

# Summit Counseling Center

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6400 Lee Highway, Suite 106  
Chattanooga, TN 37421

423-855-0402  
423-648-9369, fax

## Important Information! Please **READ**, then **INITIAL** Below

### Financial Policy:

**We expect payment in full before your session begins.** We accept cash and checks, along with VISA, Master Card & Discover. If you know you will be unable to pay at the time of service, please call us to make prior arrangements or to reschedule your appointment.

### Insurance Policy:

- ✚ Our Counselors work independently—**not all of our counselors accept insurance.**
  - Please check with our office staff for a list of Summit Counselors who are currently accepting insurance and to find out which insurance company each is contracted with.
  - Some of our counselors are in-network with Blue Cross Blue Shield and United HealthCare
  - We are not in-network with any other insurance company so if you wish to file under an insurance plan other than BCBS & UHC, you will need to call the number on your card to find out if you have out of network benefits for behavioral health.
- ✚ Some of our counselors accept **TennCare as it is managed under AmeriChoice and Premier and TennCare (BlueCare) managed under Value Options.**
- ✚ **WE ARE UNABLE TO ACCEPT MEDICARE** (as Medicare requires that patients see a Psychologist or Psychiatrist) – we are NOT allowed to file Medicare at all.
- ✚ Those whom we file insurance for must understand that you are **responsible for the full fee until your deductible is met**, co-pays and non-covered charges.

### Appointments:

- ✚ Our patients are seen by appointment Monday—Thursday.
- ✚ **We require a 24-HOUR NOTICE OF CANCELLATION. THE STANDARD FEE WILL BE CHARGED IF YOU CANCEL THE APPOINTMENT WITHIN 24-HOURS OF THE SCHEDULED TIME OR IF YOU CHOOSE TO SIMPLY NOT SHOW FOR THE APPOINTMENT.**

### HIPPA Rules and Regulations:

Summit Counseling Center is in compliance with HIPPA Confidentiality Rules and Regulations.

**Patient's Initials** (Parent or Legal Guardian if patient is a minor)

**Nature of Counseling Services**

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## Nature of Counseling

In fulfilling its explicit mission, this counseling center offers counseling services to individuals, couples and families who are seeking **Biblically based counseling**. The type of counseling provided is Biblical in nature, orientation, and application. The counselor follows a cognitive-behavioral approach that is grounded in Biblical truth. A fee is charged for certain services including testing and counseling sessions.

## Confidentiality

By its nature, counseling is personal and often involves delicate issues. **Information discussed in counseling sessions is held in confidence**. There are three exceptions to this rule of confidentiality:

Information may be disclosed under the conditions of an order of the court.

Information will be shared if there is reason to suspect that a counselee poses a threat to self or to others and cases involving suspected child abuse. Legal statute and professional ethics mandate such reporting.

*In the case of a minor, certain information may be shared with a parent(s) when it is deemed to be necessary for the best interest of the minor. This information will be discussed with the minor prior to disclosure to the parent.*

Any other sharing of information will take place only upon the written request of the counselee or by prior written permission for purposes of consultation or supervision of the counselor.

## Patient Disclosure

All successful counseling involves **honest** communication between a counselee and counselor. Specifically, the counselee must believe that full self-disclosure is of paramount value with a professional and confidential relationship.

There are two areas of critical importance:

The counselee must disclose any human relational services (e.g. psychiatric, psychological, etc.) received concurrently with counseling. This includes information regarding psychotropic medications and other relevant medical services.

It is essential for the potential counselee to disclose, prior to beginning counseling, any past, current, or potential future legal involvement that may pertain to current counseling issues. (example: any impending custody disputes, civil suits, etc.)

## Patient Agreement

***I have read the above information carefully, and I fully understand the nature of the counseling services involved.***

**Signature** (or parent, if minor) \_\_\_\_\_

**Date** \_\_\_\_\_

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## Emergency Contact:

**Name of person we may contact in the case of emergency:**

**Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

*We understand your desire for privacy/anonymity. However, should you choose to decline this opportunity to leave the emergency contact name and number of your choice and an emergency does arise, please understand that under certain circumstances we may be obligated, by law, to contact someone on your behalf.*

### **Agreement:**

In signing below, I attest to having read the above information carefully, and fully understand the [Summit Counseling Center](#) Emergency Contact Policy.

**Print Name** (of client/patient) \_\_\_\_\_

**Print Name** (of client/patient) \_\_\_\_\_

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## Payment Policy

Payment is due when services are rendered unless arrangements have been made previously with the office staff.

The Client/Patient must give a 24-hour notification of cancellation or be charged their standard fee.

### Agreement:

In signing below, I attest to having read the above information carefully, and fully understand the [Summit Counseling Center](#) Payment Policy.

Print Name (of client/patient) \_\_\_\_\_

Signature (parent or legal guardian, if patient is a minor) \_\_\_\_\_

Date \_\_\_\_\_

# Counseling Inventory (Personal & Confidential)

**Instructions: Complete Entire Form** (as much as it applies)

**Patient Information** If **COUPLE**, complete this section on **HUSBAND**; wife will be added to family section below

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Place of Employment \_\_\_\_\_ Occupation \_\_\_\_\_ How Long \_\_\_\_\_ Work Phone \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Highest Level of Education \_\_\_\_\_ College Attended?(yes/no) \_\_\_\_\_ Degree \_\_\_\_\_  
Who referred you for counseling? \_\_\_\_\_ E-mail address \_\_\_\_\_

**Marital Status** (Please indicate number of years where appropriate)

Single (never been married) \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_  
Remarried \_\_\_\_\_ Living w/ significant other \_\_\_\_\_

**Family Information**

Spouse's Name \_\_\_\_\_ Birth date \_\_\_\_\_  
Spouse's place of employment \_\_\_\_\_ Position \_\_\_\_\_ Work Phone \_\_\_\_\_  
Have you and your spouse ever been separated? \_\_\_\_\_ If yes, when and for how long? \_\_\_\_\_  
What was the reason for the separation? \_\_\_\_\_  
Have you and your spouse ever filed for divorce? \_\_\_\_\_ If yes, when? \_\_\_\_\_  
Please provide data regarding your children (Names, ages, marital status, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is your spouse the biological parent of your children? \_\_\_\_\_  
Does your spouse have children from another marriage or relationship? \_\_\_\_\_ If yes, do they live with you? \_\_\_\_\_  
Please rate your happiness in marriage on a scale of 1 to 10 (1=unhappy 10=perfectly happy) \_\_\_\_\_

**If your spouse is not attending counseling with you, please answer the following:**

- Does he/she know you are receiving counseling? \_\_\_\_\_
- May he/she be contacted concerning counseling, if needed? \_\_\_\_\_  
If not, please explain \_\_\_\_\_
- Is your spouse willing to come for counseling if needed? \_\_\_\_\_  
If not, please explain \_\_\_\_\_
- Please describe your spouse's supportiveness of your counseling at this time \_\_\_\_\_

**Health Information** (If couple, use "H" for Husband, "W" for Wife)

Rate your current health: Excellent \_\_\_\_\_ Good \_\_\_\_\_ Average \_\_\_\_\_ Declining \_\_\_\_\_ Other \_\_\_\_\_  
Are you currently taking medication( s )? \_\_\_\_\_ If so, please list: \_\_\_\_\_  
\_\_\_\_\_

Presently, do you know of or suspect any illness, imbalance of body chemistry, or abnormal body function or pain? \_\_\_\_\_  
If yes, please describe or name \_\_\_\_\_

Identify any significant past illnesses, injuries, or handicaps \_\_\_\_\_

Have you, your parents or grandparents ever been involved with the occult or extra-natural activities? (examples: Satanic Worship, Wicca, etc.)  
\_\_\_\_\_ If yes, please describe or name \_\_\_\_\_

**Summit Counseling Center**  
Spiritual Inventory - Adult

**CLIENT INFORMATION** (If **COUPLE**, use this section for **HUSBAND**; add wife to section under Spouse)

Are you a Christian? \_\_\_\_\_ How long have you been a Christian? \_\_\_\_\_

Are you a member of a local church? \_\_\_\_\_ Briefly explain what it means to be a Christian \_\_\_\_\_

\_\_\_\_\_

Do you have doubts or concerns about your salvation? \_\_\_\_ If yes, would you like to address this in counseling? \_\_\_\_

-

**Spouse of Client Information** (If attending session as a couple; use this section for wife)

Does your spouse attend church? \_\_\_\_\_ If yes, do you attend church together or do you worship at separate churches? \_\_\_\_\_ Is your spouse a Christian? \_\_\_\_ If yes, how long? \_\_\_\_\_ Does your spouse have doubts about his/her salvation? \_\_\_\_ If yes, would you (or your spouse, if attending counseling with you) like to address this issue in counseling? \_\_\_\_\_

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**Counseling Information**

Have you ever been to a counselor before (including Psychologist, clinical social worker)? \_\_\_\_\_ If yes, name of counselor and reason(s) \_\_\_\_\_

Has your spouse ever been to a counselor before? \_\_\_\_ If yes, name of counselor & reason \_\_\_\_\_

Are you willing to sign a release of information form concerning previous counseling records? \_\_\_\_\_ If not, please explain \_\_\_\_\_

Have you ever been diagnosed with a psychological disorder? \_\_\_\_ If yes, please describe \_\_\_\_\_

Has your spouse ever been diagnosed with a psychological disorder? \_\_\_\_ If yes, please describe \_\_\_\_\_

\_\_\_\_\_

What brings you to counseling at this time? \_\_\_\_\_

With whom have you discussed this issue(s)? \_\_\_\_\_

What do you hope counseling will do regarding this issue(s)? \_\_\_\_\_

\_\_\_\_\_

What do you hope the *counselor* will do in counseling? (Your expectations) \_\_\_\_\_

\_\_\_\_\_

What do *you* expect to do in counseling? \_\_\_\_\_

How will you know when counseling is to be completed (what will need to occur)?

Please list your goals in counseling:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Summit Counseling Center

## Check List

Instructions: Place a **check** beside **current problems**.  
Underline anything that has been a problem in the past (last three years)

|   |   |
|---|---|
| <input type="checkbox"/> Stress                         | <input type="checkbox"/> Sexual Abuse                           |
| <input type="checkbox"/> Fears                          | <input type="checkbox"/> Physical Abuse                         |
| <input type="checkbox"/> Anxiety                        | <input type="checkbox"/> Authority Conflict                     |
| <input type="checkbox"/> Anger                          | <input type="checkbox"/> Marital Problems                       |
| <input type="checkbox"/> Feelings of Guilt              | <input type="checkbox"/> Family Conflicts                       |
| <input type="checkbox"/> Loneliness                     | <input type="checkbox"/> Dating Conflicts                       |
| <input type="checkbox"/> Unhappiness                    | <input type="checkbox"/> Poor Social Relationships              |
| <input type="checkbox"/> Shyness                        | <input type="checkbox"/> Eating Problems (explain _____)        |
| <input type="checkbox"/> Inferiority                    | <input type="checkbox"/> Change in Appetite                     |
| <input type="checkbox"/> Self Esteem/ Self Worth Issues | <input type="checkbox"/> Vomiting                               |
| <input type="checkbox"/> Strange Thoughts               | <input type="checkbox"/> Physical Health Issues (explain _____) |
| <input type="checkbox"/> Body Image Concerns            | _____   |
| <input type="checkbox"/> Death and Grief                | _____)  |
| <input type="checkbox"/> Depression                     | <input type="checkbox"/> Nightmares                             |
| <input type="checkbox"/> Suicidal Thoughts              | <input type="checkbox"/> Tiredness                              |
| <input type="checkbox"/> Homicidal Thoughts             | <input type="checkbox"/> Excessive Sleep                        |
| <input type="checkbox"/> Spiritual Concerns             | <input type="checkbox"/> Insomnia                               |
| <input type="checkbox"/> Procrastination                | <input type="checkbox"/> Irritability                           |
| <input type="checkbox"/> Academic Problems              | <input type="checkbox"/> Headaches                              |
| <input type="checkbox"/> Career/Major Choice            | <input type="checkbox"/> Loss of Memory                         |
| <input type="checkbox"/> Lack of Goals                  | <input type="checkbox"/> Unable to Concentrate                  |
| <input type="checkbox"/> Poor Self Discipline           | <input type="checkbox"/> Tightness of Chest                     |
| <input type="checkbox"/> Self Injury Abuse              | <input type="checkbox"/> Shakiness                              |
| <input type="checkbox"/> Drug Abuse                     | <input type="checkbox"/> Rapid/Skipping Heartbeat               |
| <input type="checkbox"/> Internet Abuse                 | <input type="checkbox"/> Excessive Perspiration                 |
| <input type="checkbox"/> Pornography                    | <input type="checkbox"/> Other (explain _____)                  |
| <input type="checkbox"/> Gender Identity Problems       | _____   |
| <input type="checkbox"/> Sexual Problems                | _____)  |

If there is anything that is not listed above - or if you need additional space for elaboration, use the space below.

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Name: \_\_\_\_\_