Robert W. Bosworth, Jr., M.Div., Ph.D.

**Pastoral Counseling Agreement**

Counseling is a serious commitment on the part of the counselor and client. In counseling, clients determine the issues they want to address. Relationships, behaviors and patterns will be examined and often challenged. The first few sessions provide an opportunity for client and counselor to create a good working relationship and for the counselor to assess the presenting problems and recommend treatment. Goals and treatment plans are agreed upon mutually. Clients have a right to refuse any services offered. Counseling services are not always beneficial for a variety of reasons. Dr. Bosworth encourages clients to utilize other community resources to enhance, supplement or replace its services when needed to accomplish clients’ goals.

**Faith is an integral component of Pastoral Counseling.** Clients should expect the counselor to apply a religious dimension to their treatment plan in order for them to achieve the *fullness of life* that God created them to enjoy.  
  
**I have read and understand the following from Dr. Bosworth’s website (**<http://www.Dr-Bosworth.com>**):**

* Counseling appointments are usually scheduled for forty-five to fifty minutes.
* **Client and Counselor are to arrive on time and prepared for each session**, including having all homework completed.
* **Clients will be billed for $25 if he/they miss an appointment without providing 24 hours’ notice to the counselor.**
* **The counselor may adjust the above fee at his discretion in case of emergency.**
* ​The counselor will cancel/reschedule sessions only when necessary, giving the client a reason for so doing.
* **Client and Counselor will silence all electronic devices and will not answer them during sessions.**
* **Children under the age of fourteen** will not be left unsupervised in the building during counseling sessions.
* **Dr. Bosworth does not provide child-sitting services.**
* Client will not hold counselor or hosting building responsible for any damage done to cars driven to sessions.
* Client will provide the counselor with what he/they would like addressed/worked on in any particular session.
* Client agrees to inform the counselor in writing of any changes in contact information and/or medication.
* **Client/Counselor relationships work best when the client does not engage other counselors to discuss the same subjects.**
* Counselor will give client(s) an explanation in writing why the counselor/client relationship is to be terminated.
* **The counselor and client(s) will agree on a fee BEFORE the first counseling session ends.**
* Client understands that **payment is due at the time the counseling is provided**. Dr. Bosworth accepts check and credit/debit cards. Cash payments are discouraged.
* Client agrees to prepare for the session by thinking about where they are with their progress;
* **Client agrees to complete all “homework” assignments prior to the session;**
* C**lient** agrees to inform the counselor of changes in medication, household, email, and contact information, including but not exclusive of unlisted telephone numbers and cellular phone numbers;
* **Clients agree to come for no fewer than four appointments**. At that time a treatment plan is presented.
* **Client and Counselor will decide whether to continue counseling after the treatment plan is explained.**

**With respect to client/counselor confidentiality, I understand the following statements.**  
**​**Dr. Bosworth will keep confidential what is told privately in therapy sessions. All client is securely stored either in locked filing cabinets or on electronic devices (computers, etc.) protected with passwords. Health Insurance Portability and Accountability Act (HIPAA) regulations for client privacy and security are supplied in writing to each client before therapy begins. Information will not be released to anyone without the client's written consent. The following are HIPAA-approved exceptions to this policy:

* Mandatory reporting of child/adult abuse - KRS 630.020 states that "any person who knows or has reasonable cause to believe that a child/adult is dependent, neglected or abused: must report the same." KRS 209A.030 mandates the same for reporting adult abuse, which includes spouse abuse.

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* Duty to warn obligation - KRS 202A.400 mandates all mental health professionals to warn intended victims of client's threats of violence. Any threats of violence must be reported to any identified person and proper law enforcement authorities. In the absence of an identified person, law enforcement authorities alone are contacted.
* When a therapist judges a client to be at immediate risk for suicide and/or in need of emergency hospitalization, confidentiality is waived for the protection of the client.

I have read, understand and consent to abide by this agreement.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client/s (Parent/Guardian must sign with minor or dependent) Date

**FOR USE ONLY DURING THE FIRST SESSION**

The section below will be initialed and signed DURING your first session. Please DO NOT INITIAL prior to the session.

We have reviewed and discussed this counseling agreement together. My counselor has given me a copy of their Notice of Privacy Practices, as required by the Health Insurance Portability and Accountability Act of 1996.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/s (Initial if signed above) Counselor Date

Continue to the next page

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**INDEMNITY AGREEMENT**

**THIS INDEMNITY AGREEMENT**(the "Agreement")

made as of this \_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_ A.D. 20\_\_\_ (the "Execution Date"),

**BETWEEN:**  
**Dr. Robert W. Bosworth, Jr. of Fort Worth, Texas**

(the "Indemnitee")

OF THE FIRST PART

And

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
(the "Indemnifier")

OF THE SECOND PART

**BACKGROUND:**

1. The Indemnitee desires protection against any personal liability, claim, suit, action, loss, or damage that may result from the Indemnitee's participation in Activity.
2. The Indemnifier wishes to minimize any hardship the Indemnitee might suffer as the result of any personal liability, claim, suit, action, loss, or damage that may result from the Indemnitee's participation in the Activity.

**IN CONSIDERATION**and as a condition of the Indemnifier and the Indemnitee entering into this Agreement and/or other valuable consideration, the receipt and sufficiency of which consideration is acknowledged, the Indemnifier and the Indemnitee agree as follows:

1. **Definitions**
2. The following definitions [apply](http://www.lawdepot.com/contracts/hold-harmless-agreement/preview.aspx?loc=US&) in the Agreement:
   1. "Activity" means the following: Pastoral Counseling.
   2. "Expenses" means all costs incurred in the defense of any claim or action brought against the Indemnitee including attorneys' fees.
   3. "Notice of Claim" means a notice that has been provided by the Indemnitee to the Indemnifier describing a claim or action that has or is being brought against the Indemnitee by a Third Party.
   4. "Notice of Indemnity" means a notice that has been provided by the Indemnitee to the Indemnifier describing an amount owing under this Agreement by the Indemnifier to the Indemnitee.
   5. "Parties" means both the Indemnitee and the Indemnifier.
   6. "Party" means either the Indemnitee or the Indemnifier.
   7. "Third Party" means any person other than the Indemnifier and the Indemnitee.
3. **Indemnification**

The Indemnifier will hold harmless and indemnify the Indemnitee against any and all claims and actions arising out of the participation of the Indemnitee in the Activity, including, without limitation, Expenses, judgments, fines, [settlements](http://www.lawdepot.com/contracts/hold-harmless-agreement/preview.aspx?loc=US&) and other amounts actually and reasonably incurred in connection with any liability, suit, action, loss, or damage arising or resulting from the Indemnitee's participation in the Activity. Where prohibited by law, the above indemnification does not include indemnification of the Indemnitee against a claim caused by the negligence or fault of the Indemnitee, its agent or employee, or any third party under the control or supervision of the Indemnitee, other than the Indemnifier or its agent, employee or subcontractors.

1. In the case of a criminal proceeding, the Indemnitee will not be indemnified by the Indemnifier.
2. The Indemnifier understands that the Indemnitee is not responsible for the results of the Activity and agrees not to sue the Indemnitee for any reason, except where prohibited by law.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Indemnifier Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

R.W.Bosworth, M.Div., Ph.D./Indemnitee Signature Date

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The Rev’d Robert W. Bosworth, Jr., M.Div., Ph.D.

**Pastoral Counseling Questionnaire**

Privacy Policy – Please Review

\*\* This information is covered by the Electronic Communications Privacy Act, 18 U.S.C. Section 2510-2521 and is legally privileged. This information and any attachments hereto may contain confidential information intended only for the use of the individual or entity named below. If you are not the intended recipient(s), or the employee or agent of the intended recipient(s), you are hereby notified that any dissemination, distribution or copying of this information is strictly prohibited. If you have received this information in error, please immediately notify the sender and delete this information from your computer. The sender does not waive any privilege in the event this information was inadvertently disseminated. \*\*

**Contact Information**

Name

Your Date of Birth

Your Age

Your Email

Note: Email correspondence or texting is not considered to be a confidential means of communication.

Your Primary Phone

Is it okay to leave a message on this phone? Yes No

May I text you on this phone? Yes No

Your Secondary Phone

Is it okay to leave a message on this phone? Yes No

May I text you on this phone? Yes No

Street Address

City

State

ZIP Code

Your Spouse's Name (if applicable)

Your Spouse’s Email (if applicable)

Your Spouse’s Place of Employment (if applicable)

**Education and Occupation**

The highest education you have received High School College Grad School Post-Grad School

Degree(s) Earned

Employer

Position

How long at present job?

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**Family Information**

Marital Status

Living together Engaged Married Separated Divorced

Is your partner supportive of you seeking counseling? Yes No Don't Know

Date of Marriage

Previous marriages: 0 1 2 3 4 5 or more

How did the previous marriage(s) end and when?

Do you have children or step-children? 0 2 3 4 5 or more

Names and ages of children

If client is a child, please complete the following information.

Name, address and phone numbers of guardian(s)

Name, address and phone numbers of non-custodial/other parent

Names of siblings

With whom does the child reside?

Is the other parent / guardian aware of and supportive of counseling? Yes No Don't know

Child's school and grade level

Child's school performance / behavior Excellent Good Fair Poor

Emergency Contact Information

Name

Phone

**Referral Source**

How did you hear about Dr. Bosworth? A friend Internet Dr-Bosworth.com Facebook

Family member Priest/Minister

Is it okay for me to contact that person and thank them for their referral? Yes No Phone:

**Current Situation**

What made you start coming to therapy at this time?

What do you see as the single biggest problem?

What issues, situations, or other events do you think have contributed to this difficulty?

How do you manage stress? (Hobbies, exercise, interests, social relationships, etc.)

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**Health History**

Your medical doctor:

Doctor's Phone Number

Date of last physical exam

Reason for exam

List any prescriptions and over-the-counter medications that you presently use for any physical or medical condition:

Please list any specific health problems you are currently experiencing:

How would you rate your current sleeping habits on a scale of 1-10 (1 being Horrible; 10 being great)?

1 2 3 4 5 6 7 8 9 10

**Family and Social Relationships**

How would you rate your current marital satisfaction? (How good is your marriage?)

1 2 3 4 5 6 7 8 9 10

How would you rate your relationships with co-workers and/or friends?

1 2 3 4 5 6 7 8 9 10

How would you rate your current relationship with your children/stepchildren?

1 2 3 4 5 6 7 8 9 10

**Counseling History**

Have you been in counseling before? If yes, with whom?

May Dr. Bosworth contact that counselor for records/case notes? Yes No Phone:

What was the primary problem for which you were in counseling?

When was the counseling?

For how long?

What was the outcome?

Have you ever been in a hospital or residential program for emotional/ behavioral problems? Yes No

If yes, when and where?

If yes, what was the outcome?

Have you ever taken medication(s) for emotional or behavioral problems? Yes No

If yes, what are the medications?

If yes, which physician is prescribing these medications?

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**Substance Abuse**

Have you **ever received treatment** for substance abuse? Yes No

If yes, when and where?

Are you **currently** using any of these substances? (Circle or highlight the substance(s).)

Alcohol

Marijuana

Heroin

Amphetamines

Ecstasy

Meth

Barbiturates

PCP

Cocaine

Opiates

Sedatives

LSD

Designer Drugs

**Have you ever used** any of these substances in the past? (Circle or highlight the substance(s).)

Alcohol

Marijuana

Heroin

Amphetamines

Ecstasy

Meth

Barbiturates

PCP

Cocaine

Opiates

Sedatives

LSD

Designer Drugs

**Legal History**

Are you currently, or have you ever been, involved with the legal system? Yes No

If yes, for what reasons?

(truancy, traffic tickets, juvenile offenses, etc.)

Do you anticipate being involved in further legal action in the future? Yes No

If yes, please explain. (criminal, divorce, custody, civil, etc.)

Have you ever sued a doctor, counselor, healthcare professional or hospital Yes No

If yes, please explain.

**Finally**

What losses, changes, or crises have made a big impact on your life? What age were you when these changes occurred?

What do you consider to be some of your personal strengths and resources?

What do you consider to be some of your family's strengths and resources?

**Write a narrative, telling me about yourself, what you’re facing that’s bringing you to counseling, and what you hope to get out of counseling at this point.** (You may write this below or on another sheet of paper.)

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**Confidential Financial Information**

**This page is only necessary if you are not able to pay $125/hour for your visits.**

If you can pay full fare ($125/hour), please leave this page blank.

*This page will be helpful in determining what you will be able to pay for counseling.*

Monthly Household Income (including everyone who works outside the home: $ \_\_\_\_\_\_\_\_\_\_

Monthly Alimony/Child Support Income of Payment (underline which) $ \_\_\_\_\_\_\_\_\_\_

Monthly Mortgage/Rent Payment $ \_\_\_\_\_\_\_\_\_\_

Monthly total of all Car Payments $ \_\_\_\_\_\_\_\_\_\_

Monthly total of Automobile Insurance $ \_\_\_\_\_\_\_\_\_\_

Total of all Monthly Utilities $ \_\_\_\_\_\_\_\_\_\_

Monthly total of all Non-Public School Tuitions $ \_\_\_\_\_\_\_\_\_\_

Total spent per month on Day-Care for small children or elderly adults $ \_\_\_\_\_\_\_\_\_\_

Monthly Out-of-Pocket Health Insurance Payment $ \_\_\_\_\_\_\_\_\_\_

Additional Monthly Incomer (from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) $ \_\_\_\_\_\_\_\_\_\_

Additional Large Monthly Expense(s) $ \_\_\_\_\_\_\_\_\_\_

**Thank you for taking your time and completing these forms. They will help us spend more time on your reasons for coming to counseling, and less on the necessary paperwork that is required. Additionally, if these forms are emailed or posted back to Dr. Bosworth 48 hours before your first visit, considerable time will be saved on this visit, enabling us to spend our time more productively, therefore saving time and money.**

**Dr. Bosworth conforms to the requirements of the Privacy Act commonly knon as HIPPA. If you are unfamiliar with these policies, please request a copy of them and they will be provided for you.**

**I DO need a copy of the HIPPA policies \_\_\_\_**

**I DO NOT want HIPPA policies\_\_\_\_ your Initials: \_\_\_\_\_\_\_\_\_\_\_**