8008 SLIDE RD. #31 LUBBOCK, TEXAS 79424
(806) 787-0701 OFFICE (806) 701-5422 FAX

Client:

Last Name: ___________________________ First Name: ______________________ MI ____
Address Street: _____________________________ City: ______________ State: _____ Zip ______
Home Phone: ______________________________ Cell Phone: _____________________________
Work Phone: _______________________________ SSN# ______ - ___ - _______
Birth Date: _______________________ Age: _______ Sex: M / F
Education (or grade and name of school):

____

Marital/relationship status: ______________________ Spouses' name: _________________________
Names and ages of all others living in the home:

____
____

Who referred you to me? ____
Who shall I contact in case of an emergency? ________________________ Phone: _________________

Responsible Party, if different from client (The person signing the Consent for Treatment):

Last Name: ___________________________ First Name: ______________________ MI ____
Address Street: _____________________________ City: ______________ State: _____ Zip ______
Home Phone: ______________________________ Cell Phone: _____________________________
Work Phone: _______________________________ SSN# ______ - ___ - _______
Birth Date: _______________________ Age: _______ Sex: M / F
Responsible Party's relationship to client: ___________________________________

Custody Information (if client is a minor, choose one or explain further):

_____ Child lives together with both parents and the court has not been involved in custody rulings.
_____ Child's parents have joint legal custody. The other parent's name/address/phone is:

____

_____ Responsible party has sole custody of the child and the child lives with the responsible party.
_____ Legal guardian is ____________________________, child resides with ___________________

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Consent to Use and Disclose Your Health Information

This form is an agreement between you, ______________________________, and Rise Counseling. When I use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here: ______________________.

When I meet with, assess, diagnose, treat, or refer you, I will be collecting what the law calls "protected health information" (PHI) about you. I need to use this information in my office to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others to arrange payment for your treatment, to help carry out certain business functions, or to help provide other treatment to you.

By signing this form, you are also agreeing to let me use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to the privacy practices, I cannot treat you. In the future, I may change how I use and share your information, and so I may change our notice of privacy practices. If I do change it, you can get a copy from my office or by calling me at 806-300-0898.

If you are concerned about your PHI, you have the right to ask me not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to accept these limitations. However, if I do agree, I promise to do as you asked. This could prevent you from using your health insurance to pay for your treatment.

After you have signed this consent, you have the right to revoke it by writing. I will then stop using or sharing your PHI, but we may already have used or shared some of it, and I cannot change that.

____ ____________________
Signature of client or his or her personal representative Date

____ ____________________
Printed name of client or personal representative Relationship to the client

____
Description of personal representative's authority

____
Signature of authorized representative of this office or practice

Date of NPP _______________________ ______Copy given to the client/parent/personal representative

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Date:___________________________________

Name:__________________________________

Welcome to Rise Counseling. This document contains important information about our professional services and business policies. Please read it carefully and note any questions you might have so you can discuss them with me during your intake. Once you sign this consent form, it will constitute an agreement between us.

Qualifications

My undergraduate degree was in education. I earned a Master of Education degree in Counseling from Texas Tech University. I hold license number 62704 as a Licensed Professional Counselor with the Texas State Board of Licensed Professional Counselors.

Nature of Counseling Services

Counseling is the process where mental health distresses and disorders are assessed, prevented, evaluated, and treated. There are a variety of techniques that can be utilized to deal with the problem(s) that brought you to therapy. These services are generally unlike any services you may receive from a physician in that they require your active participation and cooperation.

Counseling can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, counseling has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, better problem-solving and coping skills, and significant reductions in feelings of distress. Given the nature of counseling, it is difficult to predict what exactly will happen. No guarantees can be made regarding outcomes or regarding what you will experience. I will at times consult with other mental health

professionals regarding treatment planning and case progress. During those consultations, your identity will not be disclosed and your confidentiality will be maintained.

Procedures

Counseling involves a large commitment of time, money, and energy, so you should be very careful about the counselor you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

If counseling is begun, I will usually schedule one hour session (approximately 50-55 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation, unless we both agree that you were unable to attend due to circumstances beyond your control. If it is possible, I will try to find another time to reschedule the appointment. For late cancellations (less than 24-hour notice) Rise Counseling will charge half your normal session fee, and for a missed appointment with no notice you will be charged the full normal session fee.

The overall length of counseling (in weeks or months) is generally difficult to predict but is something we can discuss when the initial treatment goals are established.

Professional Fees

Your session fee will be discussed and determined prior to or at your initial session. In addition to weekly appointments, this amount will be charged for other professional services you may need, though it will be prorated if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

Billing and Payments

You will be expected to pay for each session at the time it is held. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. However, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

Litigation Policy

The nature of the therapeutic process requires that clients make full disclosure with regard to many matters of a confidential nature. If you become involved in legal proceedings that may require my participation, you agree to let me know immediately and provide full disclosure regarding the nature of the legal proceeding. I am a therapist. My chosen profession is helping people get better. I prefer not to become involved in any legal proceedings. If I am subpoenaed by you or your attorney to provide records or give testimony in violation of this agreement, I will obey the subpoenas as required by law. You acknowledge and agree that I reserve the right to terminate my professional relationship with you immediately and refer you to other mental health professionals. If I am subpoenaed by another party to provide records or give testimony, I will obey the subpoena as required by law. If the subpoena is issued by someone other than you or your attorney, I will notify you if I am subpoenaed to provide records or testimony. If you do not agree with the subpoena, it will be your responsibility to take appropriate legal action. By your signature below, you agree that I have no responsibility or obligation to avoid compliance with a subpoena or court order for records or testimony.

Litigation Fees

If legal proceedings occur that require my involvement and I am subpoenaed to testify in court on your behalf, my fee is $1,500.00 and is payable no less than ten (10) days (excluding weekends) prior to any court related services or testimony PLUS $150 per hour for my professional time. My professional time for services related to all legal proceedings may include but is not limited to, preparation time (this includes research if needed); travel time to and from my office and the destination; attendance at any hearing, deposition, or other proceeding (regardless of testifying or not); and the costs of complying with a subpoena for records or testimony. Any reproduction of counseling records requires written notice, a signed authorization to release records and a flat fee of $50 due no less than 10 days (excluding weekends) prior to the release of any counseling records. Please note that you as my client are responsible for these fees whether the subpoena is issued by you, your attorneys or by any other party.

Contacting Me

I am often not immediately available by telephone, and you may need to leave a message for me. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. Rise Counseling does not have 24-hour crisis services in office. If you are unable to reach me and feel that you cannot wait for me to return your call, particularly after office hours and overnight, contact your family physician, a local crisis line (806) 740-1414, or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with emergency contacts including the name of a colleague to contact, if necessary.

I prefer using email or text messaging, if phone contact is not possible, only to arrange or modify appointments. Please do not email or text me content related to your therapy sessions, as email and text messages are not completely secure or confidential. If you choose to communicate with me by email or text message, be aware that it is possible that emails and texts are retained in the logs of your and my Internet Service Providers and/or applicable phone records. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s). You should also know that any emails and texts I receive from you and any responses that I send to you become a part of your legal record.

I do not accept friend or contact requests from current or former clients on any social networking site, such as Facebook, Instagram, or the like. I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship.

Professional Records

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, unless I believe that seeing them would be emotionally damaging to you. If this is the case, I will be happy to provide your records to an appropriate mental health professional of your choice. Although you are entitled to receive a copy of your records if you wish to see them, I may prefer to prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Clients will be charged a prorated fee for any professional time spent in responding to information requests.

The state of Texas requires that I keep your records for 5 years after termination of counseling services.

Confidentiality

In general, the privacy of all communications between a client and a therapist is protected by law, and I can only release information about our work to others with your written permission. However, there are a few exceptions:

- Client requests release of information
- Court orders a release of information
- Client initiates a malpractice lawsuit
- Client is below 18 years of age, parents have rights to therapeutic information
- A child is abused or neglected
- An elderly person is abused or neglected
- A disabled person is abused or neglected
- Client is a danger to self/others
- An insurance company or managed care company requests a diagnosis and/or relevant clinical information

One additional situation that would necessitate disclosure of information is in the case of involvement of Texas Child Protective Services (CPS) in your case. If they are the legal Managing Conservator of a minor with whom I meet with in sessions, they are legally the parent and are allowed access to the files. If I am meeting with you, and/or you and your spouse or partner, separately from the child for whom they hold conservatorship, they may request files. I would obtain your written consent before releasing records in that circumstance.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I suspect that a child, elderly person, or disabled person is being abused or neglected, I may be required to file a report with the appropriate state agency.

If I believe that a client is threatening serious bodily harm to another, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations have rarely occurred in my practice. If one of these situations occurs, I will make every effort to fully discuss it with you before taking any action.

In order to protect the confidentiality of all parties involved in the counseling sessions, recording devices of any type may not be used unless all parties have signed a separate consent related to recording session content.
I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information

confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

Physical Health

Psychological disorders and symptoms often have a strong correlation with medical illnesses. At times, some medical conditions require a medical differential diagnosis to determine symptom etiology. If your presenting symptoms are organic in origin, it is critical that you obtain medical treatment. Therefore, if you have not had a physical in the last six months, it is recommended that you do so. In addition, prescription and non-prescription medications may have significant side effects that may be important for us to consider. I expect full disclosure of all medicines and drug and alcohol intake and may request a Release of Information so that I can coordinate therapeutic services with your physician if appropriate. I cannot prescribe medication. If it is possible that medication might alleviate some symptoms for you, I will refer you to a psychiatrist or physician who can fully make a determination if medication should be a part of treatment.

Transfer Plan

In the event that I become incapacitated in some way or unexpectedly die, and am unable to continue providing services for you, I have designated the owners of Rise Counseling to access my files. All owners are licensed to practice counseling in Texas. They can be contacted at 806-300-0898. One of the owners will assist you by continuing therapy services with you if possible or assisting you to access your files and transfer them to another mental health professional of your choice. This will be true whether the situation is temporary or permanent. Once the owners are informed of my incapacitation or death, one of them will begin contacting my clients. However, if you find yourself unexpectedly unable to contact me, you may contact Rise Counseling to facilitate continued services. Rise Counseling, and its owners, will maintain confidentiality of your file and information just as I would and is bound by the same ethical codes that I am.

Signature(s)

If you have questions or concerns about any of these policies and procedures, do bring them to my attention so that we can discuss them.

Your signature below indicates that you have read the information in this document, that you have understood it, and that you agree to abide by its terms as long as you are a client of this practice.

Client Signature____ Date_______________

Parent/Guardian Signature_______________________________________ Date_______________
(If client under age 18 or legally unable to sign)

Counselor Signature____ Date_______________

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Date:____

Name:_______________________________________

Welcome to Rise Counseling. This document contains important information about our professional services and business policies. Please read it carefully and note any questions you might have so you can discuss them with me during your intake. Once you sign this consent form, it will constitute an agreement between us.

Qualifications

I earned a Master of Arts degree in Counseling from Wayland Baptist University in Plainview, Texas. I hold license number 68089 as a Licensed Professional Counselor with the Texas State Board of Examiners of Licensed Professional Counselors.

Legal Requirements for Counseling with Children

I am required by my licensing board to verify the identity of all persons who consent to the therapy of a minor child. I am further required to obtain proof that the person signing the consent for therapy is legally authorized to do so. Specifically, I am required by my Licensing Board to obtain a copy of any Court Order, Divorce Decree or other document that confirms your authority to consent to treatment before any therapy services are provided. Your cooperation in providing this document is sincerely appreciated.

Nature of Counseling Services

In counseling children, I view the child as my primary client. Because I meet with the parents, both individually and with the child throughout therapy, I view the parents as my secondary clients. Counseling is the process where mental health distresses and disorders are assessed, prevented, evaluated, and treated. There are a

variety of techniques that can be utilized to deal with the problem(s) that brought your child to therapy. These services are generally unlike any services your child may receive from a physician in that they require both yours and your child's active participation and cooperation.

Counseling can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, your child may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, counseling has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, better problem-solving and coping skills, and significant reductions in feelings of distress. Given the nature of counseling, it is difficult to predict what exactly will happen. No guarantees can be made regarding outcomes or regarding what you or your child will experience. Consistent attendance should be made a priority since it is essential for progress. However, simply attending sessions without a commitment to change cannot bring about needed progress. At times, the child may be asked to do therapeutic homework assignments to aid in progress and in transfer of change outside of the therapeutic setting.

Procedures

Counseling involves a large commitment of time, money, and energy, so you should be very careful about the counselor you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

If counseling is begun, I will usually schedule one hour session (approximately 50-55 minutes duration) per week at a time we agree on, although some sessions may be longer or more/less frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation, unless we both agree that you were unable to attend due to circumstances beyond your control. If it is possible, I will try to find another time to reschedule the appointment. For late cancelations (less than 24-hour notice) Rise Counseling will charge half your normal session fee, and for a missed appointment with no notice you will be charged the full normal session fee. Counseling services will be terminated after two consecutively missed scheduled appointments if I do not have communication from a parent or caregiver.

The overall length of counseling (in weeks or months) is generally difficult to predict but is something we can discuss when the initial treatment goals are established. Together, you and I will determine when it is time for your child's treatment to end. While you are free to end your child's therapy at any time, it is more beneficial for your child if the end of therapy is planned and explained to him/her in advance. You and your child will have a role in determining when your child has accomplished the stated therapeutic goals. Children perceive endings differently, and without planning and clear explanation, a child may perceive that therapy ended because he/she was "bad" or because the therapist did not like him/her. In my practice, we celebrate the end of therapy as a "graduation" and an achievement so the child feels a sense of accomplishment and pride at a job well done. As the parent, your cooperation with this approach is critically important.

Professional Fees

Your session fee will be discussed and determined prior to or at your initial session. In addition to weekly appointments, this amount will be charged for other professional services you may need, though it will be prorated if I work for periods of less than one hour. Other services include but are not limited to: report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you

have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

Billing and Payments

You will be expected to pay for each session at the time it is held. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. However, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I must provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

Litigation Policy

The nature of the therapeutic process requires that clients make full disclosure regarding many matters of a confidential nature. If you or your child become involved in legal proceedings that may require my participation, you agree to let me know immediately and provide full disclosure regarding the nature of the legal proceeding. I am a therapist. My chosen profession is helping people get better. I prefer not to become involved in any legal proceedings. Specifically, I do not want to become involved with any legal proceedings or other situation where one parent might try to force me to take sides over the other. Your child deserves to have a safe place to talk about his/her thoughts and problems. By entering into this agreement, you acknowledge and agree to honor your child's privacy to the extent it is possible to do so. That means that neither you nor your attorneys or anyone acting on your behalf will subpoena your child's records from my office or subpoena me to testify in court or give a deposition regarding my treatment of your child. By your signature below, you indicate that you are aware of my litigation policy and you agree to abide by it. I do not make recommendations regarding custody, visitation or parental access to children or any matters pertaining to the "best interest of the child" in Suits Affecting the Parent-Child Relationship (SAPCR), adoption or termination proceedings. If I am subpoenaed by you or your attorney to provide records or give testimony in violation of this agreement, I will obey the subpoenas as required by law. You acknowledge and agree that I reserve the right to terminate my professional relationship with you immediately and refer you to other mental health professionals. If I am subpoenaed by another party to provide records or give testimony, I will obey the subpoena as required by law. If the subpoena is issued by someone other than you or your attorney, I will notify you if I am subpoenaed to provide records or testimony. If you do not agree with the subpoena, it will be your responsibility to take appropriate

legal action. By your signature below, you agree that I have no responsibility or obligation to avoid compliance with a subpoena or court order for records or testimony.

Litigation Fees

If legal proceedings occur that require my involvement and I am subpoenaed to testify in court on your behalf, my fee is $1,000.00 and is payable no less than ten (10) days (excluding weekends) prior to any court related services or testimony PLUS $150 per hour for my professional time. My professional time for services related to all legal proceedings may include but is not limited to, preparation time (this includes research if needed); travel time to and from my office and the destination; attendance at any hearing, deposition, or other proceeding (regardless of testifying or not); and the costs of complying with a subpoena for records or testimony. Any reproduction of counseling records requires written notice, a signed authorization to release records and a flat fee of $50 due no less than 10 days (excluding weekends) prior to the release of any counseling records. Please note that you as my client are responsible for these fees whether the subpoena is issued by you, your attorneys or by any other party.

Contacting Me

I am often not immediately available by telephone, and you may need to leave a message for me. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of times when you will be available. Rise Counseling does not have 24-hour crisis services in office. If you are unable to reach me and feel that you can't wait for me to return your call, particularly after office hours and overnight, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with emergency contacts including the name of a colleague to contact, if necessary.

I prefer using email or text messaging, if phone contact is not possible, only to arrange or modify appointments. Please do not email or text me confidential information or content related to your therapy sessions, as email and text messages are not completely secure or confidential. If you choose to communicate with me by email or text message, be aware that it is possible that emails and texts are retained in the logs of your and my Internet Service Providers and/or applicable phone records. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s). You should also know that any emails and texts I receive from you and any responses that I send to you become a part of your legal record.

I do not accept friend or contact requests to my personal accounts from current or former clients on any social networking site, such as Facebook, Instagram, or the like. I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship.

Professional Records

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, unless I believe that seeing them would be emotionally damaging to you. If this is the case, I will be happy to provide your records to an appropriate mental health professional of your choice. Although you are entitled to receive a copy of your records if you wish to see them, I may prefer to prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Clients will be charged a prorated fee for any professional time spent in responding to information requests. The

state of Texas requires that I keep your records for 5 years after termination of counseling services and for minors, 5 years after the minor turns 18 years old.

Confidentiality

In general, the privacy of all communications between a client and a therapist is protected by law, and I can only release information about our work to others with your written permission. However, there are a few exceptions:

- Client requests release of information
- Court orders a release of information
- Client initiates a malpractice lawsuit
- Client is below 18 years of age, parents have rights to therapeutic information
- A child is abused or neglected
- An elderly person is abused or neglected
- A disabled person is abused or neglected
- Client is a danger to self/others
- An insurance company or managed care company requests a diagnosis and/or relevant clinical information

One additional situation that would necessitate disclosure of information is in the case of involvement of Texas Child Protective Services (CPS) in your case. If they are the legal Managing Conservator of a minor with whom I meet with in sessions, they are legally the parent and are allowed access to the files. If I am meeting with you, and/or you and your spouse or partner, separately from the child for whom they hold conservatorship, they may request files. I would obtain your written consent before releasing records in that circumstance.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I suspect that a child, elderly person, or disabled person is being abused or neglected, I may be required to file a report with the appropriate state agency.

If I believe that a client is threatening serious bodily harm to another, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations have rarely occurred in my practice. If one of these situations occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

Physical Health

Psychological disorders and symptoms often have a strong correlation with medical illnesses. At times, some medical conditions require a medical differential diagnosis to determine symptom etiology. If your presenting symptoms are organic in origin, it is critical that you obtain medical treatment. Therefore, if you have not had a physical in the last six months, it is recommended that you do so. In addition, prescription and non-prescription medications may have significant side effects that may be important for us to consider. I expect full disclosure of all medicines and drug and alcohol intake and may request a Release of Information so that I can coordinate therapeutic services with your physician if appropriate. I cannot prescribe medication. If it is determined that medication might alleviate some symptoms for you, I will refer you to a psychiatrist who can fully make a determination if medication should be a part of treatment.

Transfer Plan

In the event that I become incapacitated in some way or unexpectedly die, and am unable to continue providing services for you, I have designated the owners of Rise Counseling to access my files. All owners are licensed to practice counseling in Texas. They can be contacted at 806-300-0898. One of the owners will assist you by continuing therapy services with you if possible or assisting you to access your files and transfer them to another mental health professional of your choice. This will be true whether the situation is temporary or permanent. Once the owners are informed of my incapacitation or death, one of them will begin contacting my clients. However, if you find yourself unexpectedly unable to contact me, you may contact Rise Counseling to facilitate continued services. Rise Counseling and its owners will maintain confidentiality of your file and information just as I would and is bound by the same ethical codes that I am.

Signature(s)

If you have questions or concerns about any of these policies and procedures, do bring them to my attention so that we can discuss them.

Your signature below indicates that you have read the information in this document, that you have understood it, and that you agree to abide by its terms as long as you are a client of this practice.

Client Signature____ Date_______________

Parent/Guardian Signature______________________________________ Date_______________
(If client under age 18 or legally unable to sign)

Counselor Signature____ Date_______________

8008 SLIDE RD. #31 LUBBOCK, TEXAS 79424
(806) 787-0701 OFFICE (806) 701-5422 FAX

Session Fee Agreement

Payment is expected in full at the time of services.

Please check one:

□ Private Pay

□ Insurance My Copay is: ___________________________

Insurance carrier: ____
Insurance ID number: ____
Name on card: ____
Physical address of insured: ____
____
Date of Birth of Client: ____

All clients using health insurance please sign below; parent must sign if client is under 18
I, the undersigned, have insurance coverage with the stated insurance company and assign directly to Rise Counseling, all medical benefit payments for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I agree that a photocopy of this authorization shall be as valid as the original.

____ ____________________
Signature (Client, or parent or guardian if client is under 18 years old) Date

- -

Your counselor will fill this section out during your first appointment

Fees for Services:

One hour (50-55 min) …………………….….… $__________

45 min…………………………………………….. $__________

Missed Appointment fee…………………. $__________

Late Cancellation fee……………………….. $__________

Client Signature: ____________________________________ Date: _____________

Counselor Signature: _________________________________ Date: ____________

8008 SLIDE RD. #31 LUBBOCK, TEXAS 79424
(806) 787-0701 OFFICE (806) 701-5422 FAX

Appointment Reminders

You can receive an appointment reminder to your email address or your cell phone (via a text message) the day before your scheduled appointments.
Client name: ____

Where would you like to receive appointment reminders? (check only one)

____ Via a text message on my cell phone (normal text message rates will apply)

Your cell phone number: ____

____ Via an email message

Your email address: ____

____ None of the above. I'll remember my appointments on my own.
(Missed appointment fees will still apply)

As technology is never 100% reliable, the appointment reminder system is not fail proof. The client remains responsible for missed appointments should such a failure occur. Missed appointment fees will still apply.

____Initials

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that is be handled as I have noted above.

____________________________________ ____________________________

Signature Date

RISE Counseling
Staci Rocha, M.A., LPC
8008 Slide Road #31
Lubbock, Texas 79424
(806) 300-0898 x 7 Office (806) 701-5422 Fax

Client Info:
First Name: ___________________________ Last Name: ______________________ MI ____
Address Street: _________________________ City: ______________ State: _____ Zip ______
Home Phone: ______________________________ Cell Phone: __________________________
Work Phone: _______________________________ SSN# ______-___-_______
Birth Date: _______________________ Age: _______ Sex: M / F
Email Address: ____
Education (or grade and name of school):
____
Marital/relationship status: ______________________ Spouses' name: ______________________
Names and ages of all others living in the home:
____
____
Who referred you to me?
____
Who shall I contact in case of an emergency? ________________________ Phone: __________

Responsible Party, if different from client (The person signing the Consent for Treatment):
Last Name: ___________________________ First Name: ______________________ MI ____
Address Street: _______________________ City: ______________ State: _____ Zip ______
Home Phone: ______________________________ Cell Phone: _________________________
Work Phone: _______________________________ SSN# ______-___-_______
Birth Date: _______________________ Age: _______ Sex: M / F
Responsible Party's relationship to client: ___________________________________

Custody Information (if client is a minor, choose one or explain further):
_____ Child lives together with both parents and the court has not been involved in custody rulings.
_____ Child's parents have joint legal custody. The other parent's name/address/phone is:
____
_____ Responsible party has sole custody of the child and the child lives with the responsible party.
_____ Legal guardian is ____________________________, child resides with ___________________

Consent to Use and Disclose Your Health Information

This form is an agreement between you, _______________________________, and Rise Counseling. When I use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here: _______________________.

initial each page : _______

RISE Counseling
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When I meet with, assess, diagnose, treat, or refer you, I will be collecting what the law calls "protected health information" (PHI) about you. I need to use this information in my office to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others to arrange payment for your treatment, to help carry out certain business functions, or to help provide other treatment to you.

By signing this form, you are also agreeing to let me use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to the privacy practices, I cannot treat you. In the future, I may change how I use and share your information, and so I may change our notice of privacy practices. If I do change it, you can get a copy from my office or by calling me at 806-300-0898.

If you are concerned about your PHI, you have the right to ask me not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to accept these limitations. However, if I do agree, I promise to do as you asked. This could prevent you from using your health insurance to pay for your treatment.

After you have signed this consent, you have the right to revoke it by writing. I will then stop using or sharing your PHI, but we may already have used or shared some of it, and I cannot change that.

____ __________
Signature of client or his or her personal representative Date

____ __________
Printed name of client or personal representative (Relationship to the client) Date

____
Signature of Counselor

Date:______________________________

Name:_____________________________

initial each page : _______

RISE Counseling
Staci Rocha, M.A., LPC
8008 Slide Road #31
Lubbock, Texas 79424
(806) 300-0898 x 7 Office   (806) 701-5422 Fax

Welcome to Rise Counseling. This document contains important information about our professional services and business policies. Please read it carefully and note any questions you might have so you can discuss them with me during your intake. Once you sign this consent form, it will constitute an agreement between us.

Qualifications

I earned a Master of Arts degree in Family Psychology from Hardin-Simmons University in Abilene, Texas. I hold license number 5139 as a Licensed Marriage and Family Therapist with the Texas State Board of Examiners of Marriage and Family Therapists, PO Box 149347 Austin, Texas 78714. The telephone number for the board office is: (512) 834-6657.

Nature of Counseling Services

Counseling is the process where mental health distresses and disorders are assessed, prevented, evaluated, and treated. There are a variety of techniques that can be utilized to deal with the problem(s) that brought you to therapy. These services are generally unlike any services you may receive from a physician in that they require your active participation and cooperation.

Counseling can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, counseling has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, better problem-solving and coping skills, and significant reductions in feelings of distress. Given the nature of counseling, it is difficult to predict what exactly will happen. No guarantees can be made regarding outcomes or regarding what you will experience. I will at times consult with other mental health professionals regarding treatment planning and case progress. During those consultations, your identity will not be disclosed and your confidentiality will be maintained.

Procedures

Counseling involves a large commitment of time, money, and energy, so you should be very careful about the counselor you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

If counseling is begun, I will usually schedule one hour session (approximately 50-55 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation, unless we both agree that you were unable to attend due to circumstances beyond your control. If it is possible, I will try to find another time to reschedule the appointment. For late

initial each page : _______

cancellations (less than 24-hour notice) Rise Counseling will charge half your normal session fee, and for a missed appointment with no notice you will be charged the full normal session fee.

The overall length of counseling (in weeks or months) is generally difficult to predict but is something we can discuss when the initial treatment goals are established.

Professional Fees

Your session fee will be discussed and determined prior to or at your initial session. In addition to weekly appointments, this amount will be charged for other professional services you may need, though it will be prorated if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

Billing and Payments

You will be expected to pay for each session at the time it is held. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. However, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands.

In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

Litigation Policy

The nature of the therapeutic process requires that clients make full disclosure with regard to many matters of a confidential nature. If you become involved in legal proceedings that may require my participation, you agree to let me know immediately and provide full disclosure regarding the nature of

initial each page : _______

the legal proceeding. I am a therapist. My chosen profession is helping people get better. I prefer not to become involved in any legal proceedings. If I am subpoenaed by you or your attorney to provide records or give testimony in violation of this agreement, I will obey the subpoenas as required by law. You acknowledge and agree that I reserve the right to terminate my professional relationship with you immediately and refer you to other mental health professionals. If I am subpoenaed by another party to provide records or give testimony, I will obey the subpoena as required by law. If the subpoena is issued by someone other than you or your attorney, I will notify you if I am subpoenaed to provide records or testimony. If you do not agree with the subpoena, it will be your responsibility to take appropriate legal action. By your signature below, you agree that I have no responsibility or obligation to avoid compliance with a subpoena or court order for records or testimony.

Litigation Fees

If legal proceedings occur that require my involvement and I am subpoenaed to testify in court on your behalf, my fee is $1,000.00 and is payable no less than ten (10) days (excluding weekends) prior to any court related services or testimony PLUS $150 per hour for my professional time. My professional time for services related to all legal proceedings may include but is not limited to, preparation time (this includes research if needed); travel time to and from my office and the destination; attendance at any hearing, deposition, or other proceeding (regardless of testifying or not); and the costs of complying with a subpoena for records or testimony. Any reproduction of counseling records requires written notice, a signed authorization to release records and a flat fee of $50 due no less than 10 days (excluding weekends) prior to the release of any counseling records. Please note that you as my client are responsible for these fees whether the subpoena is issued by you, your attorneys or by any other party.

Contacting Me

I am often not immediately available by telephone, and you may need to leave a message for me. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. Rise Counseling does not have 24-hour crisis services in office. If you are unable to reach me and feel that you cannot wait for me to return your call, particularly after office hours and overnight, contact your family physician, a local crisis line (806) 740-1414, or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with emergency contacts including the name of a colleague to contact, if necessary.

I prefer using email or text messaging, if phone contact is not possible, only to arrange or modify appointments. Please do not email or text me content related to your therapy sessions, as email and text messages are not completely secure or confidential. If you choose to communicate with me by email or text message, be aware that it is possible that emails and texts are retained in the logs of your and my Internet Service Providers and/or applicable phone records. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s). You should also know that any emails and texts I receive from you and any responses that I send to you become a part of your legal record.

initial each page : _______

I do not accept friend or contact requests from current or former clients on any social networking site, such as Facebook, Instagram, or the like. I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship.

Professional Records

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, unless I believe that seeing them would be emotionally damaging to you. If this is the case, I will be happy to provide your records to an appropriate mental health professional of your choice. Although you are entitled to receive a copy of your records if you wish to see them, I may prefer to prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Clients will be charged a prorated fee for any professional time spent in responding to information requests.

The state of Texas requires that I keep your records for 5 years after termination of counseling services.

Confidentiality

In general, the privacy of all communications between a client and a therapist is protected by law, and I can only release information about our work to others with your written permission. However, there are a few exceptions:

- Client requests release of information
- Court orders a release of information
- Client initiates a malpractice lawsuit
- Client is below 18 years of age, parents have rights to therapeutic information
- A child is abused or neglected
- An elderly person is abused or neglected
- A disabled person is abused or neglected
- Client is a danger to self/others
- An insurance company or managed care company requests a diagnosis and/or relevant clinical information

One additional situation that would necessitate disclosure of information is in the case of involvement of Texas Child Protective Services (CPS) in your case. If they are the legal Managing Conservator of a minor with whom I meet with in sessions, they are legally the parent and are allowed access to the files. If I am meeting with you, and/or you and your spouse or partner, separately from the child for whom they hold conservatorship, they may request files. I would obtain your written consent before releasing records in that circumstance.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

initial each page : _______

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I suspect that a child, elderly person, or disabled person is being abused or neglected, I may be required to file a report with the appropriate state agency.

If I believe that a client is threatening serious bodily harm to another, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations have rarely occurred in my practice. If one of these situations occurs, I will make every effort to fully discuss it with you before taking any action.

In order to protect the confidentiality of all parties involved in the counseling sessions, recording devices of any type may not be used unless all parties have signed a separate consent related to recording session content.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

Physical Health

Psychological disorders and symptoms often have a strong correlation with medical illnesses. At times, some medical conditions require a medical differential diagnosis to determine symptom etiology. If your presenting symptoms are organic in origin, it is critical that you obtain medical treatment. Therefore, if

you have not had a physical in the last six months, it is recommended that you do so. In addition, prescription and non-prescription medications may have significant side effects that may be important for us to consider. I expect full disclosure of all medicines and drug and alcohol intake and may request a Release of Information so that I can coordinate therapeutic services with your physician if appropriate. I cannot prescribe medication. If it is possible that medication might alleviate some symptoms for you, I will refer you to a psychiatrist or physician who can fully make a determination if medication should be a part of treatment.

Transfer Plan

In the event that I become incapacitated in some way or unexpectedly die, and am unable to continue providing services for you, I have designated the owners of Rise Counseling to access my files. All

initial each page : _______

owners are licensed to practice counseling in Texas. They can be contacted at 806-300-0898. One of the owners will assist you by continuing therapy services with you if possible or assisting you to access your files and transfer them to another mental health professional of your choice. This will be true whether the situation is temporary or permanent. Once the owners are informed of my incapacitation or death, one of them will begin contacting my clients. However, if you find yourself unexpectedly unable to contact me, you may contact Rise Counseling to facilitate continued services. Rise Counseling, and its owners, will maintain confidentiality of your file and information just as I would and is bound by the same ethical codes that I am.

Signature(s)

If you have questions or concerns about any of these policies and procedures, do bring them to my attention so that we can discuss them.

Your signature below indicates that you have read the information in this document, that you have understood it, and that you agree to abide by its terms as long as you are a client of this practice.

Client Signature____ Date_______________

Parent/Guardian Signature_____________________________________ Date_______________
(If client under age 18 or legally unable to sign)

Counselor Signature____ Date_______________

initial each page : _______

RISE Counseling
Staci Rocha, M.A., LPC
8008 Slide Road #31
Lubbock, Texas 79424
(806) 300-0898 x 7 Office   (806) 701-5422 Fax

Session Fee Agreement

Payment is expected in full at the time of services.

Please check one:

□ Private Pay

□ Insurance   My Copay is: ___________________________

Insurance carrier: ____
Insurance ID number: ____
Name on card: ____
Physical address of insured: ____
____
Date of Birth of Client: ____

All clients using health insurance please sign below; parent must sign if client is under 18

I, the undersigned, have insurance coverage with the stated insurance company and assign directly to Rise Counseling, all medical benefit payments for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I agree that a photocopy of this authorization shall be as valid as the original.

____ __________________________
Signature (Client, or parent or guardian if client is under 18 years old)   Date

- -

Your counselor will fill this section out during your first appointment

Fees for Services:

One hour (50-55 min) ……………………….….… $__________

45 min…………………………………………….. $__________

Missed Appointment fee…………………. $__________

Late Cancellation fee……………………….. $__________

Client Signature: ___________________________________ Date: _____________

Counselor Signature: _______________________________ Date: ____________

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Appointment Reminders

You can receive an appointment reminder to your email address or your cell phone (via a text message) the day before your scheduled appointments.
Client name: ____

Where would you like to receive appointment reminders? (check only one)

____ Via a text message on my cell phone (normal text message rates will apply)

Your cell phone number: ____

____ Via an email message

Your email address: ____

____ None of the above. I'll remember my appointments on my own.
(Missed appointment fees will still apply)

As technology is never 100% reliable, the appointment reminder system is not fail proof. The client remains responsible for missed appointments should such a failure occur. Missed appointment fees will still apply.

____Initials

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that is be handled as I have noted above.

____________________________________ ____________________________

Signature Date

initial each page : _______

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CARD AUTHORIZATION FORM

Client Name:____
Date of Birth: :________________________

The purpose of this form is to authorize Staci L. Rocha, LPC to retain a valid credit card number on file for you as our client. All new clients are required to complete this form. This form will be kept confidential and only authorized staff will have access to the information.

Your supplied credit card will be charged ONLY under the following circumstances:

1. Staci L. Rocha, LPC reserves the right to charge the credit card listed below for all current clients balances, including co-pays (following insurance payments) and a receipt will be kept in your client chart, unless directed to send the receipt directly to you. This notice serves as your consent to being charged for all current client balances on your account.

2. If you, as the client, miss a scheduled appointment without 24-hour notice to cancel or reschedule, Staci L. Rocha, LPC reserves the right to charge the credit card listed below $50.00 (standard no-show fee) and a receipt will be sent to the current address file. This notice serves as your consent to being charged for any and all no-shows.

3. If we receive notice that a payment is returned to us for any reason, Staci L. Rocha, LPC reserves the right to charge the credit card listed below a $25.00 returned check fee as well as the amount of the issued insufficient check. A receipt will be sent to the current address on file. This notice serves as your consent to being charged for any returned payments.

4. Other than the conditions mentioned above, under NO circumstance will Staci L. Rocha, LPC charge your credit card for anything not discussed personally with you. In conjunction with HIPPA regulations, all credit card information will be confidentially kept within your medical chart in our office. Only authorized staff will be able to access this information.

Acknowledged, Agreed & Accepted: I have read this form and talked with Staci L. Rocha, LPC, my signature below acknowledges that I voluntarily give my authorization and consent to providing the requested information for my credit card to be charged accordingly for the conditions listed above.

X____ _______________
Client or Responsible Party Signature **Date**

X____ _______________
Counselor Signature **Date**

initial each page : _______

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CARD AUTHORIZATION FORM

NAME, AS IT APPEARS ON CREDIT CARD:___________________________________

BILLING ADDRESS: ____

ZIP CODE: ____________________________________

AMEX/DISC/MC/VISA CARD#: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

EXPIRATION DATE: _______/_______

VERIFICATION CODE (3 or 4 DIGITS): ___ ___ ___ ___

Refusal to Complete Authorization:

Refusal to complete and agree to this authorization dictates the following:

Since there is no credit card on file, Staci L. Rocha, LPC reserves the right to send only ONE statement to the address on file to notify you of your balance with our practice. It is your responsibility to send the amount due within 30 days of your statement to avoid being sent to collections and having your account closed with our practice.

X____ ______________
Client or Responsible Party Signature **Date**

X____ ______________
Counselor Signature **Date**

initial each page : _______

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Adult Intake Assessment

Please answer all of the following questions to the best of your ability.

IDENTIFYING INFORMATION

Name: ____ Today's Date: ___/___/______

Male Female Date of Birth ___/___/______ Age: ____ SSN: __________________

Home Address: ____

City: ____State: ______ Zip Code: ______________

Home phone: __________________________ Cell/other phone: ________________________________

Email Address: ____

Is it OK to contact you at home? Yes No OK to leave a message? Yes No

Special calling instructions?

____

Business phone: ____________________________

Is it OK to contact you at work? Yes No OK to leave a message? Yes No

Special calling instructions?

____

How did you learn about my services?

____

OCCUPATION/EMPLOYMENT INFORMATION

Check all that apply: employed retired disabled student homemaker unemployed If/When employed, what type of work do you do? ____

Current employer: ____ Years on Current Job: ________

Are you currently having difficulties on the job because of (Check if yes):

emotional problems?

substance abuse?

Have you ever had difficulties at work because of (Check if yes):

emotional problems?

substance abuse?

If yes to any of the above, please explain:

____

____

____

Ever in Military Service: yes no

Currently in military? yes no Branch: _______________________________________

If you served in combat, when did you serve?

____

Type of discharge: ____

Reason for discharge: ____

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MARITAL STATUS

Marital/relationship status (Check one): Married; Live with partner (check if same ___ or opposite___ sex); Single; Separated/Divorced; Widowed; or Other: MARITAL STATUS (continued) If previously married, please provide dates of Marriage(s):

____
____

Number of years currently married: ________

Are you experiencing any problems/stresses in your current marriage/relationship? yes no Did you experience any problems/stresses in your previous marriage/relationship?   yes no

Comments regarding stresses in current or previous marriage(s)/relationship(s): ______________________

____
____
____

If you have had problems in the past, what do you think caused those relationships to end?

____
____
____

initial each page : _______

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EDUCATION

Last grade completed in school/college is/was: ________________ Degree: __________________

Are you currently enrolled in school? yes no Major/focus: ____________________________

Do you have any special training, skills, or certification? (list):

____

____

Do you have any problems reading or writing? yes no

Do you have any difficulty understanding (check any that apply): spoken instructions
written instructions
demonstrated instructions

How do you learn best?

____

____

What was school like for you?

____

____

Describe any difficulties or problems you had/have in school:

____

____

REASON FOR SEEKING

Please briefly describe the problems you are experiencing. A therapist will discuss this in more detail with you shortly.

____

____

____

____

What has happened to cause you to seek help NOW? ____

____

____

____

____

What do you hope to be able to do or achieve as a result of treatment? _________________________

____

____

____

____

What do you consider to be the other stresses in your life?

____

____

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HISTORY OF THE PROBLEM

When did you first start experiencing the problem(s) that bring you to the clinic today?

____

____

How often does the problem occur?

____

How long does it last?

____

Do you currently have thoughts of harming yourself? yes no
Do you currently have thoughts of wishing you were dead? yes no
Do you currently have urges to hurt, harm, or kill someone else? yes no
If yes, whom? ______________________
Have you ever seriously considered suicide or felt like harming someone else? yes no
If yes, please explain:

____

____

____

Do you have any problem with any of the following: overspending food binging
intentional vomiting yelling/threatening risk taking/endangering self or others
hitting, shoving, choking, or hurting others throwing or breaking things
stealing internet overuse or misuse sexual feelings/behaviors
Have you ever had previous therapy/counseling of any kind? yes no
If yes, when and for how long?

____

____

What concerns did you address in previous therapy?

____

____

____

Have you ever been hospitalized for emotional problems? yes no
Have you ever been hospitalized for substance abuse problems? yes no
If yes to either of the above, when, where, and for how long were you hospitalized?

____

____

Were any of your previous treatment experiences helpful? yes no
Please explain how you benefited or did not benefit from previous treatment:

____

____

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What medication(s), if any, have you found helpful in managing your emotional problems?

____

____

____

Have you had any experience with self-help support groups? yes no

If yes, please explain when, which ones, and whether or not you found them helpful:

____

____

SUBSTANCE USE HISTORY

Have you ever experienced a problem with alcohol, drugs, or prescription medications? yes no

If yes, please explain:

____

____

____

____

____

SUBSTANCE USE HISTORY

Have you ever been treated for problems with alcohol, drugs, or abuse or prescription medications?

yes no If yes, please explain:

____

____

Has anyone (family, doctors, friends, coworkers, bosses, etc.) ever expressed concern that you might have a problem with alcohol or drugs? yes no

If, yes, please explain:

____

____

Have you had any problems related to use of alcohol/drugs in the past year? yes no

If, yes, please explain:

____

Has drinking or drug use ever caused you problems in the following areas (check if yes):

family school employment legal emotional social financial behavior

physical health other, please describe:

____

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RISE Counseling
Staci Rocha, M.A., LPC
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(806) 300-0898 x 7 Office (806) 701-5422 Fax

FAMILY BACKGROUND

PLEASE CHECK THIS BOX IF YOU HAVE NO CHILDREN

	Names of children	Living with you?	Age	Grade	School
1.	______________________________	yes no	____	______	__________________________
2.	______________________________	yes no	____	______	__________________________
3.	______________________________	yes no	____	______	__________________________
4.	______________________________	yes no	____	______	__________________________
5.	______________________________	yes no	____	______	__________________________

Other than any children already indicated above, who lives in your household?

____

Please describe your relationships with other family members:

Relationship	Living	Frequency of contact	Describe quality of relationship
Father	yes no n/a	________________	________________________________
Mother	yes no n/a	________________	________________________________
Step-father	yes no n/a	________________	________________________________
Step-mother	yes no n/a	________________	________________________________
Spouse/partner	yes no n/a	________________	________________________________
Sister(s)	yes no n/a	________________	________________________________
Brother(s)	yes no n/a	________________	________________________________
Other	yes no n/a	________________	________________________________

Whom were you raised by? ____ Were you adopted? yes no

Please list the age and sex for each of your brothers/sisters (including those deceased, and please indicate if any are step-siblings): ____

____

____

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FAMILY BACKGROUND (cont)

What family member(s) are you closest to now?

____

____

As you were growing up, what adult(s) stood out as people you could really trust?

____

____

Check the statement(s) below that describe the type of family you grew up in:

overly close family no "breathing room" everyone was in everyone else's business
no privacy boundaries not respected Comfortably close family loving
shared many positive experiences supportive distant, everyone did their own thing
not much time spent together not a lot of support angry, lots of fighting/hostility
verbal abuse and conflicts violence frightening scared to make mistakes
other descriptors:

____

Have any biological relatives ever had any emotional problems or substance abuse? yes no
If yes, please explain:

____

____

____

Has anyone in your family ever attempted or committed suicide? yes no
If yes, please explain:

____

____

RACE/ETHNICITY RELIGIOUS AFFILIATION

Self Spouse Self Spouse					
European-American	______	______	Catholic	______	______
African-American	______	______	Jewish	______	______
Hispanic-American	______	______	Muslim	______	______
Native-American	______	______	Protestant	______	______
Asian-American	______	______	Non-Denominational	______	______
Other ________________	______	______	Eastern (e.g., Hindu, Buddhist)	______	______

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HEALTH/MEDICAL INFORMATION

Physician Address & Telephone # Approx Date of last visit

____

____

Please list significant medical problems/conditions, and indicate if you are receiving treatment for them:

____

____

____

Do any of these problems affect your everyday life? yes no If yes, how so? ___________________

____

____

Briefly describe any surgeries or hospitalizations for serious illness or injuries (What, where, when, etc.):

____

____

____

HEALTH/MEDICAL INFORMATION

Have you ever had a serious head injury? yes no If yes, describe: _________________________

____

____

Are you allergic to any medications? yes no If yes, which one(s): __________________________

____

List all medications that you currently use: *(attach page if needed)*

Medication(s) Dosage (amount and times per day) Reason(s)

____

____

____

____

____

____

Please list any “alternative” therapies/treatments you are currently using and the reason for each:

____

____

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Have you ever had or do you now have a problem with any of the following? (Check all that apply):
General

Recent Fever/Chills	Diabetes	Cigarette Smoking
Chronic Fatigue	Cancer	Tobacco Use
Frequent or Terrifying Nightmares	Drug Reaction	Alcohol Use
Night Sweats	Emotional Problems	Drug Use
Chronic Pain	Exposure to Trauma (Type:)	Insomnia or Sleep Problems
Allergies	Suicide Attempt(s)	Gastrointestinal/Hepatic/Endocrine
Nausea	Hepatitis	Weight Loss/Gain
Gastritis	Constipation	Change in Appetite
Ulcers	Gall Bladder/Stones	Anemia
Vomiting Blood	Hemorrhoids	Liver Problems
Colitis	Swollen Glands	Low Blood Sugar
Pancreatitis	Jaundice	Gallbladder/Stones
Jaundice	Hemorrhoids	Swollen Glands
Diarrhea	Thyroid Problems	Rectal Bleeding
Always Thirsty	Liver Problems	Low Blood Sugar
Musculoskeletal	Cardiovascular	Pulmonary
Broken Bones	Angina	Chest Pains/Pressure

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		Arthritis
Gout	Tuberculosis	Rheumatic Fever
Neurological	Pneumonia	Heart Valve Problems
Headaches	Skin/Sensory Systems	Urinary/Genital
Migraines	Sores/Abscesses	Frequent Urination
Skull Fracture	Skin Rash	Burning on Urination
Epilepsy	Eye Trouble	Weak Urinary System
Incontinence	Stroke	Hearing Loss
Paralysis	Ringing in Ears	Urinary Tract Infection
High/Low Blood Pressure	Coughing Blood	Blood in Urine
Irregular Heart Beat	Wheezing/Asthma	Joint Pain H
Herniated Disk	Cough	Muscle Weakness
Fainting	Shortness of Breath	Lightheadedness
Bad Back	Perforated Septum	History of Head Injury
Kidney Infection	Nose Bleeds	Double Vision
Penis/Vaginal Discharge	Gum Bleeding	Memory Loss
Menstrual Difficulties	Mouth Sores	Unsteady Gait
Sexual Difficulties	STD	Difficulty Swallowing

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INTERESTS AND ACTIVITIES

Please list any leisure activities (such as sports, clubs, religious organizations, etc.) that you are involved in currently:

____

____

Please describe your personal strengths and positive characteristics:

____

____

____

____

Other information you feel is important and wasn't asked about:

____

____

____

IN CASE OF EMERGENCY

Name(s)	Relationship to Client	Telephone No.

Thank you for your time and cooperation.

Staci Rocha MA LPC

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