control, low frustration tolerance
- ❑ Thought disorganization and confusion
- ❑ Threats, violence
- ❑ Weight and diet issues
- ❑ Withdrawal, isolating
- ❑ Work problems (circle)
  unemployment / working too much / difficulty keeping a job / work dissatisfaction / discrimination
  harassment / bullying other____

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Please indicate any current problems in the following aspects of your life:

Health:

Marriage/Significant Other:

Family:

Employment:

Finances:

Faith/Spirituality:

Other concerns or issues not listed previously:

Current list of medications: (use back of form, if necessary.)

1.
2.
3.
4.
5.
6.

Current list of medical treatments and/or integrative/alternative therapies:

Would you like me to communicate with your physicians, or health care providers?
(If yes, please indicate name, address, phone, etc.)

Have you ever been in counseling before? If yes, how was the experience?

Who referred you to counseling at this time?

What would you like from this counseling experience?

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Behavioral Medicine Registration Form

Patient Information

Patient Name (Last) (First) (Middle)			___ Male ___ Female
Address City		State	Zip code
Home Telephone ( )	Cell/Work Phone ( )	Social Security #	Birth date
Occupation	Employer		How Long Employed
Employer Address City		State	Zip Code
Primary Care Physician		Referred / Recommended By	

Spouse/Legal Guardian Information

Name (Last) (First) (Middle)			Relationship
Address City		State	Zip Code
Home Telephone ( )	Cell/Work Phone ( )	S.S. # (if legal guardian)	Birth Date
Occupation	Employer		How Long Employed
Employer Address City		State	Zip Code

Insurance Information

Primary Insurance	Subscriber		Birth Date
Address City		State	Zip Code
Policy #	Group #	Employees ID /SS# /Misc#	Group Name
Insurance Company Phone # ( )		Precertification Phone# ( )	

Secondary Insurance	Subscriber		Birth Date
Address City		State	Zip Code
Policy #	Group #	Employee # /SS# /Misc#	Group Name
Insurance Company Phone# ( )		Precertification Phone # ( )	

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Emergency Contact Information

Name (Last) (First)	(Middle) Relationship
Address City	State Zip Code
Home Telephone ( )	Cell / Work Phone ( )

Signature

Patient/ Legal Guardian Signature	Date