New Life Counseling

Client Information Questionnaire

Appointments: (325) 734-8585

Office Use Only Cash/ Co-pay: $_____
Pre Auth #_____
Initial # Sessions _____ _____
90791 90834
Dates: _____ _____
First Session Last Session
DX: _____

Therapist: _____

Primary Client Name: _____ Email: _____

DOB: _____/_____/_____ (Age: _____) SSN: _____- _____ - _____ Sex: ☐ M ☐ F

Home Address : _____, _____, _____ _____
Street City State Zip

Mailing Address : _____, _____, _____ _____
(If different from Home Address) Street City State Zip

Home Phone: ( ) _____ - _____ Can we leave a message at this number? ☐ Yes ☐ No

Work Phone: ( ) _____ - _____ Can we leave a message at this number? ☐ Yes ☐ No

Cell Phone: ( ) _____ - _____ Can we leave a message at this number? ☐ Yes ☐ No

How would you prefer to receive appointment reminders? _____ Relationship Status: _____

Secondary Client Name: _____ Email: _____

DOB: _____/_____/_____ (Age: _____) SSN: _____- _____ - _____ Sex: ☐ M ☐ F

Home Address : _____, _____, _____ _____
Street City State Zip

Mailing Address : _____, _____, _____ _____
(If different from Home Address) Street City State Zip

Home Phone: ( ) _____ - _____ Can we leave a message at this number? ☐ Yes ☐ No

Work Phone: ( ) _____ - _____ Can we leave a message at this number? ☐ Yes ☐ No

Cell Phone: ( ) _____ - _____ Can we leave a message at this number? ☐ Yes ☐ No

Insurance Information:

Insured Name: _____ Insured DOB: _____/_____/_____

SSN: _____- _____ - _____ Insured Phone: ( ) _____ - _____

Group Plan # _____ ID# _____

Insurance Company Name/ Phone: _____ /( ) _____ - _____

Insured Employer: _____ Employer Phone: ( ) _____ - _____

Assignment and Release: I HEREBY AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE PROVIDER OF SERVICE. I UNDERSTAND AND I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. I ALSO GIVE PERMISSION FOR RELEASE OF MEDICAL RECORDS INFORMATION FOR THE FILING OF MY INSURANCECLAIMS.

_____ _____
Client's Signature: Date:

Current Occupation/ Place of Work: _____

I am currently ☐ Unemployed ☐ Disabled

How did you hear about New Life Counseling? _____

Do you have a religious/ spiritual preference? _____

Have you consulted a professional counselor in the past? ☐ Yes ☐ No What year? _____

What was your counselor's name? _____

Have you ever considered suicide? ☐ Yes ☐ No How long ago? _____

Have you ever attempted suicide? ☐ Yes ☐ No How long ago? _____

Who is your physician? _____

Does New Life Counseling have your permission to contact your physician in order to coordinate services?

☐ Yes ☐ No Phone: ( ) _____ - _____

Do you have any medication allergies? ☐ Yes ☐ No If yes, please list below:

_____

_____

What medications are you currently taking? ☐ None

1. _____ _____
   Name of the medication Reason for the medication

2. _____ _____
   Name of the medication Reason for the medication

3. _____ _____
   Name of the medication Reason for the medication

4. _____ _____
   Name of the medication Reason for the medication

5. _____ _____
   Name of the medication Reason for the medication

Briefly describe the reason that you are seeking services from New Life Counseling: _____

_____

_____

_____

Emergency Contact: _____ ( ) _____ - _____
Name Phone

List the Family Members and all others currently living in your house with you:

Name	Age	Relationship to you

Professional Disclosure Statement

Qualifications: Each counselor at New Life Counseling has a master's degree in the field of psychology and is fully licensed as a counselor in the state of Texas or has a Ph.D. in the field of psychology and is a licensed psychologist in the state of Texas.

New Life's practitioners have extensive training and experience in treating a variety of presenting issues including (but not limited to) depression, anxiety, stress management, relational, marital and family difficulties, emotional, sexual, or physical abuse, addiction, mood and psychotic disorders, and crisis intervention. We treat a range of ages from four to seventeen, and eighteen and above. When being referred to a practitioner at New Life Counseling, our goal is to create the most effective therapeutic relationship by choosing the particular professional(s) within the practice that will best meet each individual client's needs.

Nature of Treatment: New Life Counseling's approach to treatment is eclectic, utilizing a variety of techniques, theories, and interventions. Each practitioner works with the client to choose an approach that best fits that individual client's needs. It cannot be overstated that our Mission at New Life Counseling is to help others discover new and hopeful possibilities for their lives by providing them a respite of deep respect, genuine concern, and the highest quality of mental healthcare available. This mission is our primary purpose and is the foundation upon which New Life Counseling is built.

Informed Consent

Authorization for Assessment and Treatment: By signing at the bottom of this document, you are granting permission for you counselor at New Life Counseling to administer services such as assessment and treatment as may be indicated within the conventional therapeutic process.

Counseling Relationship: Typically, your counselor will allot approximately 45 to 50 minutes for each session once per week. Alterations to this schedule may be made at any time by both practitioner and client based on various factors. During sessions, the primary goal is to establish a trusting relationship that is honest and genuine in nature and purposed for the client's individual growth and positive change in emotional well-being. Additionally, in order to protect the client-practitioner relationship and ensure that it is a professional one, the practitioner will focus sessions solely on the client, and the contact between practitioner and client will be limited to session time only. You may leave messages

for your practitioner on the office voicemail and he or she will return your phone call as soon as possible. If you experience a mental health emergency you may obtain crisis services by calling 911, the local crisis hotline at 1-800-758-3344, or by presenting at your nearest hospital emergency room.

Client Rights and Effects of Counseling: At any time, you have the right to initiate a discussion regarding positive or negative effects of entering, not entering, continuing, or discontinuing treatment. While benefits are expected form counseling and/or medication management, specific results are not guaranteed. At New Life Counseling, we will work to ensure that all efforts are directed toward helping you realize your own personal desired outcome.

Additionally, some clients achieve their goals in only a few counseling sessions; others may require months or years of counseling to reach their desired outcomes. As a client, you are in complete control and may end your relationship with your practitioner. At New Life Counseling, we prefer that if you so choose to end your relationship with your practitioner, you attend a termination session here the conclusion of this relationship can be discussed.

Fees and Financial Policy: Most practitioners at New Life Counseling are in-network with most major insurance companies. If you are insured, and your insurance plan is accepted at New Life Counseling, you will be responsible for meeting your deductibles and paying your co-pays at the time of service. For clients without insurance coverage, (or who would prefer the self-pay option), the cost of New Life Counseling services is determined by a loose sliding scale This means that our fees are calculated according to both household income and financial circumstances. If you are without insurance, circle the Fee-Per-Session below that is in accordance with both your annual income and what you feel that you can afford at this time. Feel free to discuss any alternative pay options with your therapist.

Annual Household Income	**Fee Per Session**
0-$25,000	$50
$26-$35,000	$55
$36-$45,000	$60
$46-$55,000	$65
$56-$65,000	$77
$66-$75,000	$85
$76-$85,000	$100
$86,000+	$130

Court Appearance: Although it is not New Life Counseling's preference to testify in court, our practitioners are able to do so. Please be forthcoming if the purpose of your attendance in any of our treatment modalities is to be "be assessed" in order for your practitioner(s) to provide a written or verbal testimony in civil or criminal court proceedings. The fee for court appearances is $150 per hour, with a 4-hour minimum. There is also a fee for court preparation and report writing of $50 per day per diem. Minimum payment for theses services is expected at lease one week PRIOR to the scheduled date. New Life Counseling cannot guarantee refunds or credits in case of date changes due to major scheduling conflicts involved.

Cancellations and No-Shows: New Life Counseling has an abundance of clients, and therefore our practitioners' schedules are very full. When an appointment is scheduled for you, it is your time slot reserved specifically for you. If you are not able to attend a session, cancellation is expected at least 24 hours in advance. We do understand that emergencies arise and at times the 24-hour notice cannot be upheld. However, please make every effort to do so. In the case of failure to cancel and missing an appointment without notice, New Life Counseling will bill you for 2/3 of your standard hourly fee or a fee decided on by your individual provider. Insurance companies will not reimburse for this, therefor, it will be your responsibility to pay this out of pocket.

Record Retention and Confidentiality: All communication between practitioner and client becomes part of the clinical record. Records will remain the property of New Life Counseling and are disposed of five years after the file is closed. New Life Counseling reserves the right to deny your record request if there is substantial reason to believe that having a written copy of the record could be of detriment to you personally. However, if copies of records are obtained, the copy cost is $3.00 per page, payable upon receipt.

Furthermore, in order to protect client confidentiality, your practitioner will not release any information regarding your attendance, treatment, progress or any other aspect of your relationship with New Life Counseling without your written consent. However, there are exceptions to this statement, and they are as follows:

1. If a client reports intent of harming self or someone else, the practitioner is required by law to notify the proper authorities.
2. Any report of injury to, or neglect of a child, and elderly person, or disabled person is required by law to be reported to the proper authorities.
3. In the case of minor, the parents or legal guardians will be notified of any life-threatening or illegal activity that is reported to the practitioner.
4. If a third-party payor (i.e. BCBS, State of TX, CVCC, all other insurance companies, etc.) is involved by way of paying for part of or all of a client's treatment, New Life Counseling likely will be required to disclose certain information concerning his or her diagnosis, treatment plan, and prognosis.
5. Under certain circumstances a client's file may be subpoenaed by a Court of Law. In theses instances, New Life Counseling will take ever precaution to protect clients' information. However, in some cases, the sharing of confidential information is required by law and cannot be avoided.
6. If it is reasonable and necessary for the practitioners at New Life Counseling to discuss clinical information specific to your case in order to provide the most effective treatment for you, the practitioners will share information with one another.

Statement of Confidentiality

I understand that New Life Counseling offers confidential counseling in so far as allowed by the laws of the State of Texas. However, I understand that if my practitioner believes there exists a threat of imminent and specific harm to myself or others, my right to confidentiality may be necessarily and legally violated. By signing below, I am indicating that I have read these conditions and fully understand and agree with this Statement of Confidentiality.

By signing below, I am indicating that I have also read and understand all other content within this intake packet, and by singing below I am attesting that I agree to abide by the statements within.

_____ _____

Primary Client Signature Date

_____ _____

Signature of Legal Guardian (if client is under 18 years of age) Date

_____ _____

Secondary Client Signature Date

_____ _____

Signature of Legal Guardian (if client is under 18 years of age) Date

_____ _____

Additional Client Signature Date

_____ _____

Signature of Legal Guardian (if client is under 18 years of age) Date

_____ _____

Additional Client Signature Date

_____ _____

Signature of Legal Guardian (if client is under 18 years of age) Date

New Life Counseling
Collaborative Treatment Plan

Date: _____/_____/_____ DOB: _____/_____/_____ SSN: XXX - XX- _____

Client's Name: _____

Presenting Problem:

_____

_____

_____

_____

Diagnosis:

_____

_____

Current Symptoms:

_____

_____

_____

Supporting Others:

_____

_____

_____

Medications:

_____

_____

_____

Modality of Treatments:

_____

_____

_____

Frequency of Sessions: ☐ Weekly ☐ Twice-Weekly ☐ Monthly ☐ As Needed

Counseling Goals:

1. _____
2. _____
3. _____

Evidence of Goal Achievement:

Anticipated Discharge Date: _____/_____/_____

My therapist and I have developed this plan together and I agree to work on the issues and goals we have discussed. Part of my treatment plan is to work together with my therapist to review my progress during each session.

Signatures:

_____ _____

Client/Guardian Signature Date

_____ _____

Therapist Signature Date

INFORMED CONSENT TO TELEHEALTH

Telehealth allows my therapist to diagnose, consult, treat and educate using interactive audio, video or data communication regarding my treatment. I hereby consent to participating in psychotherapy via telephone or the internet (hereinafter referred to as Telehealth) with the clinician listed below:

Client Name:_____ Clinician:_____

I understand I have the following rights under this agreement:

I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in -person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential.

There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger. Further, I understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.

I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of metal disorders, personal and relational issues, there is n o guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

I further understand that there are risk unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. In addition, I understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, I will be referred to a therapist in my geographic area that can provide such services.

I understand that our teletherapy occurs in the state of Texas and is governed by the laws of such state.

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.

I understand that I can withdraw my consent to Telehealth communications by providing written notification to my therapist.

I understand that my therapist will be utilizing the teletherapy from a closed room with no other individuals unless discussed and agreed upon otherwise. I agree to secure a non-public environment for the duration of my telehealth sessions, including, but not limited to the following criteria: quiet, well-lit, enclosed area with minimal distractions and headphones/earbuds available. I will ensure confidentiality of my sessions by attending in a private setting.

Fees/Insurance: If your provider is paneled with your insurance that covers mental health, then your fee will be that same as an in person visit. Co-pays can be mailed by a check or card number provided via phone. The same process can be used for those out of pocket and not utilizing insurance.

For minors seeking treatment: I agree to verify guardianship of minors seeking treatment by providing requested documentation. Additionally, I confirm that the minor seeking therapy is 17 years of age or younger. If the teletherapy is for a minor, a signature by a guardian is required below.

My signature below indicates that I have read this agreement and agree to its terms.

_____ _____

Client/Authorized Signature for client Date

_____ _____

Therapist Signature Date