

**Miracles Inc. Healing Center**  
**Treatment Agreement:**

**Client's Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Please Initial:**

Co -payments are due at the time of service. \_\_\_\_\_

I hereby assign payment of insurance benefits directly to miracles incorporated While Miracles Incorporated will bill my insurance company, I will be responsible for any charges incurred if my insurance company does not pay.

\_\_\_\_\_

It is my responsibility to contact my insurance company to obtain the proper authorizations if required. If I fail to do this and charges are denied I will be responsible for all charges. \_\_\_\_\_

If your portion of the bill is not paid within 90 days from the last date it was incurred a letter will sent giving you 14 days to pay your account or to arrange for a payment plan. If you do not respond you will be sent to collections.

\_\_\_\_\_

A 1% interest will be added to your portion of the bill that remains unpaid after 30 days. \_\_\_\_\_

Returned check fees 35.00 and the check amount.

You will be charged **\$125** for missing an appointment: no show/ not giving at least 24 hours prior notice to canceling an appointment. \_\_\_\_\_

I HAVE received the treatment agreement and disclosure statement I understand and agree to abide by my financial responsibilities. I understand that information will be released to my insurance company, if necessary, and any charges that my insurance company will not cover I am responsible for.

Credit card Visa/MasterCard/Discover number

Name \_\_\_\_\_ Exp \_\_\_\_\_  
Sec. code \_\_\_\_\_

Client Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

To enable my therapist with accurate and confidential services please complete the following:

Please be aware that fax transmissions arrive at Miracles Incorporated office and are distributed to the individual therapist. Confidentiality is maintained with these records, as with all records in our office.

Messages regarding appointments may be left on my voice mail. \_\_\_\_\_ Yes \_\_\_\_\_ No

The following individuals may schedule and or confirm appointments:

\_\_\_\_\_

My Commitment to Recovery/Growth is 25% \_\_\_\_ 50% \_\_\_\_ 100% \_\_\_\_ (Initial)

Miracles Commits 100% every time \_\_\_\_\_ (Therapist Initial)

**Desired services (please check all that apply)**

Counseling	Meditation classes
Vision coach	Acupuncture
Yoga 1-1 or 1-2	Naturepath/physician

Client's Name \_\_\_\_\_

Date \_\_\_\_\_

**Strengths assessment  
(check all that apply)**

Trustworthy  
Listens well  
Kind  
Playful  
Sense of humor  
Flexible  
Spontaneous  
Open to grow  
Courageous  
Forgiving  
Enjoys learning  
Creative  
Walks erect  
Calm  
Fun  
resourceful  
happy most of the day  
good communication skills  
living on purpose  
living up to your potential  
up to date  
decisive  
organized  
keeps your word  
confident  
financially stable  
does not make assumptions  
does not take things personally  
does your best everyday  
friendly  
team player  
relaxes  
eats nutritionally balanced foods  
articulate  
generous  
accepting others  
exercises

**Please check individual items you want to address.  
Please circle the two most important:**

marriage concerns  
improve communication skills  
intimacy  
career/job  
concentration  
health problems  
bowel trouble  
stomach trouble  
self esteem  
hopelessness  
guilt  
sexual problems/perform  
temper  
depressed  
self control  
drug use  
harm to self  
finances  
impulsivity  
alcohol use  
harm to others  
work /career  
high energy  
low energy  
suicidal concerns  
unhappy  
headaches  
attention difficulties  
lack of motivation  
memory  
legal matters  
anger  
sleep problems  
repetitive thoughts  
dreams

abuse  
education needs  
night mares  
trauma  
nervousness  
anxiety  
fears  
stress  
shyness  
meaningless crying spells  
appetite/weight  
unresolved grief  
spiritual concerns  
use of time  
panic  
negative  
eating/food/hording  
stress  
infidelity/affairs  
parenting needs  
jealousy  
divorce/transition  
housing  
physical fighting

**Client's Name**

**Date**

**Health Information:**

List all current medications & vitamins:

\_\_\_\_\_

List all current health problems including allergies:

\_\_\_\_\_

Past psychiatric history (mental health and chemical dependency):hospitalizations(Please Explain)

\_\_\_\_\_

Prior outpatient therapy (include previous practitioners, dates of treatment, previous treatment interventions, response to treatment and/or medications:

\_\_\_\_\_

Name of your Primary Care Physician: \_\_\_\_\_ May we contact? Y/N

Phone number: \_\_\_\_\_

When were you last seen? \_\_\_\_\_

I give my consent or do not give consent (circle) for my therapist, \_\_\_\_\_ to release my records to my primary physician to discuss my treatment:

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

**Risk Assessment**

Suicidal Ideation - None noted Thoughts only Plan Means Attempt Able to contract

Homicidal Ideation - None noted Thoughts only Plan Means Attempt Able to contract

**Drug and Alcohol Assessment:**

Are drugs or alcohol used by yourself or someone else a significant factor in why you are coming to our office? Y / N

If yes , self / other and their relationship to you:

\_\_\_\_\_

Frequency of Alcohol use:

\_\_\_\_\_ never \_\_\_\_\_ less than 1 time/month \_\_\_\_\_ 1-4 times per month \_\_\_\_\_ 2-3 times per week \_\_\_\_\_ daily

Usual Alcohol Consumption:

\_\_\_\_\_ never \_\_\_\_\_ 1-2 drinks per sitting \_\_\_\_\_ 3-4 drinks per sitting \_\_\_\_\_ 5 or more drinks per sitting

Frequency of use to levels of intoxication:

\_\_\_\_\_ never \_\_\_\_\_ 1 time/month \_\_\_\_\_ 2-4 times per month \_\_\_\_\_ 2-3 times per week \_\_\_\_\_ daily

Self-perception of alcohol use:(check all that apply)

\_\_\_ Occasional or social \_\_\_\_\_ Problem use \_\_\_\_\_ Psychological dependence

\_\_\_ Addicted-cannot stop \_\_\_\_\_ Does not want to stop \_\_\_\_\_ Motivated to stop

History of treatment attempts:(check all that apply)

\_\_\_ None \_\_\_\_\_ Stopped on own \_\_\_\_\_ Attended AA/ other 12 step program

\_\_\_ Attended outpatient program \_\_\_\_\_ Attended inpatient program \_\_\_\_\_ Attended community-based program

**Client's Name**

**Date**

**Other Substance use Assessment: (Check Frequency and Duration)**

Choice                      Amount                      Frequency                      Duration                      Last Use

Marijuana

Sedative

Stimulant

Cocaine

Opiates/Narcotics

Inhalants

Hallucinogens

Caffeine

Prescription Meds

Tobacco

Amphetamines

Others:

Please describe any drug-related problems:(e.g. legal, job, physical, or social)

\_\_\_\_\_

Self-perception of Drug Use:(check all that apply)

Occasional or social                       Problem use                       Psychological dependence  
 Addicted-cannot stop                       Does not want to stop                       Motivated to stop

History of treatment attempts:(check all that apply)

None                       Stopped on own                       Attended NA/ other program  
 Attended outpatient program                       Attended inpatient program                       Attended community-based program

List a community resource you are currently benefitting:

\_\_\_\_\_

**Children and Adolescents:**

Developmental History (developmental milestones met early, late, normal):

\_\_\_\_\_

Peri-natal History (details of labor/delivery):

\_\_\_\_\_

Pre-natal History ( medical problems during pregnancy, mother's use of medications):

\_\_\_\_\_

**Risk Factors to Include:**

Non-compliance with treatment	Domestic Violence	Eating Disorder
AMA/elopement potential	Child Abuse	Suicidal/Homicidal
Prior behavioral health inpatient admissions	Sexual Abuse	Other:

**Legal information:**

Do you have a probation officer or case worker? If yes, what is his/her Name, Phone number, and Address:

Do you have an attorney? If yes, what is her/her Name, Phone number, and Address:

**Marital Information:**

Married: \_\_\_\_ Divorced: \_\_\_\_\_ Living together: \_\_\_\_ Separated: \_\_\_\_\_ Single: \_\_\_\_\_

If "other" please explain:

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List dates and lengths of any previous marriages:

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Write 3 of your beliefs that support your life:

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**Miracles Inc. Healing Center  
Treatment Plan**

A treatment goal must be objective and measurable, with estimated time frames for completion. The treatment plan is to be developed with the patient, and the patient's level of understanding/acceptance of the goals developed is to be documented in the medical record.

**Treatment Goals:**

- Reduce Risk Factors of: \_\_\_\_\_
- Reduce Major Symptoms of: \_\_\_\_\_
- Ameliorate Functional Impairments of: \_\_\_\_\_
- Develop Coping Strategies to Deal with the Stress of: \_\_\_\_\_
- Stabilize(short term) Crisis of: \_\_\_\_\_
- Maintain(long term) Stabilization of Symptoms of: \_\_\_\_\_
- Medication referral to: \_\_\_\_\_

**Planned Interventions-Patient Participation:**

- |  |   |
|--|---|
| <input type="checkbox"/> Assertiveness Training      | <input type="checkbox"/> Problem Solving Skills Training  |
| <input type="checkbox"/> Anger Management            | <input type="checkbox"/> Solution Focused Techniques  |
| <input type="checkbox"/> Cognitive Restructuring     | <input type="checkbox"/> Stress Management  |
| <input type="checkbox"/> Communication Training      | <input type="checkbox"/> Supportive Therapy   |
| <input type="checkbox"/> Grief Work                  | <input type="checkbox"/> Self/Other Boundaries Training   |
| <input type="checkbox"/> Imagery/Relaxation Training | <input type="checkbox"/> Decision Option Exploration  |
| <input type="checkbox"/> Parent Training             | <input type="checkbox"/> Pattern Identification and Interruption  |
| <input type="checkbox"/> Addiction Referral          | <input type="checkbox"/> Bibliotherapy <input type="checkbox"/> Support Group <input type="checkbox"/> Homework |

- Engage Significant Others in Treatment \_\_\_\_\_
- Facilitate Decision Making Regarding \_\_\_\_\_
- Explore /Monitor \_\_\_\_\_
- Teach Skills of \_\_\_\_\_
- Educate Regarding \_\_\_\_\_
- Assign Tasks of \_\_\_\_\_
- Referrals Planned \_\_\_\_\_
- Use of Resources/Strengths \_\_\_\_\_
- Preventative Strategies \_\_\_\_\_
- Obstacles to Change \_\_\_\_\_
- Anticipated Frequency of Visits \_\_\_\_\_

**Client Sign** \_\_\_\_\_ **Date** \_\_\_\_\_  
**Therapist Sign** \_\_\_\_\_ **Date** \_\_\_\_\_