Thrive Coaching & Counseling, LLC

Margaret A. MacQueen, MS, NBCC, LPC

17 S. Church Street

West Chester, PA 19382

Welcome!

Please complete all forms that follow.

Thank you!

Life History Questionnaire

(Confidential)

Date: _____

First Name: _____ MI: _____ Last Name: _____

If child, Parent/Guardian Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ Age: _____ Gender: Male ☐ Female ☐

Home Phone: _____ Cell Phone: _____

May I leave a message? No ☐ Yes ☐

If yes, at which number may I leave one? (Please circle) Home Cell Both

Email Address: _____

Emergency Contact: (At least 1 required)

Name: _____ Phone Number: _____

Relationship: _____

Name: _____ Phone Number: _____

Relationship: _____

Ethnicity

Asian/Pacific Islander ☐

American Indian ☐

Caucasian ☐

Hispanic ☐

African American ☐

Other ☐

Relationship Status

Single ☐

Married ☐ Year(s) _____

Divorced ☐ Time(s) _____

Engaged ☐ Wedding Date _____

Separated ☐ Month(s) _____

Widowed ☐

Education: (last level completed) _____

Occupation: _____ Employer: _____ Since: _____

Spouse's Name: _____ Age: _____ Occupation: _____

Education: (last level completed) _____ Employer: _____

Please list all the names and ages of your children:

_____

_____

Physical Health:

Very Good ☐ Good ☐ Poor ☐

Recent Major Illnesses or Disabilities: _____

Are you currently taking any prescription medications? No ☐ Yes ☐

If yes, please list and specify dosage: _____

_____

Primary Physician: _____

Date of last physical: _____ Thyroid level checked? No ☐ Yes ☐

Mental Health:

Have you previously been involved in counseling?	No ☐ Yes ☐
Do you currently use alcohol or other non-prescription drugs?	No ☐ Yes ☐
Is there a history of alcohol or drug problems in your family?	No ☐ Yes ☐
Is there any history of mental health problems in your family?	No ☐ Yes ☐
Have you ever been physically abused?	No ☐ Yes ☐
Have you ever been emotionally abused?	No ☐ Yes ☐
Have you ever been sexually abused or assaulted?	No ☐ Yes ☐
Are your concerns interfering with your work performance?	No ☐ Yes ☐
Are you concerns interfering with your family life?	No ☐ Yes ☐
Have you ever attempted suicide?	No ☐ Yes ☐
Have you ever been hospitalized for mental health reasons?	No ☐ Yes ☐
Have you ever been in legal trouble?	No ☐ Yes ☐

How long has the problem that you are coming in for persisted? _____

Under what condition do your problems get worse? Better? _____

_____

How serious do you consider your concern(s)? Not at all ☐ Mildly ☐ Moderately ☐ Highly ☐

How motivated are you to resolve your concern(s)? Not at all ☐ Mildly ☐ Moderately ☐ Highly ☐

How expectant are you that your concern can be resolved? Not at all ☐ Mildly ☐ Moderately ☐ Highly ☐

Family History:

Mother's Age: _____ If deceased, at what age were you when she died? _____

Father's Age: _____ If deceased, at what age were you when he died? _____

If your parents are separated, at what age were you then? _____

Number of brother(s): _____ What are their ages? _____

Number of sister (s): _____ What are their ages? _____

If you were adopted or raised by parents other than your birth parents, please explain: _____

_____

_____

Briefly describe your mother's personality: _____

_____

Briefly describe your father's personality: _____

_____

If applicable, briefly describe your step-parent(s) personality: _____

_____

Briefly describe your past and current relationships with your:

Mother: _____

Father: _____

Step-mother: _____

Step-father: _____

Do you want your faith to be included in your therapy? No ☐ Yes ☐

Consent to Treatment/Confidentiality Policy

Margaret A. MacQueen, MS, NBCC, LPC is experienced and professionally trained. I/We understand the relationship established with our therapist is voluntary and I/we have the right to end the relationship at any time. All client information and client records are strictly confidential. The only exceptions to this policy are as follows:

- If I, **Margaret A. MacQueen, MS, NBCC, LPC**, have reason to believe that a child has been physically or sexually abused, I am required by law to report it to the state protection service. I am not making a determination that any behavior is unlawful or improper. That determination is made by the state.
- If I, **Margaret A. MacQueen, MS, NBCC, LPC**, have reason to believe that a client may seriously harm him/herself or another person, I am required to release information to protect the person who may be harmed.
- Selected records may be made available certifying or licensing organization for review of our record-keeping procedures.
- If information is shared during an individual counseling session that will impact the couples' therapy or relationship, the therapist may share that information with the spouse/partner. Either spouse/partner may choose to end couple's therapy and begin individual therapy, at which point, information shared would be confidential, even from the spouse/partner.
- If you choose to have electronic therapy. Through the use of cell phones or email, please understand the security risks that are involved. I, **Margaret A. MacQueen, MS, NBCC, LPC**, will do my best to ensure confidentiality and security, but with technology, confidentiality and security cannot always be guaranteed.
- Children under the age of 14 need signed parental consent from both parents or all legal guardians for treatment.

I/We allow the following people to hear conveyed information from counseling sessions:

_____

_____

I/We understand in order to protect confidentiality, any inquiries other than those mentioned above (written, telephone, or personal) will not be answered until I/we sign a release of information. In the treatment of couple or a family, **Margaret A. MacQueen, MS, NBCC, LPC**, will seek authorization of all members of the treatment unit before the release of confidential information to third parties.

Fee Scale/Payment Policies

I/We understand the fee scale and payment policies for private session and that an hourly fee of $_____ has been determined by **Margaret A. MacQueen, MS, NBCC, LPC.** Since her time has been reserved, I/we agree to give at least a 24-hour advance notice when unable to keep an appointment. If there is less than 24 hours, a fee may be charged. I/We accept financial responsibility for charges incurred during the course of having **Margaret A. MacQueen, MS, NBCC, LPC** provide services, including bank fees for returned checks.

Litigation Limitation

As a participant in therapy at **Thrive Coaching & Counseling,** I/we understand and agree that **Margaret A. MacQueen, MS, NBCC, LPC** shall not be called as a witness to testify on behalf of my/our children in any legal proceedings concerning my/our therapy. Further, I/we understand and agree for myself/ourselves and for those who would represent us, that no documentation other than recommendations prepared in conjunction with **Thrive Coaching & Counseling** shall be subject to subpoena or records deposition for use in legal proceedings. I/we understand that this provision is necessary in order to understand that I am/we are giving up our right to use testimony, records or other information contained at **Thrive Coaching & Counseling**, but that I/we do so voluntarily, and without undue influence, for the purpose of establishing confidentiality and privilege for myself and **Margaret A. MacQueen, MS, NBCC, LPC**, which right and privilege shall not hereafter be revoked by me or my legal representative.

I/We understand that the only communication between **Margaret A. MacQueen, MS, NBCC, LPC** and/or Court will be limited to a form letter stating when the services began/or whether the client completed, did not complete, or is still undergoing therapy. I/We further understand that I/we can be disqualified from treatment if it is determined in the clinical judgment of **Margaret A. MacQueen, MS, NBCC, LPC** that I/we have a diagnosable psychiatric disorder which interferes with treatment, at which time a recommendation for treatment will be made to the Court.

I/We acknowledge by our individual signatures below that each of us has read this policy, that I/we understand it and have had an opportunity to discuss its content with **Margaret A. MacQueen, MS, NBCC, LPC** and that I/we enter therapy in agreement with this policy.

_____	_____	_____
Signature (Parent or Guardian)	Print Name	Date
_____	_____	_____
Signature	Print Name	Date
_____	_____	_____
Signature	Print Name	Date

Clients' Rights and Responsibilities

Statement of Clients' Rights

- Clients have the right to be treated with dignity and respect.
- Clients have the right to fair treatment, regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Clients have the right to have their treatment and other client information kept private.
- Client treatment records may be released without client permissions only if an emergency happens or is required by law.
- Clients have the right to easily access care in a timely fashion.
- Clients have the right to know about their treatment choices. This is regardless of cost or coverage by the client's benefit plan.
- Client have the right to share in developing their plan of care.
- Clients have the right to information in a language they can understand.
- Clients have the right to have a clear explanation of their condition and treatment options.
- Clients have the right to information about **Margaret A. MacQueen, MS, NBCC, LPC** and their insurance company as well as her role in the treatment process.
- Clients have the right to information about clinical guidelines used in providing and managing their care.
- Clients have the right to ask **Margaret A. MacQueen, MS, NBCC, LPC** about her work history and training.
- Clients have the right to give input on this Clients' Rights and Responsibilities policy.
- Clients have the right to know about advocacy, community groups and prevention services.
- Clients have the right to know of their rights and responsibilities in the treatment process.
- Clients have the right to receive services that will not jeopardize their employment.

Statement of Clients' Responsibilities

- Clients have the responsibility to treat **Margaret A. MacQueen, MS, NBCC, LPC** with dignity and respect.
- Clients have the responsibility to give **Margaret A. MacQueen, MS, NBCC, LPC** the information she needs. This is so she can deliver the best possible care.
- Clients have the responsibility to let her know when the treatment plan no longer works for them.
- Clients have the responsibility to ask questions about their care. This is to help them understand their care.
- Clients have the responsibility to follow the treatment plan. The plan of care is to be agreed upon by both the member and **Margaret A. MacQueen, MS, NBCC, LPC.**
- Clients have the responsibility to follow a medication plan that has been agreed upon.
- Clients have the responsibility to tell **Margaret A. MacQueen, MS, NBCC, LPC** and their primary care physician about medication changes, including medications given to them by others.
- Clients should not take actions that could harm the lives of Health employees.
- Clients have the responsibility to keep their appointments. Clients should call **Margaret A. MacQueen, MS, NBCC, LPC** with a 24-hour notice of an appointment cancellation.
- Clients have the responsibility to pay their fees for therapy sessions.
- Clients have the responsibility to report abuse and fraud.
- Clients have the responsibility to openly report concerns about the quality of care they receive.

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

_____

Client Signature Date

The signature below shows that I have explained this statement to the patient. I have offered the client of a copy of this form.

_____

Provider Signature Date

HIPAA Privacy Policy

Name: _____

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

You have the right to inspect and receive a copy of your records.

All responses to requests for PHI will be limited to the minimum amount of information needed to accomplish the purpose of the request or disclosure.

Margaret A. MacQueen, MS, NBCC, LPC may use or disclose the client's Protected Health Information (PHI), as defined in the Health Insurance Portability and Accountability Act of 1996, for the purpose of conducting, planning and directing your treatment, making or obtaining payment for care, or otherwise allowed by HIPAA. I may use or disclose your PHI for purposes permitted or required by federal, state, or local law, for example if I am court ordered or I determine that you are a danger to yourself or to others.
Also, it is mandatory that I report child abuse. Finally, you may give me permission to release your information.

I do not share your information with anyone for their own marketing purposes. For this reason, I am not required to obtain an "opt-in election" or an "opt-out election".

My signature verifies that I have read and understood the HIPAA Privacy Policy.

Signature Date

Margaret A. MacQueen, MS, NBCC, LPC
17 S. Church Street
West Chester, PA 19382

Information and Consent for Psychotherapy and Counseling Services

Welcome to my practice. Whether individual, marital, or family therapy, I view the process of therapy as a collaborative journey of identifying and understanding the problems, issues and situations that create barriers to mental, physical and spiritual health. I believe using all available resources and tools to facilitate healing and wholeness. To that end, I believe that the relationship between therapist and client is one of the most important foundational pieces. It is important for you to feel comfortable and safe, without fear of being judged. I will strive to collaborate with you in reaching your goals for therapy and thus a happier and more fulfilling life. If you have any questions or concerns at any time, please feel free to discuss them with me.

Sessions are approximately 45 to 50 minutes in duration. Together we will work to achieve the best possible results for you. However, as a client you have the right to end our counseling relationship at any time if you determine that I am not the right therapist for you. I can provide referrals to other therapists, if you desire. Similarly, if in my judgment, my training and skills are not sufficient to help you, I will inform you of this fact and refer you to another therapist who may be able to meet your needs more effectively.

II. Confidentiality

I will keep confidential anything you say, with the following exceptions: (1) In writing, you direct me to release information to someone else, (2) I determine that you are a danger to yourself or others, or (3) I am ordered by court/judge to disclose information. Also, (4) it is mandatory per Pennsylvania State Law that I report child abuse.

From time to time, I may discuss your case (your name(s) will not be used) with a clinical consultant. By signing this document, you are acknowledging and giving permission for this.

III. Legal Issues

If you are in the midst of any type of legal issue such as litigation, a dispute with your employer, separation or divorce, please inform me immediately. Please be aware that in custody cases, I will need signed permission from both parents, to release information. Please note that medical records are frequently subpoenaed when litigation is involved.

IV. Payment Policy

I agree to provide psychotherapy/counseling services for you in return for a $_____ fee. The fee for each session will be due at the time of service. Cash and personal checks are acceptable for payment. There is a $25 service charge fee for all returned checks. If requested, I will provide you with a receipt for all fees paid.

Initials _____

V. Cancellation/Office Hours

In the even that you will not be able to keep an appointment, you must notify me 24-hours in advance. If I do not receive such an advance notice, you will be responsible for paying a $50.00 cancellation fee. My office is open _____.
My voice mail is available 24 hours a day, 7 days a week.

VI. Emergencies

I cannot assume responsibility for clients' day to day functioning, as some more intensive treatments are designed to do. If necessary, an appropriate referral can be made for a higher level of care that is more intensive. Please keep my phone number handy (484.995.1166). In the case of an emergency, when a client fears harm to him/herself or another, please dial 911 or go to your nearest emergency room.

My signature below indicates that I understand these policies and I grant consent for Margaret A. MacQueen, MS, NBCC, LPC to provide psychotherapy services and counseling to myself and/or minor members of my family. I also acknowledge that I have received a copy of *Clients Rights and Responsibilities.*

Client/Guardian Signature _____ Date _____

Client/Guardian Signature _____ Date _____

Therapist Signature _____ Date _____

To Parents of Teenagers:

I understand the need for confidentiality between my teenager and his/her therapist and that confidentiality will be maintained unless the therapist determines that my teenager us a danger to him/herself or others.

Parent/Guardian Signature _____ Date _____