FAMILY MATTERS
COUNSELING CENTER

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 Relationship: _____
Emergency Contact Phone Number: _____

How Were You Referred?

- ☐ Found On My Own
- ☐ Facebook/LinkedIn
- ☐ Website
- ☐ Psychology Today Listing
- ☐ Counselor/Doctor/Clinician
- ☐ Friend/Family
- ☐ Attorney
- ☐ Church
- ☐ Other: _____

Current Employment Status

- ☐ Full-time
- ☐ Part-time
- ☐ Unemployed
- ☐ Homemaker
- ☐ Student
- ☐ Retired
- ☐ Other: _____

Employment Information

Current Job Title: _____
Current Employer: _____
Skills Used in Current Position: _____
_____

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

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

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

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

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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.

PART I: The Counseling Process

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 (familymatters@familymatterscounselingcenter.com) **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 full fee for the session you missed.**

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

Counseling:
Dr. Robyn Bone, PhD, LPC
$120 per 50-60 minute online individual session
$120 per 50-60 minute individual session
$60 per 50-minute group session

Eureka Williams, MS, LCSW
Ciara O'Neal, MS, LPC
Beatrice "Bea" Holtz-Ilumin, PhD, MS, LPC
$100 per 50-60 minute online individual session
$100 per 50-60 minute individual session
$50 per 50-minute group session

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

**Phone consultations that last longer than 15 minutes are subject to half the usual and customary fee.

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.

Cash, personal checks, 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.

INSURANCE & PAYMENTS ACCEPTED
Insurance:
Family Matters is in-network with Blue Cross Blue Shield of Texas, Cigna, Optum, United Healthcare, Humana, 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.

Payment:
Cash, checks, credit cards and HSA cards are accepted for payment.

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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.

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.

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)

_____
Date Signed

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? _____Yes _____ No

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 about 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
- ☐ Decreased libido or sexual interest
- ☐ Racing thoughts
- ☐ Impulsive thoughts or behaviors
- ☐ Increase in risky behaviors
- ☐ Increased libido
- ☐ Decreased need for sleep
- ☐ Excessive energy
- ☐ Increased irritability
- ☐ Volatility or crying spells
- ☐ Anxiety attacks
- ☐ Avoidance
- ☐ Hallucinations
- ☐ Suspiciousness

Please describe any other symptoms not listed above:

The following are a list of behaviors or actions you may take to avoid feeling or to help you to manage difficult feelings. Please check all boxes that illustrate behavioral choices you do or have made historically to manage challenging 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 convicted of a crime? _____ Yes _____ No

Are you currently on parole/probation? _____ Yes _____ No

Are you currently involved in any legal 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 categories below and provide as much detail as you can including your age at the time of the abuse.

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 Neglected _____ Yes _____ No

If yes, please explain:

Witnessed Violence by Parents/Caregivers _____ Yes _____ No

If yes, please explain:

Abused as Part of Religious/Group Activities _____ Yes _____ No

If yes, please explain:

Personal Insights & Goals for Therapeutic Intervention:

What are your goals in seeking psychological services?

Have you created physical and mental room in your schedule to seek help?

What are your personal strengths, assets, and capacities that have assisted you in coping in the past?

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 information associated with the debit card you wish to use. ☐ I prefer to use a credit card.

Name: _____

Address: _____ City_____ State: _____ Zip: _____

Email: _____

I authorize all service fees to be deducted from the card ending in _____ (last four digits of the card)

Please enter the CVV code _____ (last three digits on back of card)

I authorize the use of this card for all services and fees at the time they are rendered for the following parties:

Full Name(s) _____

I understand that this form authorizes my provider to charge this card for varying session types, across multiple dates of service. *By authorizing use of this card, and signing this electronic payment authorization form, I certify that I am the cardholder and my signature below authorizes each individual charge for all dates of service.

_____ _____

Cardholder Signature **Date**

Payments are processed by Therapy Partner.
Therapy Partner is a registered ISO/MSP of Fifth Third Bank, Cincinnati, OH and HSBC Bank USA National Association, Buffalo, NY.

Debit Card Information: ☐ I prefer to use a credit card.

Please provide your payment information below. The card information you provide on this form will be destroyed once your information has been securely encrypted and stored.

Card (circle one): Visa MasterCard Discover

Card Number: _____ Expiration Date: _____

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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 (Please print)_____

Client Signature _____

Date Signed _____

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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.

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

Client Name (Please print): _____

Client Signature: _____

Date Signed: _____

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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.

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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