HOPE CENTER

Accountability Contract

Welcome Innovator! Congratulations on endeavoring in this course of healing. The HOPE Center is a short-term therapy mental-wellness facility offering free mental-wellness services. Each innovator is allotted 5 sessions and then referred to a long-term therapeutic community partner. HOPE Center practitioners seek to establish a therapeutic alliance through working with all innovators in a collaborative effort. This collaboration is based on the goals and tasks developed by the practitioner and innovator. It is understood the therapeutic alliance is a two-person team effort that is dependent on the innovator's ability to be honest about the ways they engage living, and the practitioner's competence and ability to support the innovator in rallying their inner resources toward wholeness.

If the practitioner or innovator refuses to take the alliance and this course of healing seriously, the process has the potential to be fruitless. For each session the innovator must be equipped with presence in mind and spirit. **If an innovator is 15-minutes late their session will be rescheduled for a later date in-office, by phone, or through e-mail. In addition, refusal to sign the accountability contract affords the innovator a maximum of 3 sessions.**

The practitioner may use a variety of evidenced-based techniques, skill sets, and interventions that are individualized. The healing process has the potential to reveal moments of discomfort, unhealed wounds, and painful circumstances. Do not be alarmed or dismayed, for revelation gives way to transformation.

The healing process and therapeutic alliance also has the potential to yield great benefits in promoting individual internal development, external advancement, and increased spiritual growth. The practitioner agrees to keep all information shared by innovators confidential as provided by law.

It must be understood that confidentiality does not apply if practitioners determine you are a danger to yourself or others, ordered by a court to disclose information, or to any unlawful acts such as sexual and/or physical abuse. There is no statute of limitation for sexual abuse. Each licensed practitioner is obligated by law to report such acts. If you have any questions regarding confidentiality, please feel free to discuss this prior to scheduling an appointment for service.

By signing this form, you are consenting to have your practitioner discuss your case in supervision with the Pastoral Leadership of First Corinthian Baptist Church. Names are not routinely used, however your practitioner's supervisor will have access to the file and will be consulted on occasion. Your signature required below indicates that you understand and agree to the nature and process as stated in this contract and that you agree to release First Corinthian Baptist Church and The HOPE Center of claims of liability.

_____ _____

Participant's Signature Date

_____

Printed Name

_____ _____

Practitioner's Signature Date

Confidentiality Agreement

The confidentiality of all communications between an innovator and a Practitioner is protected by law, and we can only release information about our work to others with your written permission. However, there are a number of exceptions. In most judicial proceedings, you have the right to prevent us from providing any information about your treatment. However, in some circumstances such as child custody proceedings and proceedings in which your emotional condition is an important element, a judge may require my testimony if he or she determines that resolution of the issues before him or her demands it.

There are some situations in which we are legally required to take action to protect others from harm, and this requires revealing some information about a client's treatment. For example, if we believe that a child, an elderly person, or a disabled person is being abused, we must file a report with the appropriate state agency. If we believe an innovator is threatening serious bodily harm to another, we are required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If an innovator threatens to harm him or herself, we may be required to seek hospitalization for the client or to contact family members or others who can help provide protection.

Should such a situation occur, we will make every effort to fully discuss it with you before taking any action. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential challenges, it is important that we discuss any questions or concerns that you may have at our next meeting.

_____ _____

Innovator's Signature Practitioner's Signature

_____ _____

Date Date

HOPE CENTER

"Where Healing Takes Center Stage!"

Pledge to Self and Healing

I, _____, commit to seeing and loving myself
(First and Last Name)

fully. My presence at the HOPE Center as an innovator means I desire to know how to access my power within, to manifest the life I desire and was created for. I will learn to accept all of who I am as beautiful. I commit to learning how to identify and release myself from the internalized judgments that hinder my ability to live life more abundantly. I recognize my engagement in this course of healing speaks to my strength and courage. In this moment I celebrate myself! I am also aware that in order to love those who love me effectively, I must first love myself fiercely. I am determined to Heal On Purpose and Evolve (HOPE).

_____ Printed Name of Innovator

_____ Signature of Innovator

_____ Date

Authorization for Release Of Information

The execution of this form does not authorize the release of information other than that specifically described below. The information on this form is solicited under Title 38 U.S.C. and will authorize release of information you specify. Your disclosure of the information requested on this form is voluntary.

INFORMATION AND REQUEST:

I, _____, voluntarily request and authorize for the release of

☐ Information pertinent to the Psychological or Psychiatric care of the individual specified

☐ Physician diagnoses related to neurological, neuropsychological, or medical status of the individual specified.

for (innovator)_____

from (physician or provider)_____

to (physician or other provider)_____

I certify that this request has been made freely and voluntarily. I understand that I may revoke this authorization at any time. Without my express revocation, the consent will automatically expire: (1) upon satisfaction of the need for disclosure; or (2) on _____(date supplied by patient) or (3) one calendar year from the date of signature below.

_____

Signature of Innovator or person authorized to sign for patient Date

HOPE CENTER

"Where Healing Takes Center Stage"

HOPE Questionnaire

On your HOPE journey we desire to know information that is helpful to us in supporting your wholeness. Please be aware the information you provide is protected as confidential. We applaud your courage and thank you in advance for assisting us as we companion with you to heal on purpose and evolve.

Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

How did you hear about us? _____

Best Phone Contact: May we leave a message? □ Yes □ No
May we send you a Text Message □ Yes □ No

May we email you? □ Yes □ No E-mail*: _____
*Please note: Email correspondence is not considered to be a confidential medium of communication.
Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female
Marital Status: □ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Please list any children/age: _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?
□ No
□ Yes, if so Please list: _____
_____

HOPE CENTER

"Where Healing Takes Center Stage"

HOPE Questionnaire

Have you ever been prescribed psychiatric medication?

□ No

□ Yes, if so please list and provide dates:_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

   Poor Unsatisfactory Satisfactory Good Very good

   Please list any specific health problems you are currently experiencing:

   _____

2. How would you rate your current sleeping habits? (please circle)

   Poor Unsatisfactory Satisfactory Good Very good

3. How many times per week do you generally exercise? _____

   What types of exercise do you enjoy _____

4. Please list any difficulties you experience with your appetite or eating patterns

_____

HOPE CENTER

"Where Healing Takes Center Stage"

HOPE Questionnaire

5. Are you currently experiencing overwhelming sadness, grief or depression?

□ No
□ Yes

6. Are you currently experiencing anxiety, panic attacks or have any phobias?

□ No
□ Yes, if so when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? □ No □ Yes

8. Are you at all concerned about your drinking or drug use? □ No □ Yes

9. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10 (10 = Very Satisfied, 1 = Not Satisfied), how would you rate your satisfaction with this relationship? _____

10. What significant life changes or stressful events have you experienced recently:

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	**List Family Member**
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	

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Schizophrenia	yes/no
Suicide Attempts	yes/no
Bi-Polar	yes/no

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

   If yes, what is your current employment situation:

   _____

   Do you enjoy your work? Is there anything stressful about your current work?

   _____

   _____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

   If yes, describe your faith or belief:

   _____

3. What do you consider to be some of your strengths?

_____

_____

_____

_____

4. What do you consider to be some of your weaknesses?

_____

_____

_____

_____

HOPE CENTER

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HOPE Questionnaire

5. What would you like to accomplish out of your time in therapy?

_____
_____
_____
_____