Lifeway Counseling Center

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:

1. _____ Single
2. _____ Engaged
3. _____ Married
4. _____ Separated
5. _____ Divorced
6. _____ Remarried
7. _____ Widowed

How Long?

_____ Years _____ Months
_____ Years _____ Months
_____ Years _____ Months
_____ Years _____ Months
_____ Years _____ Months
_____ Years _____ Months
_____ 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?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

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:

_____

_____

POLICIES AND PROCEDURES

ABOUT OUR FEES

The practice of Lifeway Counseling Center, PLLC strives to provide comprehensive, ethical and cost-effective mental health / behavioral health care for our clients. In order for us to continue this mission, we have instituted the following policy. **If you do not understand these policies, please ask our staff to explain before you are seen.**

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.
- A sliding fee scale is available for appointments with LPC-Interns and/or LMFT-Associates and is negotiated based on a formula derived from household income and number of dependents. **Interns / Associates do not accept insurance**. All Interns/Associates are under supervision by a Board Approved Supervisor who is a licensed clinician.

PAYMENT

- Payment is to be made prior to the beginning of each session. We accept all major credit cards, cash or check as forms of payment. If paying by check, please make it payable to: ***LCC***. ***Please note that there will be a $25.00 fee assessed for any returned check.***

IF YOU ARE USING INSURANCE

- At the present time, Lifeway Counseling Center accepts only Blue Cross/Blue Shield PPO. Please check with your specific therapist for more information. Please note:

    - 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.

    - 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 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 any information acquired in the course of my 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*

I AM NOT USING INSURANCE and understand that my fee will be $120.00 per session.

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.
- Additional services related to court preparation including all correspondence with attorneys or other service providers via phone, email or letter, documentation review and/or documentation preparation are also billed at $250.00 per hour, rounded to the nearest 15-minute increment.

- In cases where a therapist is being contracted to work with a child in a divorce/custody case, a certified copy of the temporary orders or divorce decree must be provided prior to the therapist beginning treatment.
- Parenting Coordinator / Parenting Facilitator services begin at $175.00 an hour rounded to the nearest 15-minute increment and requires a $700.00 retainer prior to beginning services. Services include any and all correspondence / phone consultations / production of written documentation or review of written documentation with attorneys or other professionals involved in the case as well as correspondence between the parties.
- Clients using PC/PF services are required to complete separate intake and consent for treatment paperwork which can be found on our website.

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*
Failing to show for appointment without notification = *full fee*

X_____ _____
Signature of client or parent/guardian *Date*

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
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, 8105 Rasor Blvd., Ste 293, Plano, TX, 75024, 214.620.5469) 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*

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

All communication with your therapist / counselor becomes part of the clinical record. Files are closed once the counseling relationship ends. Records for adult clients are destroyed seven years after the file is closed. Records for minor clients are destroyed seven years after the client turns 18 years of age. Records are the property of Lifeway Counseling Center. If at any time in the future you would like to request a copy of your records, you will need to submit a written letter of request in which your therapist / counselor has up to 15 days to produce copies (at a cost of $.50/page) for you. For more information on records request, please see the Texas Health and Safety Code, Title 7, Subtitle E, Chapter 611.

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 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

(CLIENT COPY OF POLICIES & PROCEDURES)

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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