
# New Client Intake Form

Date: _____

Client Name: _____ Preferred Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

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

Gender: ◯ M ◯ F Client Age: _____ School Grade (if applicable): _____

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

_____

Spouse's Name (if married): _____

**Marital Status**:

Single ◯ Engaged ◯ Married ◯
Separated ◯ Divorced ◯ Remarried ◯ Widowed ◯

**Employment Status**:

_____ Employed full-time
_____ Unemployed
_____ Retired
_____ Part-time student
_____ Employed part-time
_____ Full-time homemaker
_____ Full-time student
_____ Other _____

Place of Employment: _____ Occupation: _____

May we leave a "call back" message at your preferred phone number? ◯ Yes ◯ No

May we contact you via mail at the home address given above? ◯ Yes ◯ No

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 concerns bring you to counseling?

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

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

_____ Premarital Counseling
_____ Remarried relationship
_____ Sexual difficulties
_____ Anxiety
_____ Family relationships
_____ Stress
_____ Physical problem
_____ Suicide Attempt
_____ Childhood Emotional abuse
_____ Childhood Sexual abuse
_____ Anger
_____ Work related concerns
_____ Physical Abuse/Violence
_____ Eating Disorder
_____ Cutting/Self-Mutilating Behaviors
_____ Divorce Recovery
_____ Marital relationship
_____ Poor communication
_____ Parenting concerns
_____ Depression
_____ Excessive alcohol/drug use
_____ Self-esteem
_____ Suicidal thoughts
_____ Incest
_____ Childhood Physical abuse
_____ Financial concerns
_____ Grief/Loss
_____ Illness
_____ Verbal Abuse/Violence
_____ Rape
_____ Divorce Contemplation
_____ Custody issues
_____ Other (please describe) _____
_____
_____

**GO TO NEXT PAGE**

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If coming to counseling regarding concerns about your child / children, please check ALL of the following items that apply

____ NOT APPLICABLE

_____ Stealing
_____ Physical violence
_____ Truancy
_____ Adolescent pregnancy
_____ Sexual abuse victim
_____ Divorce adjustment
_____ Anger
_____ Peer relationships
_____ Bedwetting/soiling
_____ Issues with stepchildren/step-parenting
_____ ADD/ADHD concerns
_____ Eating Disorder
_____ Cutting/Self-Mutilating Behaviors
_____ Poor communication
_____ Fire setting
_____ Drugs/alcohol
_____ Sexual **abuser**
_____ Physical abuse victim
_____ Death/loss/grief
_____ High anxiety
_____ Poor self-esteem
_____ Destructiveness
_____ Disobedience
_____ Depression
_____ Suicide Attempt
_____ 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 _____ 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

The practice of Lifeway Counseling Center, PLLC strives to provide comprehensive, ethical and cost-effective mental health / behavioral health care for our clients. 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 $125.00 for a 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.

### 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.***
- You must complete a credit card authorization form prior to your first appointment. Your card and accompanying authorization will be stored on file.

### IF YOU ARE USING INSURANCE

- Currently, Lifeway Counseling Center only accepts 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.**

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**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 $125.00 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.

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## LATE CANCELLATION / NO-SHOW FEES

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*

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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

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 six years after the file is closed. Records for minor clients are destroyed six 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 at which time your therapist / counselor has up to 15 days to produce copies (at a cost of $.50/page) for you upon receipt of your written request. 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

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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 or its agent 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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### FEES

- Usual and customary fees are $125.00 for a 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.***
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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.**

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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
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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

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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 or its agent 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: _____

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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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