New Client Intake Form

Date: ____________

Client Name: ______________________________ Preferred Phone: ________________

Address: __________________________ City: ____________ State: ____ Zip: ______

Date of Birth: _____/_____/_____ Ethnicity/Race: ___________________________

Gender: M__ or F__ Client Age: _________ School Grade (if applicable):______

Adult Client/Parent Information Below:

Parent/Guardian's Name (if client is less than 18 years of age): ______________________

Spouse's Name (if married): ____

Marital Status:	**How Long?**
1. ____ Single	______ Years ______ Months
2. ____ Engaged	______ Years ______ Months
3. ____ Married	______ Years ______ Months
4. ____ Separated	______ Years ______ Months
5. ____ Divorced	______ Years ______ Months
6. ____ Remarried	______ Years ______ Months
7. ____ Widowed	______ Years ______ Months

Employment Status:

1. Employed full-time
2. Employed part-time
3. Unemployed
4. Full-time homemaker
5. Retired
6. Full-time student
7. Part-time student
8. Other ________________________

Place of Employment: ________________________ Occupation: ____________________

Work Number: ______________ Cell Phone Number: __________________________

May we leave a "call back" message **at your home**? Y__ N__ **At your work**? Y__ N__

May we leave a "call back" message at your cell phone number? Y ___ N ____

May we contact you via mail at the home/work address given above? Y__ N__

If you would like to be contacted by email instead please provide your email address:

____

Church / Religious affiliation: ____

In case of emergency, please notify (include address & phone number):

____

Please List All Household Members

Name:	Age:	D.O.B.	Relationship:
______________________	_________	____/____/____	_________________
______________________	_________	____/____/____	_________________
______________________	_________	____/____/____	_________________
______________________	_________	____/____/____	_________________
______________________	_________	____/____/____	_________________

Medical History

Currently under Doctor's care: Yes __ No __

Doctors involved in your care/child's care (use reverse side if necessary): ____________

____

Health Problems (include allergies): ____

Medication currently used: NONE ___

Medication	Dosage	Prescribing Doctor	Reason prescribed
_______________	__________	________________	_______________________
_______________	__________	________________	_______________________
_______________	__________	________________	_______________________

Past Hospitalizations:

Date(s)	Reason(s)	Hospital
_______________	______________________	_____________________________
_______________	______________________	_____________________________
_______________	______________________	_____________________________

Previous Counseling, Psychiatric Services or Chemical Dependency Services

Counselor/Facility Name	Date(s)	Reason(s)	Helpful?
______________________	__________	____________________	___________
______________________	__________	____________________	___________
______________________	__________	____________________	___________

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What is the highest level of education you (*the primary client or parent if client is younger than 18 years of age*) have completed?

(circle number)

1. No formal education
2. Some grade school
3. Completed grade school
4. Some high school
5. Completed high school (Diploma or G.E.D.)
6. Some college
7. Completed college
8. Some graduate work
9. A Master's degree
10. A Doctorate degree
11. Other Professional degree (J.D., M.D.)

What concerns bring you to counseling?

What changes do you want to see as a result of counseling?

Please circle ALL of the following items that are currently a concern to you regarding ***YOU AND/OR YOUR PRESENT RELATIONSHIP***.

1. Premarital Counseling
2. Marital relationship
3. Remarried relationship
4. Poor communication
5. Sexual difficulties
6. Parenting concerns
7. Anxiety
8. Depression
9. Family relationships
10. Excessive alcohol/drug use
11. Stress
12. Self-esteem
13. Physical problem
14. Suicidal thoughts
15. Suicide Attempt
16. Incest
17. Childhood Emotional abuse
18. Childhood Physical abuse
19. Childhood Sexual abuse
20. Financial concerns
21. Anger
22. Grief/Loss
23. Work related concerns
24. Illness
25. Physical Abuse/Violence
26. Verbal Abuse/Violence
27. Eating Disorder
28. Cutting/Self-Mutilating Behaviors
29. Rape
30. Divorce Contemplation
31. Divorce Recovery
32. Custody issues
33. Other (please describe) ____

GO TO NEXT PAGE

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Please circle ALL of the following items that are currently a concern to you regarding
YOUR CHILD OR CHILDREN (IF APPLICABLE).

____ NOT APPLICABLE

1. Stealing
2. Poor communication
3. Physical violence
4. Fire setting
5. Truancy
6. Drugs/alcohol
7. Adolescent pregnancy
8. Sexual **abuser**
9. Sexual abuse victim
10. Physical abuse victim
11. Divorce adjustment
12. Death/loss/grief
13. Anger
14. High anxiety
15. Peer relationships
16. Poor self-esteem
17. Bedwetting/soiling
18. Destructiveness
19. Issues with stepchildren/step-parenting
20. Disobedience
21. ADD/ADHD concerns
22. Depression
23. Eating Disorder
24. Cutting/Self-Mutilating Behaviors
25. Suicide Attempt
26. Other (please describe) ____

Please use the section below to list / describe the various strengths / positive attributes you, your spouse, your child, etc. possess:

____

____

____

____

____

____

____

____

How did you hear about Lifeway Counseling Center?

_____ Facebook _____ Foursquare _____ Twitter _____ Google Ads
_____ Brochure _____ Church _____ Direct Mail _____ Bing Ads
_____ Doctor _____ Friend _____ Attorney
_____ Psychology Today Listing _____ Other ____________________

May we send the person who referred you a "Thank You" for the referral?
If yes, please provide the referring person's name and address below:

____

____

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POLICIES AND PROCEDURES

ABOUT OUR FEES

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FEES

- ♦ Usual and customary fees are $120.00 for an individual, 50-minute counseling session. ***Should a session last more than the usual 50-minutes, fees will be adjusted accordingly***.
- ♦ Phone consultations that last longer than 15 minutes are subject to half the usual and customary fee.
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USING INSURANCE

- ♦ At the present time, Lifeway Counseling Center accepts only Blue Cross/Blue Shield. Please check with your specific therapist for more information. Please note:
  - o We will file insurance only with plans the therapists / counselors are contracted with. **All insurance co-payment and/or deductible amounts are due at the time of the service.** Any disallowed amounts are due from the patient.
  - o Your insurance policy is a contract between you and your insurance company. It is important that you understand what counseling / therapy services are and are not covered, before seeing your counselor / therapist. There is no guarantee of payment of your claims by your insurance company. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. **If any portion of your claim or any service is not covered by your insurance, you will be responsible.**

I ________________________________ understand that I am responsible for all charges not paid by my insurance company(ies). I consent to pay for these charges in a timely manner in accordance with office policy. I am also responsible for

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all charges incurred by the office in collecting on my account if my bill goes unpaid, including but not limited to collection agency fees, attorney fees, and court costs.

My signature below serves as authorization to release to my insurance company(ies) any information acquired in the course of my examination, evaluation or treatment for the purpose of reimbursement by my insurance company to Lifeway Counseling Center and/or my specific counselor/therapist. I authorize direct payment by my insurance company(ies) to Lifeway Counseling Center and/or the specific therapist with whom I am working. I attest that a copy of the below signature for insurance purposes is as valid as the original.

X ____ ________________

Signature of client or parent / guardian *Date*

OTHER FEES AND SERVICES

COURT RELATED SERVICES

- Court testimony costs begin at $250.00 an hour with a minimum charge of three hours. A retainer of $1000.00 is ***due one week prior*** to the court date. Travel is billed at .50/mile. Failure to provide the specific fees as described constitutes a release from the requested court appearance.
- It is required that a minimum of 36 hours' notice be given if the testimony is not required, otherwise the entire retainer is forfeited. If proper notice is given, the retainer will be refunded.
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- Clients using PC/PF services are required to complete separate intake and consent for treatment paperwork which can be found on our website.

CAREER COUNSELING AND ASSESSMENTS

- For career counseling and assessments, usual and customary rates are between $75.00 and $95.00 depending on the specific needs of the client.

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GROUP COUNSELING

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- ♦ All Supportive Out-Patient (SOP) groups are billed at $45.00 a session. Average length of time for the SOP group is eight (8) sessions.

PAYMENT

- ♦ Payment is to be made prior to the beginning of each session / group and all checks need to be made payable to: ***LCC**. **Please note that there will be a $25.00 fee assessed for any returned check.***

I understand that my fee will be $____________for each counseling session or $___________ for court related services. **(Please initial ______)**

CLIENT COMMITMENT TO LIFEWAY COUNSELING CENTER

I, _______________________ will make every effort to come for each counseling appointment. If it is necessary to cancel an appointment, I understand that this should be done at **least 24 hours in advance**. Should I fail to notify the counselor and miss an appointment, I understand that the usual fee will be assessed and that it will be my responsibility to pay for the missed session. Further, should I need to reschedule an appointment, I understand that fees will be assessed based on the following schedule regardless of whether insurance is being used:

24 hour notice (or more) = *no charge*
Less than 24 hour notice = *35% of normal fee*
Less than 8 hour notice = *65% of normal fee*
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X____ _______________
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STATEMENT OF CONFIDENTIALITY

Confidentiality: Under Texas law, a counselor cannot guarantee confidentiality under the following circumstances:

1. There is suspected or witnessed child abuse or a belief that a child may be in imminent danger of abuse/maltreatment
2. There is suspected or witnessed elder abuse or a belief that an elderly person may be in imminent danger of abuse/maltreatment
3. There is suspected or witnessed abuse of a disabled person or a belief that a disabled person may be in danger of abuse/maltreatment

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4. There is a threat of suicide / homicide, in which case the counselor may contact the appropriate authorities who can help prevent harm
5. In response to a properly issued subpoena from the court or order from a presiding judge.
6. There is a request from the State Licensing Agency for the client's records. In this event, those records shall be made available for the purpose of insuring professionalism.

I have read, understand and agree to the limits to confidentiality:

X ____ ________________

(Signature of client or parent/guardian) *Date*

ADDITIONAL CONFIDENTIALITY NOTICE REGARDING TREATMENT BY AN LPC-INTERN / LMFT ASSOCIATE:

- If you are receiving treatment from one of our LPC-Interns / LMFT-Associates, all LPC-Interns and/or LMFT-Associates are in their post-Master's degree clinical rotations and hold a provisional licensure. They are currently earning hours towards full licensure. You, the client, may, at any time, request to see an Intern's / Associate's supervisor, **Sean Stokes, Ph.D., LPC-S, LMFT-S** (Lifeway Counseling Center PLLC, PO Box 50084, Denton, TX 76206, 940-382-0109) for concerns or questions regarding your experience.

- Further, by signing below, you, the client, are stating that you understand that if you are receiving treatment by an LPC-Intern / LMFT-Associate, the dynamics of your case will be discussed for staffing and licensure / educational requirements with the LPC Intern / LMFT Associate and their supervisor.

I have read, understand and agree to the limits to confidentiality if I am being treated by an LPC-Intern / LMFT-Associate:

X ____ ________________

(Signature of client or parent/guardian) *Date*

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DISCLOSURE STATEMENT & CONSENT FOR TREATMENT

RISKS AND BENEFITS

You have the right to competent, quality treatment that is consistent with professional standards established in practice and supported by research. Please be aware that the therapeutic process may involve personal awareness that may be emotionally painful, may cause heightened emotions, may cause anxiety, tension or stress and may cause some disruption or turmoil in your life as well as the lives of your significant others due to the subject matter being disclosed.

Counseling/therapy also has the potential to provide emotional support and stability for any family member involved in therapy. Further, it may relieve anxiety and create a safe environment for children or family members who are distressed. Finally, counseling/therapy has the potential for creating positive life changes in the form of long-term solutions to difficulties, and creating better communication. No guarantee can be offered for services as to results.

DESTRUCTION OF RECORDS

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ACKNOWLEDGEMENT OF HIPAA NOTICE

All clinical records are stored and maintained according to HIPAA guidelines. As a consumer of mental health / behavioral health services, you have certain rights under HIPAA guidelines. By signing below, you are attesting to the fact that you have read and that you understand the HIPAA guidelines as outlined in the HIPAA notice posted on our website and/or in our office.

CRISIS / AFTER-HOURS SERVICES

We do not provide 24-hour crisis stabilization services. If you experience a crisis, please contact 911 or immediately go to your nearest emergency room. You may also contact the Denton County MHMR Crisis Hotline at: 1.800.762.0157.

INCAPACITY OR DEATH

In the event of the death or incapacitation of your counselor / therapist it will be necessary to assign care, custody, and control of your treatment records to another professional within our office. By your signature on this form, in the event of the

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death or incapacitation of your counselor / therapist, you hereby consent for Lifeway Counseling Center, PLLC to assign another counselor/therapist employed by Lifeway Counseling Center, PLLC to take possession of your treatment records and provide copies at your request, or to deliver those records to another therapist of your choosing.

ACKNOWLEDGEMENT & CONSENT TO TREATMENT

I have read and understand all the above statements (**session / court fees**, **client commitment**, **limits to confidentiality** & **the disclosure statement**) and I / WE VOLUNTARILY CONSENT TO TREATMENT.

Signature of self/parent/legal guardian:

____

Signature of spouse / witness: ______________________________

Date: ____

____

Any suspected violations of counselor ethics may be reported in writing to the following governing agencies:

TX State Board of Examiners of Professional Counselors OR TX State Board of Examiners of Marriage & Family Therapists

Complaints Management and Investigative Section
P.O. Box 141369 Austin, Texas 78714-1369
http://www.dshs.texas.gov/counselor/
http://www.dshs.texas.gov/mft/default.shtm

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(CLIENT COPY OF POLICIES & PROCEDURES)

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Signature of spouse / witness: ____

Date: ____

____

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Complaints Management and Investigative Section
P.O. Box 141369 Austin, Texas 78714-1369
http://www.dshs.texas.gov/counselor/
http://www.dshs.texas.gov/mft/default.shtm

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