

# INTAKE FORM FOR NEW CLIENTS

Client Information			
First Name:		Today's Date:	
Last Name:		Date of Birth:	
Relationship Status:		How Long?:	
Race/Ethnicity:		Gender:	
Contact Information			
Home/Cell Phone:		OK to leave a message? Y / N	
Work Phone:		OK to leave a message? Y / N	
Email:		OK to send email to you? Y / N	
Mailing Address:		OK to send you information? Y / N	
Emergency Contact Information			
Emergency Contact Name:			
Emergency Contact Name:Emergency Contact Relationship:			
Emergency Contact Phone Number:			
How Were You Referred?			
☐ Found On My Own		Friend/Family	
☐ Facebook/LinkedIn		Attorney	
□ Website		Church	
☐ Psychology Today Listing		Other:	
☐ Counselor/Doctor/Clinician	Ш	ouler.	
Current Employment Status			
□ Full-time		Student	
□ Part-time		Retired	
□ Unemployed		Other:	
☐ Homemaker			
<b>Employment Information</b>			
Current Job Title:			
Current Employer.			
Skills Used in Current Position:			



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

1.	Premarital counseling	14. Suicidal thoughts	25. Verbal abuse/violence
2.	Marital relationship	15. Suicide attempt	26. Gender identity
3.	Remarried relationship	16. Childhood emotional	27. Cutting/self-harm
4.	Poor communication	abuse	behavior
5.	Parenting concern	17. Childhood physical	28. Divorce contemplation
6.	Sexual difficulties	abuse	29. Custody issues
7.	Anxiety	18. Incest	30. LGBT issues
8.	Depression	19. Anger	31. Eating disorder
9.	Family relationships	20. Grief/loss	32. Illness
10.	. Alcohol/drug abuse	21. Financial concerns	33. Rape
11.	. Stress	22. Work related concerns	34. Divorce recovery
12.	. Physical problem	23. Job loss	35. Other:
13.	. Self-esteem	24. Physical abuse/violence	

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

1.	Stealing	10. Adolescent pregnancy	19. Depression
2.	Poor communication	11. Sexual abuse victim	20. Bedwetting/soiling
3.	Fire setting	12. Divorce adjustment	21. Issues with step-
4.	Drugs/Alcohol	13. Anger	children/step-parenting
5.	Sexual abuser	14. High anxiety	22. ADD/ADHD concerns
6.	Physical abuse victim	15. Peer relationships	23. Eating disorder
7.	Physical violence	16. Poor self-esteem	24. Suicide attempt
8.	Death/loss/grief	17. Destructiveness	25. Cutting/self-harm
9.	Truancy	18. Disobedience	behavior
			26. Other:



### CONSENT AND INFORMATION FORM FOR COUNSELING SERVICES

We are very pleased and honored that you have chosen Family Matters Counseling Center, LLC. Please take the time to carefully read the following information regarding some important aspects of the counseling process. If you have any questions at all, please do not hesitate to discuss them with us.

### CONFIDENTIALITY

Confidentiality refers to the process whereby the information that is shared by you with your counselor is kept private. In fact, even your identity as a client will remain confidential unless you yourself choose to disclose this information to someone else. Therefore, information regarding your counseling will not be released without your written authorization. However, please understand that in certain specific instances, there are limits to this confidentiality agreement. (1) In cases where a counselor has reason to believe that a person may be in imminent danger of harming him/herself or others, the counselor may notify the proper authorities. (2) The State of Texas mandates that any person who knows or suspects that a child, an elderly person, or a disabled person is in danger of being physically, emotionally, or sexually abused must report such abuse or suspected abuse to the proper authorities. Counselors are also required to report suspected or actual sexual exploitation of counseling clients by mental health professionals. (3) In Texas, confidentiality does not extend to criminal proceedings or to legitimate subpoenas from a judge in civil proceedings. If a court subpoenas counseling records, the therapist is required to provide the requested information.

### BENEFITS/OUTCOMES

Counseling will seek to meet goals established by the individual. A major benefit that may be gained from participating in counseling includes a reduction in distress and a better ability to handle or cope with conflict, and gain confidence and assurance. Other benefits relate to the probable outcomes resulting from continued progress and effort put into the counseling process by the individual. I will do my best to assess progress on a regular basis and solicit your feedback regarding the counseling process to help provide you with the needed help you are seeking.

### REALISTIC EXPECTATIONS

Work outside of the counseling sessions is a necessary element for success; therefore, we may ask you to perform some 'homework' related to your goals and our session content. We promise to work as efficiently as possible; at the same time, counseling may move more slowly than you anticipated. We will review your goals with you periodically, and we ask that you request a conversation about the status of our counseling whenever you have questions about progress.

### RESPONSIBILITY REGARDING APPOINTMENTS AND CANCELLATIONS

You are responsible for meeting each appointment you agree upon. However, we understand that in certain cases, unexpected things can arise which prevent individuals from being able to keep a scheduled appointment.

Therefore, we adhere to the following policy. If we are prevented from keeping an appointment (e.g. due to sickness, an emergency, called out of town, etc.), we will notify you as soon as possible. Similarly, if you are prevented from keeping a scheduled appointment, we simply ask that you notify us by phone (817-361-4545) or email

(<u>familymatters@familymatterscounselingcenter.com</u>) 24 HOURS in advance so that another client may have the opportunity to utilize that time slot. If we do not receive such advance notice, you will be responsible for paying the <u>full</u> fee for the session you missed.

### PHONE CONTACTS AND EMERGENCIES

Our phone is answered by voice mail 24 hours a day. Due to our work schedule, it may take several hours before we are able to return your call, with the exception of weekends and holidays. The phone number provided is not a crisis-hotline. For emergencies, please call 911.



### FEES

The per-session fee you agree to pay is to be paid at the conclusion of each session.

### Counseling:

Dr. Robyn Bone, Ph.D., LPC \$140 per 50-60 minute online individual session \$140 per 50-60 minute individual session

Eureka Williams, MS, LCSW Sydney Martin, MA, LMFT Virginia Lott, M.Ed., LPC, NCC \$100 per 50-60 minute online individual session \$100 per 50-60 minute individual session \$65 per 75-minute group session

Erin Perry, MS, LPC-Associate Associates Offer a Sliding Scale Fee \*Based on a 50-60 minute session

### Career Development:

- The rate for a professional resume created by a resume expert is \$120.00.
- The rate for a cover letter added to each resume is \$60.00.

### Testing & Assessments:

- Usual and customary fees are between \$8.00 and \$20.00 for interest and ability testing.
- Usual and customary fees are between \$25.00 and \$45.00 for drug and alcohol assessments.
- Usual and customary fees are between \$360.00 and \$1,500 for Gifted/IQ testing and accommodation assessments.
- Usual and customary fees are between \$250 and \$500 for Pre-Surgical or Bariatric psychological evaluations.
- Usual and customary fees are between \$1,500 and \$3,500 for psychological testing.

### Rush Fees:

Results are available on our standard 15 business day turnaround. If you need results in less than 15 business days, please see our rush fees below:

- 13-14 business days (+\$500)
- 10-12 business days (+\$1000)
- 7-9 business days (+\$1500)
- 4-6 business days (+\$2,000)

### Payments:

Cash, personal checks, HSA, and credit cards are accepted for payment (in the event of a check being returned due to insufficient funds, you will be responsible for paying the balance plus a \$25 fee). You will be provided with a receipt for all fees paid via paper or email. In the event that you miss your scheduled appointment time, you will need to pay the remaining balance by the beginning of your next session. In the event that you miss two scheduled appointment times in a row, another appointment time will not be scheduled until you have paid your remaining balance. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, our staff has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which would require releasing information about you. If such action is necessary, its costs will be included in the claim.

<sup>\*\*</sup>Phone consultations that last longer than 15 minutes are subject to half the usual and customary fee.

<sup>\*</sup>To maintain the quality of our work, we cannot accommodate requests for results of assessments in less than 3 business days.



### **INSURANCE**

Family Matters is in-network with Blue Cross Blue Shield of Texas, Cigna/Evernorth, Optum, United Healthcare, Humana, First Care (Baylor Scoot & White), and Magellan. Clients with other insurance providers are welcome to use their out-of-network benefits. Benefits will need to be verified prior to initial appointment.

### **COURT APPEARANCES**

Because the client-counselor relationship is built on the foundation of trust, and that trust being confidentiality, it's often damaging to the therapeutic relationship for the counselor to be asked to present records to the court, testify whether factual or in an expert nature, in court or deposition. Therefore, we ask that you only request a court appearance in extreme cases. In the event that it's necessary for a therapist to testify before any court, arbitrator, or other hearing officer at a deposition, whether the testimony is factual or expert, or to present any or all records pertaining to the counseling relationship to a court official, the client agrees to pay for services, including travel, preparation, and necessary expenditures (copies, parking, meals, and the like) at the rate of \$250/hour, rounded to the nearest half hour, with a minimum commitment of eight hours, for a total minimum charge of two thousand dollars (8 hours x \$250 = \$2,000). The client further agrees to pay the \$2,000 two weeks prior to the appearance, presentation of records, or testimony requested.

# COMPLAINTS A consumer who wishes to file a complaint against an individual licensed by the board may call: 1-800-942-5542 or write to: Complaints Management and Investigative Section P.O. Box 141369 Austin, Texas 78714-1369 I have read and understand the information contained in this consent form. Furthermore, I have discussed any questions that I may have had regarding this information with my therapist. My signature below indicates that I give my full and informed consent to receive counseling services. Client's Signature (Guardian if a minor) Client's Printed Name (Guardian if a minor)



# **Mental Health Questionnaire**

The following questionnaire is intended to help your clinician to best understand your history and current psychological needs. The questions are intended to help your provider to gather a complete history and allow you to make the most of your therapeutic experience; though many may be challenging to complete, do your best to answer openly and honestly.

Your Full Name
DOB:
Primary Phone Number
Past/Current Medical & Psychological History:
Primary Care Physician
Phone Number
May we contact your PCP? Yes No
Current Therapist or Psychologist
Phone Number
May we contact your therapist/psychologist? Yes No
Who Referred You?
Phone Number
May we contact your referring party?YesNo
Current medical history including hospitalizations or surgeries:
Family Medical or Psychiatric History:

# **Current Medications and Dosage**

Medication Name	Dosage	Frequency	Prescribed For	Is Medication Helping?	Side Effects

Past and Current Psychiatric Medications (Please include dosage):

Have you ever had an outpatient or inpatient psychiatric hospitalization? (Include reason, dates, location. Please indicate V if voluntary N if hospitalization was non voluntary):

Have you ever seriously thought abou	rt suicide?`	Yes No
Have you attempted suicide before?	Yes	No

# **Current Functioning:**

Please describe below how you have been feeling and what drove you to request treatment now?

Current Symptom Checklist		
Depressed mood Unable to enjoy activities Sleep disturbance Loss of interest Problems with concentration/focus Change in appetite Excessive guilt/worry Fatigue Please describe any other sympton	Decreased libido or sexual interest Racing thoughts Impulsive thoughts or behaviors Increase in risky behaviors Increased libido Decreased need for sleep Instructions not listed above:	Excessive energy Increased irritability Volatility or crying spells Anxiety attacks Avoidance Hallucinations Suspiciousness
	rs or actions you may take to avoid boxes that illustrate behavioral cho g feelings.	
Compensatory Behavior Checklist		
Codependence Over use of technology Over eating Under eating Withholding food Laxatives, vomiting, or weight loss supplements Over working Staying chronically busy Cleaning Avoiding others Over exercise	Creating drama/chaos Sleeping too much Sleeping too little Shopping Promiscuity Unsafe sexual practices Masturbation Video/computer games Use of pornography Unhealthy online relationships Violence	Getting into physical fights Abuse of prescription drugs Use of illegal drugs Use of alcohol Skin picking Hiding: Ruminating and avoiding Cutting/self-harm
Legal History:		
Have you ever been arrested or co	nvicted of a crime?	Yes No
Are you currently on parole/probat	tion?	Yes No
Are you currently involved in any le	egal proceedings of any nature?	Yes No
If yes, please explain:		

Are you mandated by court to participate in mental health services?	Yes	No
If yes, please explain:		
Do you or your children currently have legal representation?	Yes	No
If yes, please explain:		
Chemical Use History		
Do you consume alcohol? Yes No		
If yes, how much alcohol do you consume per day and week?		
Do you use tobacco or tobacco products? Yes No		
If yes, how much do you consume per day and week?		
Do you use marijuana? Yes No		
If yes, how much do you consume per day and week?		
Do you use any other substances? Yes No		
If yes, please describe by type and use below:		
Have you ever considered reducing your consumption?	Yes	No
Have others criticized your substance use or encouraged you to reduce?	Yes	No
Do you have feelings of guilt or a sense of being out of control with your use?	Yes	No
Have drugs or alcohol led to problems in your relationships?	Yes	No
Have drugs or alcohol ever interfered with your work or school?	Yes	No
Have you ever been arrested or convicted of a crime secondary to substance use	?Yes _	No
Have you ever received treatment for drugs or alcohol?	Yes	No
If yes, please describe:		

# **Abuse History:**

Please check any of the cat the time of the abuse.	egories below an	d provide as much detail as you can including your age a
Emotionally Abused	Yes	No
If yes, please explain:		
Physically Abused	Yes	No
If yes, please explain:		
Sexually Abused	Yes	No
If yes, please explain:		
Physically or Emotionally No	eglected	Yes No
If yes, please explain:		
Witnessed Violence by Pare	ents/Caregivers	Yes No
If yes, please explain:		
Abused as Part of Religious,	Group Activities	Yes No
If yes, please explain:		
Personal Insights & Goal	s for Therapeuti	ic Intervention:
What are your goals in seek	ing psychological	services?
Have you created physical a	and mental room	in your schedule to seek help?
What are your personal stre	anothe accete an	d canacities that have assisted you in coning in the nast?

Do you consider yourself to have good emotional and social insight/intelligence?
What do you currently do to manage your stress?
What type of communication works best for you?
Do you consider yourself open to the therapeutic process? What reservations, if any, do you have about seeking treatment?
Are you open to homework or strategies/techniques you may utilize or practice outside of the treatment room?
What are you looking for in a mental health provider, what would this look like if treatment was a success?
Client Name (Please print):
Client Signature:
Date Signed:

## **ELECTRONIC PAYMENT AUTHORIZATION**

Please indicate the card you wish to use for all services rendered through this practice. Charges for services rendered will be deducted from the card designated below at the time services are rendered. We accept: Visa, MC and Discover.

**Client Information:** 

Client Name:		Date of Birth:	
Address:	City	State:	Zip:
Home Number:	Mobile Number:	SSN:	
Email:			
Billing Information:			
Please indicate the informa	ation associated with the debit ca	ard you wish to use.	$\square$ I prefer to use a credit card.
Name:			
Address:	City	State:	Zip:
Email:			
I authorize all service fees	to be deducted from the card end	ding in	(last four digits of the card)
Please enter the CVV code	(last three digits o	n back of card)	
I authorize the use of this o	card for all services and fees at th	e time they are rend	ered for the following parties:
Full Name(s)			
dates of service. *By autho	authorizes my provider to charg rizing use of this card, and signin nd my signature below authorizes	g this electronic pay	ment authorization form, I certify
Cardholder Signature		Date	e
Therapy Partner is a regis	Payments are processed stered ISO/MSP of Fifth Third Bank, Cincinn		SA National Association, Buffalo, NY.
Debit Card Information:	☐ I prefer to use a credit card.		
	ent information below. The card in been securely encrypted and sto	• .	ide on this form will be destroyed
Card (circle one): Visa	MasterCard Discover		
Canal Number		Frusinski	an Data



### HIPPA PRIVACY NOTICE

This notice describes how mental health information about you may be used and discussed and how you can get access to this information. Please review it carefully.

- 1. Your protected mental health information (i.e. individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security number, and demographic data) may be used or disclosed by us in one of more of the following respects:
  - a. To other care providers in connection with our rendering treatment.
  - b. To third party payers or spouses (i.e. insurance companies, employers with direct reimbursement, administrators of flexible accounts, etc.) in order to obtain payment of your account (i.e. to determine benefits, date of payments, etc.)
  - c. To certifying, licensing, accrediting bodies (i.e. American Psychological Association, state boards, etc.) in connection with obtaining certification, licensure, or accreditation.
  - d. Internally, to all staff members who have a role in your treatment.
  - e. To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.
  - f. To you family and close friends involved in your treatment.
  - g. We may contact you to provide appointment reminders or information about treatment alternatives or other mental health related benefits and services that be of interest to you.
  - h. Any other uses or disclosures of your protected mental health information will be made only after obtaining your written authorization, which you have the right to revoke.
- 2. Under the new privacy rules, you have the right to:
  - a. Request restrictions on the use and disclosure of your protected mental health information.
  - b. Request confidential communication of your protected mental health information.
  - c. Inspect and obtain copies of your protected mental health information through asking us.
  - d. Amend or modify your protected mental health information due to certain circumstances.
  - e. Receive an accounting of certain disclosures made by us of your protected mental health information.
  - f. You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 190 days of violation).
- 3. We have following duties to you:
  - a. By law, to maintain the privacy of protected mental health information and to provide you with this notice of setting fourth our legal duties and privacy practices with respect to such information.
  - b. To abide by the terms of our Privacy Note that is currently in effect.



- c. To advise you of our right to change the terms of this Privacy Note and to make the new notice provisions effective for all protected mental health information maintained by us and that if we do so, we will provide you with a copy of the revised Privacy Notice.
- 4. Please note that we not obligated to:
  - a. Honor any request by you to restrict the use or disclosure of your protected mental health information.
  - b. Amend your protected mental health information if, for example, it is accurate and complete.
  - c. Provide an atmosphere that is totally free of the possibility that your protected mental health information may be incidentally overheard by other clients and third parties.
  - d. This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your question to this person at our office address.

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Client Name (Please print):		
Client Signature:		
Date Signed:		

I hereby acknowledge that I have received a copy of this Privacy Notice.



### FINANCIAL OBLIGATIONS

I understand that as a courtesy to me, Family Matters Counseling Center, LLC will file to my insurance provider.

I understand that I am responsible for payment of services rendered and also for paying any co-payment or deductible that my insurance does not cover.

I hereby authorize payment directly to Family Matters Counseling Center for the group benefits otherwise payable to me.

I hereby authorize the release of any information, including the diagnosis and records of treatment rendered, to my insurance company.

I understand that I am personally responsible for all costs of mental health treatment at time of service; this includes all co-pays and fees.

I understand it is my responsibility to obtain prior authorization for treatment from my insurance provider.

I understand that my insurance provider is not responsible for any No-Show/Late Cancellation charges and I will be directly responsible for these charges.

I hereby acknowledge that I have received a copy of this Financial Obligation

Client Name (Plea	ise print)		
Client Signature _			
Date Signed			



# THE 2019 NOVEL CORONAVIRUS (COVID-19) ACKNOWLEDGEMENT AND ASSUMPTION OF RISK

I acknowledge the contagious nature of the Coronavirus/COVID-19 and that the CDC and many other public health authorities still recommend practicing social distancing.

I further acknowledge that Family Matters Counseling Center, LLC has put in place preventative measures to reduce the spread of the Coronavirus/COVID-19.

I further acknowledge that Family Matters Counseling Center, LLC cannot guarantee that I will not become infected with the Coronavirus/COVID-19.

I understand that the risk of becoming exposed to and/or infected by the Coronavirus/COVID-19 may result from the actions, omissions, or negligence of myself and others, including, but not limited to, counselors, and other clients and their families.

I voluntarily seek services provided by Family Matters Counseling Center, LLC and acknowledge that I am increasing my risk to exposure to the Coronavirus/COVID-19.

I acknowledge that I must comply with all set procedures to reduce the spread while attending my appointment.

### I attest that:

- I am not experiencing any symptom of illness such as cough, shortness of breath or difficulty breathing, fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell.
- I have not traveled internationally within the last 14 days.
- I have not traveled to a highly impacted area within the United States of America in the last 14 days.
- I do not believe I have been exposed to someone with a suspected and/or confirmed case of the Coronavirus/COVID-19.
- I have not been diagnosed with Coronavirus/Covid-19 and not yet cleared as non-contagious by state or local public health authorities.
- I am following all CDC recommended guidelines as much as possible and limiting my exposure to the Coronavirus/COVID-19.

I hereby release and agree to hold Family Matters Counseling Center, LLC harmless from, and waive on behalf of myself, my heirs, and any personal representatives any and all causes of action, claims, demands, damages, costs, expenses and compensation for damage or loss to myself and/or property that may be caused by any act, or failure to act of the center, or that may otherwise arise in any way in connection with any services received from Family Matters Counseling Center, LLC.

I understand that this release discharges Family Matters Counseling Center, LLC from any liability or claim that I, my heirs, or any personal representatives may have against the center with respect to any bodily injury, illness, death, medical treatment, or property damage that may arise from, or in connection to, any services received from Family Matters Counseling Center, LLC. This liability waiver and release extends to the center together with all owners, partners, and employees.



# THE 2019 NOVEL CORONAVIRUS (COVID-19) ACKNOWLEDGEMENT AND ASSUMPTION OF RISK (SIGNATURE PAGE)

Name of Client (Please print)		
Signature of Client	Date Signed	
(If client is a minor) Name of Parent of Guardian (Please print)		
(If client is a minor) Signature of Parent Guardian	Date Signed	
Signature of Therapist	Date Signed	