COUNSELING INTAKE

River City Advocacy & Counseling Center
145 Landa St., New Braunfels, TX 78130
830-643-0200
www.rivercityadvocacy.org

Client Information

Date _____/_____/_____

First name _____ **Middle initial** _____ **Last name** _____

Parent/Legal Guardian (for 17 and under) _____

Address _____

Phone number Home _____ Cell _____ Other _____

Date of birth _____/_____/_____ Sex _____ Marital Status _____

Ethnicity _____ Employment status: Employed Unemployed Retired Veteran Disability

Employer or School _____ Full time _____ Part time _____

Are you a military veteran? Yes ☐ No ☐ (*proof in form of DD 214 required for counseling fee reduction)*

Email _____ Referred by: _____

Emergency contact name _____

Emergency contact address _____

Emergency contact phone number _____

Relationship to client _____

Permission to contact this person (sign name) _____

If applicable:

Name/Phone number of attorney _____

Permission to contact this person (sign name) _____

Name/phone number of parole officer _____

Permission to contact this person (sign name) _____

Name/case number/phone number of judge _____

Permission to contact this person (sign name) _____

Children or siblings (names and ages):

_____

_____

Please note: If we are providing services to your child and you are divorced, a current copy of custody orders is required prior to services.

Annual Household Income _____Family Size_____ Session Fee _____

Client initials: __ Counselor initials: __

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Client History

Are you currently receiving treatment for an illness, injury, or other medical condition? ☐Yes ☐No
Please explain diagnosis and treatments:

_____

_____

Are you currently taking any prescription or over-the-counter medications or illegal drugs? ☐Yes ☐No
If yes, please tell us the name and dosage of each medication:

_____

_____

Legal Issues and History: Please tell us if you have any current legal issues (arrests, convictions, civil or criminal lawsuits, judgments, order of protection, juvenile delinquency):

_____

_____

In your history, have you experienced and/or had concerns about any of the following? (Circle all that apply):
ABUSE/VIOLENCE: Physical, sexual, verbal, victim or offender
CHILD: Behavior, runaway, truancy, pregnancy, tantrums
JUDICIAL: Convicted of any crime, probation
M&F: Relationship, divorce, pre-marital, communication
MEDICAL: Disease, illness, injury, grief
COGNITIVE: Mental illness, suicide
PERSONALITY: Motivation, esteem, body image, eating disorder
SCHOOL: Academic problem, low grades, learning disability
SOCIAL: Peer relationships, social skills
WORK: Employment or job concerns
Other (Please specify): _____

Presenting Problem/Goals for Therapy:

_____

_____

_____

The above information is true and correct to the best of my knowledge.

Signature (If a minor, Parent/Guardian) _____ Date_____/_____/_____

Signature of minor_____ Date _____/_____/_____

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Notice of Financial Responsibility

I understand that I will be charged on a sliding scale fee based on my household income of _____and family size of _____ for each **45-50** minute session. I am responsible for payment at the time of my session.

Please note that fee schedules are reviewed annually.

COURT APPEARANCES: RCA clinicians will not agree to court appearances or other legal involvements unless we have discussed the matter thoroughly with the client and both agree that such involvement is within range of competence for the counselor and will not interfere with the treatment relationship. Extended or frequent telephone contact will also be charged for. **Professional fees for court appearances, depositions, and attorney consultations are $85 per hour, and are payable in advance only. A four-hour minimum ($340) is required** and must be paid prior to any testimony, provision of a clinical opinion, or treatment summary, response to attorneys via telephone call or mail, subpoenas, or preparation of any report for litigating parties.

Cancellation Policy

I understand and agree with the policy of RCA concerning cancellation of counseling appointments which requires **24 hours notice of a cancellation.**

I understand that if I do not give 24 hours' notice of a cancellation, or if I miss my appointment, I will still be charged the session fee.

I also understand termination of counseling services will result if I miss 3 consecutive appointments without notification. If applicable, my case worker will be notified if a session is missed without notification.

By signing below, I confirm that I have read, agreed to, and received the above information.

Signature (If a minor, Parent/Guardian) _____Date_____/_____/_____

Signature(minor)_____ Date_____/_____/_____

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Informed Consent

I, _____request River City Advocacy to provide counseling services in order to help me achieve the goals I have set with my counselor. (If a minor, Parent/Legal Guardian sign).

I understand degreed professionals, interns, and practicum students will provide counseling services, and that consultation may, with my permission, be directly observed and audio and/or video-recorded for review by practicum students and degreed professionals for educational purposes and research.

BENEFITS/RISKS OF COUNSELING: One major benefit that may be gained from participating in counseling is the resolution of the concerns brought to sessions. Other possible benefits may include an increased ability to cope with marital, family, and other interpersonal relationships, and/or a greater understanding of personal goals and values. I understand that I may experience discomfort and feel worse before I begin to feel better as I address counseling issues. Seeking to resolve concerns between family members, marital partners, and other persons can similarly lead to discomfort as well as relationship changes that may not have been originally intended. I understand that counseling alone may not resolve my concerns and that there is no guarantee of its success. I also understand that if my situation fails to improve, or if it worsens, I may be provided a referral to another professional for consultation or treatment.

CONFIDENTIALITY: RCA values the privacy of clients and acts accordingly. No information about my treatment will be shared with other parties without my written permission and a thorough discussion of the disclosure. I understand the clinician is obligated by law or professional ethics to report incidents of threat to self, threat to others, child abuse/neglect, elderly or dependent adult abuse/neglect, or client abuse by a therapist. In the event a litigation case is filed that concerns my clinical file, my records may be subpoenaed and my clinician may be obligated to honor these subpoenas.

FOLLOW-UP: I am aware that there may be follow-up contact by my therapist after I terminate services. This contact is to ensure the best possible services to clients through quality control. This contact may be in the form of a phone call or short questionnaire.

SERVICES TO CHILDREN: I verify that I am the legal parent, legal guardian, managing conservator, or a person designated by the court to have the authority of consent to provide psychological services to the child or children. (Please attach a copy of Legal Guardianship if applicable)**.**

By signing below, I confirm that I have read, agreed to, and received the above information.

Signature (If a minor, Parent/Guardian) _____Date_____/_____/_____

Signature(minor)_____ Date_____/_____/_____

Clinician Signature_____ Date_____/_____/_____

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About Counseling Services at RCA

I understand that our paths may cross in social situations, but that the therapeutic relationship comes first, along with protection of my confidentiality.

I understand that if I have a complaint I cannot resolve with my counselor and I wish to file a formal complaint, I will make a good faith effort to report to River City Advocacy, Inc. the nature of the complaint in order to offer River City Advocacy, Inc. an opportunity to correct the situation or otherwise provide a remedy.

I understand that payment is due at the time of service and I am responsible for all fees incurred.

I understand that I will be charged the session fee if I fail to give at least 24 hours' notice of cancellation of an appointment.

I understand that I may be required to pay any outstanding account balance to River City Advocacy, Inc. before continuing counseling services.

I understand that my counselor is not a psychiatrist or other physician, and cannot prescribe medications.

I understand that my counselor does not perform psychological testing or court-ordered assessments, but may refer me to those who do.

I understand that if I have questions or concerns with counseling, I have the right to discuss this with my counselor.

Emergencies: I understand that although my counselor does not provide formal emergency services. If you are in crisis or are having thoughts of suicide, call the Mental Health Crisis line (1-877-466-0660) or the National Suicide Prevention Lifeline (1-800-273-8255) or go to your nearest emergency room.

Death or incapacity: I understand that in the event my counselor dies or becomes unable to continue providing clinical services, River City Advocacy, Inc. will be designated as conservator for my patient records and will take possession of said records at that time. Upon written request, River City Advocacy, Inc. will make these records available to me or a mental health provider of my choice.

By signing below, I confirm that I have read, agreed to, and received the above information.

Signature (If a minor, Parent/Guardian) _____Date_____/_____/_____

Signature(minor)_____ Date_____/_____/_____

Clinician Signature_____ Date_____/_____/_____

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Veterans Counseling Policy

As part of our mission here at River City Advocacy and Counseling Center, we strive to serve those who have served us. Due to the generosity and support of our community partners, we are able to offer our veterans ___4__ free counseling sessions and a reduced fee on all subsequent sessions. The session fee is determined by household income and family size with a reduction of $10 per session for the veteran. Veterans status is verified by DD-214.

Please keep in mind that all other policies are the same to include the financial responsibility and cancellation policies.

Signature (If a minor, Parent/Guardian)_____Date_____/_____/_____

Military service verified by (Clinician Signature): _____Date _____/_____/_____

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NOTICE OF PRIVACY PRACTICES

This notice tells you how we make use of your health information at River City Advocacy, how we might disclose your health information to others, and how you can get access to the same information. Please review this notice carefully and feel free to ask for clarification about anything in this material you might not understand. The privacy of your health information is very important to us and we want to do everything possible to protect that privacy.

We have a legal responsibility under the laws of the United States and the state of Texas to keep your health information private. Part of our responsibility is to give you this notice about privacy practices. Another part of our responsibility is to follow the practices in this notice.

This notice will be in effect until we replace it. We have the right to change any of these privacy practices as long as those changes are permitted or required by law.

Any changes in our privacy practices will affect how we protect the privacy of your health information. This includes health information we will receive about you or that we create here within the counseling process. These changes could also affect how we protect the privacy of any of your health information we had before the changes.

When we make any of these changes, we will also change this notice and give you a copy of the new notice.

When you are finished reading this notice, you may request a copy of it at no charge to you. If you request a copy of this notice at any time in the future, we will give you a copy at no charge to you. If you have any questions or concerns about the material in this document, please ask us for assistance, which we will provide at no charge to you.

Here are some examples of how we use and disclose information about your health information.

We may use or disclose your health information…

1. To any person required by federal, state, or local laws to have lawful access to your treatment program.
2. To receive payment from a third party payer for services we provide for you.
3. To anyone you give us written authorization to have your health information, for any reason you want. You may revoke this authorization in writing anytime you want. When you revoke an authorization it will only effect your health information from that point on.
4. To a family member, a person responsible for your care, or your personal representative **in the event of an emergency.** If you are present in such a case, we will give you an opportunity to object. If you object, or are not present, or are incapable of responding, I may use my professional judgment, in light of the nature of the emergency, to go ahead and use or disclose your health information in your best interest at that time. In so doing, we will only use or disclose the aspects of your health information that are necessary to respond to the emergency.
5. To appropriate authorities in cases of abuse or neglect or threats of violence according to applicable state laws.

We will not use your health information in any marketing, development, public relations, or related activities without your written authorization.

We cannot use or disclose your health information in any ways other than those described in this notice unless you give us written permission.

As a client of you have these important rights:

A. With limited exceptions, you can make a written request to inspect your health information that is maintained by us for my use.

B. You can ask us for photocopies of the information in part "A" above. A fee for these copies may be applicable.

C. You have a right to a copy of **this** notice at no charge.

D. You can make a written request to have us communicate with you about your health information by alternative means, at an alternative location. (An example would be if your primary language is not spoken at this Center, and we are treating a child of whom you have lawful custody.) Your written request must specify the alternative means and location.

E. You can make a written request that we place other restrictions on the ways we use or disclose your health information. We may deny any or all of your requested restrictions. If we agree to these restrictions, we will abide by them in all situations except those, which, in our professional judgment, constitute an emergency.

F. You can make a written request that we amend the information in part "A" above.

G. If we approve your written amendment, we will change our records accordingly. I will also notify anyone else who may have received this information, and anyone else of your choosing.

H. If we deny your amendment, you can place a written statement in my records disagreeing with my denial of your request.

I. You may make a written request that I provide you with a list of those occasions where I disclosed your health information for purposes other than treatment, payment, or private practice operations. This can go back as far as six years.

J. If you request the accounting in "I" above more than once in a 12-month period we may charge you a fee based on my actual costs of tabulating these disclosures.

K. If you believe we have violated any of your privacy rights, or you disagree with a decision I have made about any of your rights in this notice you may complain in writing to

Texas State Board of Examiners of Professional Counselors
Complaints Management and Investigative Section P.O. Box 141369 Austin, Texas 78714-1369

or call 1-800-942-5540 to request the appropriate form or obtain more information.

You may request a copy of this privacy policy at any time.

_____

CLIENT SIGNATURE/ DATE

_____

CLINICIAN SIGNATURE/ DATE

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[PLEASE COMPLETE THIS BRIEF SURVEY BEFORE YOUR FIRST COUNSELING SESSION]

Outcome Rating Scale (ORS)

Name _____Age (Yrs):____ Gender_____
Session # ____ Date: _____
Who is filling out this form? Please check one: Self_____ Other_____
If other, what is your relationship to this person? _____

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

Individually
(Personal well-being)

I----------I

Interpersonally
(Family, close relationships)

I----------I

Socially
(Work, school, friendships)

I----------I

Overall

(General sense of well-being)

I----------I

International Center for Clinical Excellence

www.scottdmiller.com