Welcome to New Perspective Counseling Services. We look forward to providing you with excellent and efficient counseling services. Please take a few minutes to fill out this form. The information will help us to better understand your situation as well as potential solutions in helping you and your partner. Please note - the information is confidential, for our use only, and will not be released to anyone without your written permission.

PERSONAL INFORMATION FOR PARTNER 1

First Name: _____ Last Name: _____ Middle Initial: _____

Street Address: _____ City/State: _____ Zip Code: _____

Date of Birth: _____ SSN: _____ Sex: ☐ Male ☐ Female

Highest Level of Education Completed: _____ Religious Affiliation (if any): _____

Please check mark if it is ok to leave a message.

Home Phone _____ ☐ Yes ☐ No Work Phone _____ ☐ Yes ☐ No

Cell Phone _____ ☐ Yes ☐ No Email: _____ ☐ Yes ☐ No

Employer: _____ Length of Employment: _____ Occupation: _____

Name of Person Responsible for Payment: _____

How did you learn about this office? _____

Emergency Contact: _____ *Contact Number:* _____ *Relationship:* _____

MEDICAL AND MENTAL HEALTH HISTORY / INFORMATION

Are you being treated by a physician for any medical conditions?: _____

Are you currently taking medication? ☐No ☐ Yes; Medication name/dose: _____

Have you ever seen a Psychiatrist or any other mental health provider? If yes, when? _____

☐No ☐ Yes; Focus of treatment: _____ Helpful? ☐ Yes ☐ No

ALCOHOL / SUBSTANCE USE SURVEY

How often do you have a drink containing alcohol? ☐Never ☐ 1/month ☐ 2-4/month ☐ 2-4/week ☐more than 4/week

How many drinks containing alcohol do you consume on a day you are drinking? ☐1-2 ☐ 3-4 ☐ 5-6 ☐7 or more

Do you use marijuana or other "street drugs"? ☐No ☐ Yes; what type/quantity/frequency of use: _____

If you prefer not to answer in writing and choose to discuss this privately with the therapist, check here ☐

RISK ASSESSMENT

Is there any family history of mental illness or substance abuse? If so, please list relationship & diagnosis: _____

_____

Please list family/friends/support groups which are helpful to you: _____

Have you experienced a personal history of emotional, physical, and/or sexual abuse? _____

Has a family member or close friend ever committed suicide? ☐No ☐ Yes, relationship: _____

Have you been having any thoughts of harming yourself or others?: ☐Yes ☐ No If so, ☐ Self ☐ Other(s)

Are there any guns or weapons in your house (specify whose & what type) _____

Have you ever been involved in any significant legal actions, currently or in the past (e.g.: lawsuit, probation, parole)? If so, please stat under what circumstances: _____

PERSONAL INFORMATION FOR PARTNER 2

First Name: _____ Last Name: _____ Middle Initial: _____

Street Address: _____ City/State: _____ Zip Code: _____

Date of Birth: _____ SSN: _____ Sex: ☐ Male ☐ Female

Highest Level of Education Completed: _____ Religious Affiliation (if any): _____

Please check mark if it is ok to leave a message.

Home Phone _____ ☐ Yes ☐ No Work Phone _____ ☐ Yes ☐ No

Cell Phone _____ ☐ Yes ☐ No Email: _____ ☐ Yes ☐ No

Employer: _____ Length of Employment: _____ Occupation: _____

Name of Person Responsible for Payment: _____

How did you learn about this office? _____

Emergency Contact: _____ *Contact Number:* _____ *Relationship:* _____

MEDICAL AND MENTAL HEALTH HISTORY / INFORMATION

Are you being treated by a physician for any medical conditions?: _____

Are you currently taking medication? ☐No ☐ Yes; Medication name/dose: _____

Have you ever seen a Psychiatrist or any other mental health provider? If yes, when? _____

☐No ☐ Yes; Focus of treatment: _____ Helpful? ☐ Yes ☐ No

ALCOHOL / SUBSTANCE USE SURVEY

How often do you have a drink containing alcohol? ☐Never ☐ 1/month ☐ 2-4/month ☐ 2-4/week ☐more than 4/week

How many drinks containing alcohol do you consume on a day you are drinking? ☐1-2 ☐ 3-4 ☐ 5-6 ☐7 or more

Do you use marijuana or other "street drugs"? ☐No ☐ Yes; what type/quantity/frequency of use: _____

If you prefer not to answer in writing and choose to discuss this privately with the therapist, check here ☐

RISK ASSESSMENT

Is there any family history of mental illness or substance abuse? If so, please list relationship & diagnosis: _____

_____

Please list family/friends/support groups which are helpful to you: _____

Have you experienced a personal history of emotional, physical, and/or sexual abuse? _____

Has a family member or close friend ever committed suicide? ☐No ☐ Yes, relationship: _____

Have you been having any thoughts of harming yourself or others?: ☐Yes ☐ No If so, ☐ Self ☐ Other(s)

Are there any guns or weapons in your house (specify whose & what type) _____

Have you ever been involved in any significant legal actions, currently or in the past (e.g.: lawsuit, probation, parole)? If so, please stat under what circumstances: _____

Couple's Relationship / Family Information

How long have you been in this relationship together? _____

How long have you been engaged? _____When is your wedding date?_____

Have either one of you previously been married?_____

Do clients have children together? Y / N If so, please provide names and ages: _____

_____

Do either of you have children from a previous partner? If so, please state which client and list names and ages of the children: ___

_____

Do you have any pets in the home? If so, what type? _____

List any other individuals living in either of your homes:_____

PRE-MARITAL GOALS

Goals are very important in counseling. They provide me with a focus and direction that will help us to help you. Please list the goal(s) that you hope to address and achieve in counseling. Please be as specific as possible.

PARTNER 1:_____

PARTNER 2:_____

Please rate the following topics from 1-6 (with 1 being most needed) indicating in what area you feel you need the most assistance as a couple:

___ Finances ___ Distribution of Household Responsibilities ___ Children/Parenting ___ Intimacy/Sex

___ Role of Friends/Extended Family ___The role of Spirituality/Religion in your lives

What would you say that your greatest strengths are as a couple?_____

_____

By signing below, I confirm that the information I have provided is true and correct. I understand that I must be committed to attend sessions on a consistent basis in order to receive the greatest benefit from therapy. Although I may stop therapy at any time, I agree to inform my therapist of my decision **prior** to my last visit. If my therapist believes that I can receive more effective treatment elsewhere, I will be given referrals. I understand that I may not attend a session if I am under the influence of alcohol or drugs, or if I am in possession of a dangerous weapon. My signature below indicates my desire and consent to receive mental health services from New Perspective Counseling Services (NPCS).

I understand that I have the right to agree to, or to refuse mental health services provided by NPCS. By signing below, I am indicating my desire to receive Mental Health services from a NPCS therapist

_____	_____	_____
Partner 1 Name - Printed	Signature of Partner 1	Date
_____	_____	_____
Partner 2 Name - Printed	Signature of Partner 2	Date

New Perspective Counseling Services

Client Services Agreement

PAYMENT INFORMATION:

I understand that I (the client) am fully responsible for the payment of all fees for services provided and that NPCS will not bill my insurance company for premarital counseling. I understand that it is NPCS' policy that the fee for any session is payable at the beginning of the session. NPCS accepts cash, checks or credit cards as forms of payment. *All sessions are 45 - 50-minutes in length*. The fee for an initial intake session is $160.00. The remaining 5 sessions are $135 each.

I understand that NPCS offers a reduced fee for prepayment of the 6-session premarital program. If paid on the day of each session, the total fee paid would be $835. However, if I elect to prepay for the program, I will pay only $725 total (saving $110).

CANCELLATIONS AND MISSED APPOINTMENT AND POLICY

I understand that unless a verifiable emergency exists, I must cancel or re-schedule my appointment 24 hours in advance. Same-day cancellations will incur a $50 fee applied to my account and my failure to attend a scheduled appointment without cancellation (a "no-show") will incur a $100 fee to my account. I can expect an invoice to be mailed directly to me if I do not show up or timely cancel a scheduled appointment. The voicemail system at NPCS records the day and time of all messages left. If I cancel appointments on a consistent basis or miss appointments twice in a row without reasonable cause, NPCS reserves the right to refer me elsewhere for services. I understand that this policy is not meant to be punitive, but instead is to request consideration for the professionals who are providing me a valuable service. My appointment time is reserved for me at the exclusion of others who may be waiting to see the therapist. Since NPCS' practice is fee for service, my late cancellation or failure to show for an appointment may result in a loss of income for the therapist.

RETURNED CHECKS

Any check not honored by your bank for any reason will result in a $35 returned check fee. Returned checks, in some cases, may or may not be processed by the bank twice before deemed insufficient. Returned checks must be paid by cash, money order or credit card. Failure to pay any returned check and fees may result in criminal prosecution.

My signature below indicates that I have read, understand, and agree to the statements made above regarding Treatment, Payment & Insurance Reimbursement, and Cancellations and Missed Appointment and Returned Check Policy.

CLIENT 1 Name (please print): _____

PARTNER 2 Name (please print): _____

PARTNER 1 Signature: _____

PARTNER 2 Signature:_____

Date: _____/_____/_____

Date: _____/_____/_____

New Perspective Counseling Services

Limits of Confidentiality

I understand that the contents of a counseling, intake, or assessment session are protected under the confidentiality laws of the State of Texas. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of this office not to release any information about a client without a signed release of information. Noted exceptions are as follows:

- Signed authorization to release information to a specific individual or organization.
- Therapist determination that you may harm yourself or someone else
- Disclosure of abuse, neglect, or exploitation of a child, the elderly, or disabled
- Disclosure of professional misconduct of another mental health professional
- Court order or requirement by law to disclose information
- Prenatal exposure to controlled substances
- In the event of a client's death (the spouse or parents of a deceased client have a right to access their child's or spouse's records)
- Minors/Guardianship (parents or legal guardians of non-emancipated minor clients have the right to access the client's records)
- Insurance Companies (only information required for billing purposes)

By my signature below, I agree that I understand my right to confidentiality and the above noted exceptions.

PARTNER 1 Name (please print): _____ PARTNER 2 Name (please print): _____

PARTNER 1 Signature: _____ PARTNER 2 Signature:_____

Date: _____/_____/_____ Date: _____/_____/_____