CONFIDENTIAL CHOICES COUNSELING CENTER CONFIDENTIAL

INTAKE

Intake Date:______________________

Name:____

SSN:_________-_________-_________ D.O.B.:____________________ Gender: ______M / F______

Address:____

City:________________________________ State:___________________ Zip:_________________

Phone: *Home*:___________________ *Work*:___________________ *Cell*:___________________

Email Address:_____________________________ Best way to reach you: ____________________

Highest Level of Education:______________________ Referred by:_________________________

Relationship/Marital Status: *M*_________ *S*_________ *D*_________ *W*_________ *SEP*________

How Many Marriages:______________ Length of Marriage(s):_____________________________

If not married, are you involved in a relationship?____

Spouse/Significant Other's Name:_______________________________ Age:_________________

Occupation:___________________________ How long married/together?____________________

Describe present relationship?____

____

What are your partners feelings about your treatment?___________________________________

Do they have any compulsive/addictive/psychological issues? ____________________________

If yes, please describe:____

____

Religious/Spiritual Background:____

What is your presenting problem(s):____

____

____

HEALTH HISTORY

Are you under a physician's care now? – If yes, for what:___________________________________

Please provide physician's name and number:____

List any major surgeries/accidents/physical problems:____________________________________

____

Have you ever been treated by a psychiatrist or psychologist? – If yes, who/when/how long:

____

Have you ever been in a psychiatric hospital? – If yes, where/when?________________________

____

What was the diagnosis?____

Any other therapy/counseling? – If yes, who/when/how long:_____________________________

____

Have you ever experienced meditation/relaxation or guided imagery?______________________

Have you ever had alcoholism/chemical dependency education?__________________________

Have you ever struggled with Anorexia Nervosa, Bulimia or Over-eating?___________________

Do you find yourself preoccupied with food and eating or not eating?_____________________

Do you find yourself often/constantly on diets – If yes, please explain?____________________

____

Have you used diet pills, diuretics and/or laxatives primarily for the purpose of controlling your weight? – If yes, explain: ____

Do you find yourself thinking of food even after a meal? – If yes, explain:__________________

____

Are you pregnant or have you ever been pregnant? – If yes, please explain:________________

____

List any current medications (prescribed & over-counter):________________________________

____

MEDICAL HISTORY

PLEASE SELECT SYMPTOMS YOU HAVE OR HAD IN PAST 3 YEARS

Name:______________________________ **D.O.B.:**____________________________

Age:_______________ **Weight:**_________________ **Height:**_______________

GENERAL:

- ☐ **Allergies**
- ☐ **Anxiety**
- ☐ **Chills**
- ☐ **Depression**
- ☐ **Dizziness**
- ☐ **Fatigue**
- ☐ **Fainting**
- ☐ **Headaches**
- ☐ **Loss of sleep**
- ☐ **Loss of weight**
- ☐ **Memory loss**
- ☐ **Nervousness**
- ☐ **Numbness**
- ☐ **Shaking/Tremors**
- ☐ **Sweats**
- ☐ **Weight gain**
- ☐ **Other:**____________

MUSCLE/JOINT/BONE:
(Pain, weakness, numbness, injured in):

- ☐ **Arms**
- ☐ **Back**
- ☐ **Feet**
- ☐ **Hands**
- ☐ **Hips**
- ☐ **Legs**
- ☐ **Neck**
- ☐ **Shoulders**
- ☐ **Other:**____________

SKIN:

- ☐ **Bruise easily**
- ☐ **Hives**
- ☐ **Itching**
- ☐ **Rash**
- ☐ **Other:**____________

GASTROINTESTINAL:

- ☐ **Bloating**
- ☐ **Bowel changes**
- ☐ **Constipation**
- ☐ **Diarrhea**
- ☐ **Excessive hunger**
- ☐ **Excessive thirst**
- ☐ **Gas**
- ☐ **Indigestion**
- ☐ **Nausea**
- ☐ **Poor appetite**
- ☐ **Stomach pain**
- ☐ **Vomiting**
- ☐ **Other:**____________

CARDIOVASCULAR:

- ☐ **Chest pain**
- ☐ **High blood pressure**
- ☐ **Irregular heartbeat**
- ☐ **Low blood pressure**
- ☐ **Poor circulation**
- ☐ **Rapid heart beat**
- ☐ **Swelling of ankles**
- ☐ **Other:**____________

EYE, EAR, NOSE, THROAT:

- ☐ **Bleeding gums**
- ☐ **Blurred vision**
- ☐ **Difficulty swallowing**
- ☐ **Earache**
- ☐ **Loss of hearing**
- ☐ **Nosebleeds**
- ☐ **Persistent cough**
- ☐ **Ringing in ears**
- ☐ **Sinus problems**
- ☐ **Vision flashes**
- ☐ **Other:**____________

CONDITIONS:

- ☐ **AIDS**
- ☐ **Alcoholism**
- ☐ **Anemia**
- ☐ **Anorexia Nervosa**
- ☐ **Arthritis**
- ☐ **Asthma**
- ☐ **Bleeding Disorders**
- ☐ **Bronchitis**
- ☐ **Bulimia**
- ☐ **Cancer**
- ☐ **Chemical Dependency**
- ☐ **Chicken Pox**
- ☐ **Diabetes**
- ☐ **Emphysema**
- ☐ **Epilepsy**
- ☐ **Gonorrhea**
- ☐ **Gout**
- ☐ **Heart Disease**
- ☐ **Hepatitis**
- ☐ **Herpes**
- ☐ **High Cholesterol**
- ☐ **HIV Positive**
- ☐ **Kidney Disease**
- ☐ **Liver Disease**
- ☐ **Measles**
- ☐ **Migraine Headaches**
- ☐ **Miscarriage**
- ☐ **Multiple Sclerosis**
- ☐ **Prostate Problem**
- ☐ **Psychiatric Care**
- ☐ **Stroke**
- ☐ **Suicide Attempt**
- ☐ **Thyroid Problems**
- ☐ **Tuberculosis**
- ☐ **Ulcers**
- ☐ **Vaginal Infections**
- ☐ **Venereal Disease**
- ☐ **Other:**____________

FAMILY HISTORY

Place of birth:________________________ Where were you raised? ________________________

Anyone in your family have physical or emotional problems? If yes, who and present status:__

____

Was there alcoholism/chemical dependency or drug use in your family of origin? If yes, who?
Grandparents:________ Parents:________ Siblings:________ Relatives:________

Did anyone in your family of origin die of alcoholism or chemical dependency: ______________

Did anyone commit or attempt suicide?____

List any other physical, mental or emotional disorders that were in your family (migraine headaches, depression, overeating, arthritis, etc.)_______________________________________

____

Describe your early life at home growing up:____

____

Mother: Age______ if living. If deceased, when/how?___________________________________

Give three adjectives to describe your mother:____

Father: Age______ if living. If deceased, when/how?____________________________________

Give three adjectives to describe your father:____

Parents divorced or separated?________________ How long?__________ Remarried?_________

If yes, three adjectives describing your step-father/mother:______________________________

List siblings: include ages, any compulsive/addictive behaviors, your relationship and description:____

____

List children: Include ages, any addictive/compulsive behaviors, your relationship and description:____

____

Name of spouse/significant other: include age, any compulsive/addictive behaviors, your relationship and description:____

____

PERSONAL HISTORY

Describe early dating patterns:____

____

Age when you became sexually active:____

Describe your feelings about sexuality - any current problems or concerns:________________

____

Do you ever experience shame/guilt about your sexual behavior?_________________________

If yes, please explain:____

____

Have you ever experienced some type of sexual dysfunction or difficulties?________________

If yes, please explain:____

____

Do you find yourself focusing on sex or your sexual behavior a great deal of the time?________

If yes, please explain____

____

Has your sexual behavior changed noticeably in the last year to six months?_______________

If yes, please explain:____

____

Have you had more than one sexual partner in the last year?____________________________

Is your sex life what you would like it to be?_____________ **Please explain:**_________________

____

Have you ever been physically, emotionally or sexually abused?__________________________

If yes, please explain:____

____

Describe your relationships, other than family, and how you feel about them. Include problem areas, things that upset you:____

____

DRUG & ALCOHOL HISTORY

Do you drink alcohol?____________ If yes, how often?_________________________________

Do you smoke cigarettes? _____________ If yes, how many?_____________________________

Do you use other chemicals/substances?____________ If yes, what and how often?__________

____

What age was your first drink/drug and describe how you felt:___________________________

____

Have you ever been hospitalized or treated for alcohol or chemical use?___________________

If so, when and where? ____

____

Have alcohol/chemicals caused problems in *any* area of your life?________________________

If yes, please explain:____

____

Have you had any legal problems?___________________ Any arrests?______________________

If yes, list charges and outcome:____

____

Are you alcoholic/chemically dependent? ___________ If yes, are you recovering?___________

How long?_______________ Have you had any relapses?__________________________________

Do you now, or have you ever attended any of the self help groups such as AA, Alanon, NA, OA,

ACO, SLAA, etc.?____________ How long/often have you been attending?___________________

Please list all past and present substances you have used – include date/age:_______________

____

____

____

DRUG & ALCOHOL QUESTIONNAIRE

PLEASE COMPLETE AS HONESTLY AS POSSIBLE. WHEREVER APPLICABLE, SUBSTITUTE THE WORD "DRUG" FOR "DRINK."

1. **Have you looked forward to the end of a day's work so that you could have a couple of drink to relax? ____________**
2. **Do you sometimes look forward to the end of the week so that you could have some fun drinking? _____________**
3. **Have you felt a need to have a drink at a particular time of day? __________**
4. **Do you usually order a double or like to have your first two or three drinks quickly? ____________**
5. **Do you have a couple of drinks before going to a party or out to dinner? _____________**
6. **Do you find that you can drink more than others and not show it much? _____________**
7. **Has anyone ever commented or worried about your alcohol intake? ______________**
8. **Do you ever drink to calm your nerves or reduce tension? _____________**
9. **Do you find it difficult to enjoy a party or dance if there is nothing to drink? ___________**
10. **Do you ever use alcohol to relieve physical discomfort? ____________**
11. **Do you ever use alcohol as a nightcap to help you get to sleep at night? ____________**
12. **Do you ever stop in a bar and have a couple of drinks by yourself? ___________**
13. **Do you sometimes drink at home alone or when not one else is drinking? _____________**
14. **Have you ever had an experience of not being able to remember everything that happened the night before? _____________**
15. **Have you ever had difficulty recalling how you got home after drinking? ____________**
16. **Have you ever hid a bottle in the house in the event you might need a drink? __________**
17. **Do you ever stop to have drinks when you planned to go straight home or someplace else? ____________**
18. **Do you sometimes drink more than you think you should? ___________**
19. **Have you ever had the shakes or tremors after a night of drinking? ____________**
20. **Do your family/friends think you drink too much or object to your drinking? ___________**
21. **Has your spouse/significant other ever threatened to leave you because of your drinking? ___________**
22. **Do you sometimes drink even though you cannot afford to? ___________**
23. **Have you ever missed work because of a hangover? ____________**
24. **Has drinking ever caused you to be less efficient in your work? ____________**
25. **Have you ever been threatened or lost a job because of your drinking? ______________**
26. **Has a doctor ever told you to cut down or stop your drinking for any reason? __________**
27. **Have you ever been hospitalized because of your drinking? _____________**
28. **Do you have a preference to associate with people who drink rather than with those who do not? ___________**
29. **Do you sometimes do things while drinking that you are ashamed of? _____________**
30. **Has drinking become so important or time consuming that previous hobbies or interests are neglected? __________**

DATE:_________________ **SIGNATURE: _____________________________**

RISK ASSESSMENT

PLEASE READ EACH OF THE FOLLOWING QUESTIONS AND CIRCLE YOUR ANSWER.

Question		
• **Have you ever used a needle to take drugs including steroids (intravenously - IV, intramuscularly - IM, or skin popping)?**	**YES**	**NO**
• **Have you ever shared needles or works with anyone?**	**YES**	**NO**
• **Did you ever forget what you did when you were high?**	**YES**	**NO**
• **Have you ever had sex when you were high?**	**YES**	**NO**
• **Have you ever been in jail or prison?**	**YES**	**NO**
• **If yes, did you engage in sex, willingly or unwillingly, while in jail or prison?**	**YES**	**NO**
• **Have you ever exchanged money or drugs for sex?**	**YES**	**NO**
• **Have you had more than one sex partner in the past year?**	**YES**	**NO**
• **Have you ever had Herpes, Hepatitis B, Syphilis, Gonorrhea, Chlamydia, or any other STD?**	**YES**	**NO**
• **Have you ever shared a needle or had sex with someone who is HIV positive or has AIDS?**	**YES**	**NO**
• **(FOR MEN ONLY) Have you ever had male to male sex?**	**YES**	**NO**
• **Have you ever had sex with anyone who would answer yes to any of the above questions?**	**YES**	**NO**

______________________________ __________________

CLIENT'S NAME **DATE OF BIRTH**

______________________________ __________________

CLIENT SIGNATURE **DATE**

INSURANCE INFORMATION

WE DO NOT ACCEPT INSURANCE. WE WILL PROVIDE ANY NECESSARY INFORMATION FOR YOU TO COMPLETE INSURANCE CLAIMS.

Insurance Company:____________________ **Insurance Phone Number:**______________________

Policy Holder Name:____

D.O.B.:________________________________ **SSN #:**_____________________________________

Primary Holder Address:____

Policy #:____________________________________ **Group #:**______________________________

Please Circle:____ **PPO / HMO / OTHER** _______ **Relationship to Client:**____________________

Employer:_______________________________________ **Position:**__________________________

Employer Address:____

PATIENTS RIGHTS & RESPONSIBLITIES

PROTECTION OF PATIENTS: Unless abridged by a Court of Law, the rights of Patients who are admitted to Choices Counseling Centers' programs must be assured of the following:

PATIENTS:

1. shall be treated by the staff with courtesy and respect, with appreciation of his or her individual dignity and with protection of his or her need for privacy consistent with the need for safety.
2. shall be assigned a primary counselor and the right to know who is responsible for his/her care.
3. shall be given the right to a prompt and reasonable response to questions and requests.
4. shall have the right to know what rules and regulations apply to his or her conduct.
5. have the right to be given information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis.
6. have the right to refuse any treatment, except as otherwise provided by law.
7. have the right to know that Choices Counseling Center does not accept Medicare assignments.
8. have the right to know a reasonable estimate of charges for medical care (Schedule of fees attached).
9. have the right to receive a copy of a reasonably clear and understandable itemized bill and, upon request, to have the charges explained.
10. have the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap or source of payment.
11. have the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure as outlined below and to the appropriate state licensing agency.
12. have the right to treatment for any emergency medical condition that will deteriorate from failure to assist client in obtaining treatment.
13. will be afforded access to the least restrictive treatment alternative available consistent with the needs of the client.
14. will be assured that client identifying information is confidential.
15. will be assured freedom from neglect, abuse exploitation, or any form of corporal punishment.
16. will be assured that any search or seizure is carried out in a manner consistent with programs standards and only to insure safety.
17. are responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to his/her health.
18. are responsible for reporting unexpected changes in his/her condition to the health care provider.
19. are responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him/her.
20. are responsible for following the treatment plan recommended by the health care provider.
21. are responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or facility.
22. are responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
23. are responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
24. are responsible for following health care facility rules and regulations affecting patient care and conduct.

______Initials

CLIENT GRIEVANCE PROCEDURE

What is a Grievance?

A grievance is a formal expression of concern about any particular issue thought to be unjust, unfair or abusive. Filing a grievance means putting in writing anything that you have experienced that you believe was harmful or unfair. You have the right to file a grievance at any time without fear of retaliation. We are committed to consistently providing services to you while a resolution regarding your grievance is formulated.

When Issues or Concerns Arise:

Discuss any issues or concerns with the agency staff. If a mutually agreed upon decision is not met through this discussion, you are to contact the appropriate Supervisor. The Supervisor will then schedule a meeting with you within five business days to discuss the unresolved concerns. Hopefully, you and the Supervisor can reach a mutually agreed upon resolution through this process.

If you want to report a grievance, please do the following:

1. **Report grievance to primary therapist.**
2. **If not resolved, report grievance to Assistant Director**
3. **File formal complaint to Program Director.**
   - **A. Nature of reported grievance**
   - **B. Date of grievance**
   - **C. Brief description of complaint**
   - **D. Recommended remedy**
4. **File formal complaint to Clinical Director**
   - **A. Nature and date of reported abuse grievance**
   - **B. Steps already taken**
   - **C. Brief description of complaint**
   - **D. Recommended remedy**
5. **File formal complaint to Executive Director**
   - **A. Same as above**
   - **B. Same as above**
   - **C. Same as above**
   - **D. Same as above**

Employees of Choices Counseling Center will not discourage or prevent Client's right to bring reported grievances to the Agency for Health Care Administration or to report abuse at 1 800 96-ABUSE.

________Initials

AGREEMENT TO TREATMENT RULES

1. No alcohol or other mood altering drugs are to be used on the premises or while in treatment at Choices.

2. No violence, threats of violence or verbal abuse will be permitted on or about the Center's premises or Program locations. No weapons are permitted on the premises

3. No sexual activity will be permitted on the premises.

4. No acts of vandalism to the property of Choices, it's programs locations, it's staff or clients will be permitted.

5. No smoking is permitted in the offices of Choices Counseling Center.

6. No phone privileges (other than emergency) are recommended during therapy sessions and Programs.

7. No visiting privileges are recommended during the Weekend/Five Day Programs.

8. Choices Counseling Center is required to report any communicable disease (as described on HRS form 2001, a copy of which may be obtained upon request) to the Department of Health & Rehabilitative Services.

9. As addressed in the Federal Confidentiality Law, all clients attending group at Choices are bound by the statute which requires that all information shared by any client is confidential and will not be discussed in any manner outside of the group.

10. As addressed in the Federal Confidentiality Law, regarding Chapter 415, F.S., any cases of abuse, physical, sexual, verbal or emotional, divulged by clients to counselors must be reported to the Abuse Registry, regardless of the time elapsed.

11. Florida Law requires that information about any client exhibiting behavior which may be considered dangerous to themselves or others or that the client is endangered by another, is excluded from the Florida Confidentiality Law, and that the proper authorities and agencies will be notified.

12. As addressed in the Florida Confidentiality Law, regarding Chapter 415 F.S., any information compelled by a Court of Law must be divulged to that Court.

13. Information shared in individual sessions or with other clients will not necessarily be held apart from group sessions unless specifically requested by the patient. All reasonable efforts will be made by the Choices Professional staff to preserve the patient's confidentiality within the group.

14. Upon entry to the Extended Care program:

a. Client agrees that all luggage will be searched by a therapist for inappropriate material such as drugs or drug paraphernalia, alcohol, inappropriate clothing or jewelry, etc. and it is the client's responsibility to have those inappropriate items shipped home or stored. All jewelry and valuables, credit cards, bank cards, extra monies (other than needed to attend) should be left at home. Any additional cash will be credited to client's account.

b. Client agrees that monies for clients benefit (i.e. grocery and spending monies) may be held by other recovering individuals for the client until such time that therapist recommends otherwise.

I UNDERSTAND THE ABOVE STATED RULES, AND I AGREE TO ABIDE BY THEM WHILE ON THE PREMISES AND/OR IN TREATMENT AT CHOICES COUNSELING CENTER AND AT ANY LOCATION OF ANY PROGRAMS OFFERED BY CHOICES COUNSELING CENTER. I FURTHER UNDERSTAND THAT VIOLATION OF ANY OF THESE RULES IS GROUNDS FOR IMMEDIATE TERMINATION.

DATE:________________________ CLIENT SIGNATURE:_____________________________________

CHOICES COUNSELING CENTER
INFORMED CONSENT AND AUTHORIZATION FOR TREATMENT

I or We (if a minor) do hereby consent to therapy and authorize the Professional Staff of Choices Counseling Center to render such therapeutic care and treatment as they deem therapeutically appropriate and beneficial to my ultimate goals of therapy.

I or We fully understand that neither Choices Counseling Center nor any member of Its Professional Staff can guarantee the final outcome of my care and treatment. I or We covenant and agree that no warranties of any type or kind have been made to me or us as to the final outcome of my care and treatment. I or We further covenant, agree and certify that no inducement of any type or kind has been made to cause me or us to choose Choices Counseling Center other than information generally disseminated to the general public.

CONDITIONS FOR ADMISSION

1. Any patient may be terminated from care and treatment at any time upon the recommendation of Choices Professional Staff that the patient is failing and refusing to follow the recommendations for care and treatment of Choices Professional Staff. Such termination shall be referred to as a "Termination for Cause," and no part of any advance fees paid are refundable to the patient or their family.

2. By accepting a patient for admission to outpatient treatment at Choices Counseling Center, the Center does not in any way warrant the final outcome of any patient's progress.

3. The undersigned patient and his or her parent or parents acknowledge, covenant and agree that they fully understand that Choices Counseling Center is an outpatient facility only and that all patients who attend Choices Counseling Center programs do so on a strictly voluntary basis and are free to terminate their participation at any time. In the event of a "Voluntary Termination" by the patient, no part of any advance fees paid are refundable to the patient or their family.

4. The undersigned patient further understands that should he or she attend group sessions at Choices Counseling Center, information that may be shared in individual sessions may not necessarily be held apart from group sessions unless specifically requested by patient.

5. Because Choices Counseling Center is an outpatient program, patients who participate in Choices' therapeutic programs may require assistance of Choices Administrative Staff to assist them in finding suitable housing. I or We covenant and agree that we fully understand that Choices Counseling Center does not have any financial interest in any housing where patients of Choices may reside from time to time and that Choices Counseling Center is not liable in any way for the particular living arrangement any patient may make during the course of their therapy.

6. In the event a patient makes a determination to reside with any other patient or patients of Choices in a common facility then and in that event, I or We fully understand that the rules and regulations of that facility must be followed to allow Choices to achieve the maximum possible benefit to the patient. Thus, the failure of the patient to abide by the Rules and Regulations of the living facility shall also constitute good and sufficient grounds for "Termination or Cause" of their Therapy at Choices.

_________Initials

7. I or We have fully read and have had a full opportunity to discuss with the intake member of Choices Professional or Administrative Staff the specific terms and conditions of this Informed Consent and Authorization for Treatment and the Conditions of Admission and I or We agree to abide and be bound by those conditions.

8. Any dispute arising pursuant to this Informed Consent and Authorization for Treatment shall be governed by the laws of the State of Florida and shall be enforceable in the Circuit Court in and for Orange County, Florida and in no other Court or Forum. In the event a patient shall bring an action against Choices arising from their admission, care and treatment at Choices Counseling Center, they shall be fully liable for all of Choices attorneys' fees and costs.

9. I or We personally warrant, covenant and agree to pay all outstanding bills which shall include but not be limited to costs of therapy and medical bills which are due and owing as a result of the care and treatment rendered to me by Choices Counseling Center and its agents and employees within fifteen (15) calendar days from the date the expenses are incurred. This Personal Guarantee is subject to the provisions Florida Law and shall include indemnification of Choices for all actual attorney's fees and costs.

This Consent for Treatment encompasses Schedule of Fees and Office Hours, Agreement for Program Rules, Patients Rights & Responsibilities and Clients Grievance Procedure and are all made a part hereof.

I____DOB:__________________________

who reside at____
covenant and agree that I have read and have explained to me this Informed Consent and Authorization for Treatment and I agree to abide by the terms and conditions of this Agreement.

______________________________	______________________________
DATE	**PATIENT'S NAME (PRINT)**
______________________________	______________________________
PATIENT SIGNATURE	**PARENT/GUARDIAN (IF MINOR)**

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RESPONSIBLE FINANCIAL PARTY

CHOICES COUNSELING CENTER
SCHEDULE OF FEES AND OFFICE HOURS

OFFICE STAFF:

Elizabeth A. Traynor, M.A., Licensed Mental Health Counselor & Licensed Marriage & Family Therapist National Certified Counselor Director	Indiv. Appt.	135/hr. (1 person) 160/hr (2 or more)
Vanessa Roeser, MS Registered Mental Health Counselor Intern	Indiv. Appt.	85/hr. (1 person) 100/hr (2 or more)

*Appointments scheduled with more than one therapist at client's request is $170 per hour with Elizabeth Traynor and $135/hr. with all other counselors. Alcohol and Drug Evaluations require minimum of 4 individual sessions. If written report is required an additional fee of $135.00 is charged.

* * * * * * * * * * * * * * *

GROUP RATES: 1 – 2 hr. sessions $50/per group session

* * * * * * * * * * * * * * *

Administrative Office Hours are 9:00 to 5:00 Monday thru Friday. Group Times are as follows (subject to change):

Monday	3:00PM - 5:00PM	Vanessa Roeser, Facilitator
Tuesday	10:00AM – 12:00PM	Elizabeth Traynor, Facilitator
Wednesday	4:00PM – 6:00 PM Adv Couples*	Elizabeth Traynor, Facilitator
Thursday	5:00 PM –7:00 PM	Vanessa Roeser, Facilitator

WEEKEND TREATMENT PROGRAM: Held once per month, this program consists of apprx. 19 hours of group therapy. It begins on Friday evening at 5:30PM and concludes at approximately noon on Sunday. See Brochure for scheduled dates and additional information. Cost is $475 exclusive of meals & room.

FIVE DAY TREATMENT PROGRAM: Also held once per month immediately following the Weekend program. The program begins at 5:00PM on Sunday and concludes on Friday at approximately 11:00AM. See brochure for scheduled dates and additional information. Cost is $1875 inclusive of meals and room.

PAYMENT FOR PROFESSIONAL SERVICES IS DUE WHEN RENDERED. A $10 Late Fee will be charged on past due balances. Medicare and Medicaid are not accepted. **Choices does not accept upfront insurance assignments**.

Please provide 24 hour notice for cancellation of individual appointments or you will incur a $50.00 No Show or Late Cancellation Fee.

_______Initials