NEW CLIENT INFORMATION SHEET

Thank you for choosing **Elledge Counseling Associates** for your counseling needs. The following pages contain:

- Directions to the Counseling Center
- Fee Scale and Counselor Experience
- Professional Disclosure and Informed Consent
- Financial Consent Statement and Fee Accountability
- Limits of the Counseling Relationship
- Notice of Privacy Practices
- Notice of Your Health Information Rights
- Child Intake Form

Please complete each of the attached pages (one set each, if participating in marital or family counseling) and bring them with you to your first appointment.

If you are divorced, we will also need a copy of the divorce decree documenting your right to seek counseling for your child before we can proceed with the appointment.

If you have any questions, prior to your appointment, please feel free to call 972-268-3096. Again, thank you for choosing **Elledge Counseling Associates**. We look forward to meeting with you soon.

DIRECTIONS TO OUR LOCATIONS

Red Oak 103 W. Red Oak Rd., Red Oak, TX 75154

From Interstate 35 East, exit Red Oak Rd. and continue. We are located on your left in an unmarked, brick house across the street from Rock Community Church. Please park in the gravel parking lot and ring the doorbell if the door is locked when you arrive. Your counselor will be with you as soon as possible.

From FM 342, go west onto Red Oak Rd and cross the railroad tracks. We are located on your right in the unmarked, brick house across the street from Rock Community Church. Please park in the gravel parking lot and ring the doorbell if the door is locked when you arrive. Your counselor will be with you as soon as possible.

Waxahachie 210 YMCA Dr., Waxahachie, TX 75165

From Hwy 77/Ferris Avenue turn west onto YMCA drive and follow it to the dead end. The offices of The Avenue Church will be on the right. We are located inside. Please come in and your counselor will be with you as soon as possible.

Ferris 304 W 5th St., Ferris, TX 75125

From Red Oak travel east on Ovilla Road/ FM 664. FM 983 and FM 664 will merge. Soon after the merge, turn left on N. Wood St. Next, take the first right onto 5th St. The counseling sessions are held inside the church offices and you will enter under the awning. You may wait outside by the door or in your car and your counselor will come for you as soon as possible.

From FM 983/6th St., traveling west, turn right onto N. Church St. and take the first left onto 5th St. The counseling sessions are held inside the church offices and you will enter under the awning. You may wait outside by the door or in your car and your counselor will come for you as soon as possible.

Ennis 1200 Country Club Rd., Ennis, TX 75119

Following I-35E and U.S. 287 exit US-287 Business. From, US-287 Business turn north onto Jeter Dr. Turn right on Country Club Rd. The church will be on your left. Park near the covered driveway entrance. You may wait outside by the door or in your car and your counselor will come for you as soon as possible.

Duncanville 227 W. Center St., D'ville, TX, 75116

From Hwy 20, traveling west, exit Duncanville Rd./Main St. Turn left onto Main St. going south and then veer right at fork to make a right onto Center St. Cross the railroad tracks. Our offices are in a white house with a red door, surrounded with a large porch and rocking chairs out front. A sign in the yard will say, "Project Duncanville." Please come right in and your counselor will be with you as soon as possible.

From Hwy 20, traveling east, exit Cedar Ridge and turn right. Take a left on W. Center St. Travel east about a mile and our offices will be on your left in a white house with a red door, surrounded with a large porch and rocking chairs out front. A sign in the yard will say, "Project Duncanville." Please come right in and your counselor will be with you as soon as possible.

Midlothian 620 N Hwy 67, Midlothian, TX 76065

From 287 North take the Hwy 67 N./Dallas exit. Take the frontage road and the church entrance will be on your right. During the day you may come right in and wait in the church foyer. All other times please wait outside or in your car and your counselor will be with you as soon as possible.

From Hwy 67 S. exit U.S. 287/Ft.Worth. Turn left under the highway and follow the frontage road to the church entrance on your right. During the day you may come right in and wait in the church foyer. All other times please wait outside or in your car and your counselor will be with you as soon as possible.

FEE SCALE AND COUNSELOR EXPERIENCE

Fee Scale

The fees for a 45/50 minute counseling session range in price from $25-$75 and are based on your counselor's education, experience, and office location. We accept exact cash or personal checks. We also accept credit cards; however, you will incur a processing fee in addition to your regular session fee. Please call for more details.

If your insurance company allows you to seek mental health benefits out of network, then there is a good chance they will reimburse you whatever percentage of "normal and customary charges" they have agreed to cover, less your deductible (if any). If you are part of an HMO, they will not pay for counseling through **Elledge Counseling Associates**, as we have chosen not to be on provider panels for any insurance company.

If you choose to seek reimbursement from your insurance company, we will provide you with a receipt for services that should suffice for you to file your own claim.

Counselor Experience

A Licensed Professional Counselor (LPC) in the state of Texas has completed a master's degree in psychology or counseling, passed the state exam, and completed 3,000 postgraduate hours of supervised experience with clients.

A Licensed Professional Counselor Intern (LPC Intern) in the state of Texas has completed a master's degree, passed the state exam, and is currently working on the required 3,000 postgraduate hours of supervised experience with clients.

A practicum student is at the end of their master's program working on the required hours of supervised counseling experience to complete their graduate degree.

PROFESSIONAL DISCLOSURE AND INFORMED CONSENT

I consent to my child taking part in treatment with a counselor of **Elledge Counseling Associates**. I understand that the counselor will develop a treatment plan consisting of goals I have for my child, goals my child may have and those the counselor determines are in the best interest of my child. I agree to participate as deemed necessary and helpful by the counselor.

I understand that no promises have been made to me as to the results of treatment.

I am aware that I may stop treatment at any time, however, I agree to talk with the counselor if I feel like ending therapy before all the treatment goals for my child are met.

Sessions last for 45/50 minutes. I also understand that if I am late to my appointment the counselor will not run over into another client's time.

In the case of an emergency after regular business hours I may call the after-hours number to speak to the counselor on call. That number is 972-268-3096.

Confidentiality is the ethical right of all clients. However, there are certain exceptions, which supersede the confidentiality of the client-therapist relationship. Exceptions to Confidentiality: 1. The therapist makes an assessment of an impending suicide risk. (Chapter 611, Family Code) 2. A client reports past or present instances of the abuse or neglect of a child, elderly person, or mentally challenged person (Chapter 261, Family Code) 3. A client acknowledges committing abuse or neglect of a child, elderly person, or mentally challenged person either in the present or the past. (Chapter 261, Family Code) 4. There is a probability of imminent harm to the client or others. (Chapter 611, Sec. 004(a)(2) Health and Safety Code) 5. Counseling records may be released when they are subpoenaed by a court of law. I have read the preceding exceptions and understand that under the above stated circumstances the confidentiality of the client-therapist relationship is superseded. I understand that in such instances the therapist is bound ethically and legally to inform the proper authorities.

If any counselor from **Elledge Counseling Associates** is compelled to appear or testify on my or my child's behalf, either in a deposition or in court, I agree to pay that counselor for his or her time out of the office. The associated cost will be the counselor's regular session fee for up to 60 minutes of the counselor's time, with an additional regular session fee charged for every hour (or partial hour) thereafter. Billable time will include the average drive time to and from the Counseling Center office and the place of testimony.

Elledge Counseling Associates charges a counselor's regular session fee per hour to complete requested or subpoenaed documentation on you or your child's behalf. There is *no charge* for providing you with a standard receipt needed for insurance reimbursement purposes.

If the client is under the age of 18 years, I testify with my signature below that I have legal custody and authority and give my consent for _____ to receive counseling from **Elledge Counseling Associates**.

By signing below you are stating that you have read and understood this policy statement. In addition, you consent to participate in evaluation and/or treatment. You have had your questions concerning this document answered to your satisfaction.

Parent/Guardian Signature _____ Date _____

FINANCIAL CONSENT AND ACCOUNTABILITY STATEMENT

I am aware that I must call to cancel an appointment within 24 hours of that appointment in order to avoid full financial responsibility for that session. It is my responsibility to call my counselor (day/night/weekend) to cancel my appointment.

Furthermore, I agree to the one time charge or debit to my credit/debit card in the amount of my regular appointment fee plus the service charge, following any missed session or appointment cancelled with less than 24 hours notice. **Elledge Counseling Associates** is not required to notify me of this charge.

I am aware that payment is due at the beginning of each session. All checks should be made out to **Elledge Counseling Associates**. If paying by cash, only exact amounts will be accepted. If you do not bring exact cash, your counselor will not be able to make change and the excess will be applied to your next session. If you choose to pay ahead for sessions, please be aware that we do not provide refunds for unused sessions.

If my check is returned for insufficient funds I agree to bring cash payment for the session and the NSF bank charge before my next scheduled appointment. If no cash payment is made, I agree to a one-time credit/debit charge to my account plus the NSF fee and the service charge to be made. **Elledge Counseling Associates** is not required to notify me of this charge.

If I fail to provide payment at the beginning of my session, my counselor will be unable to meet with me for our regularly scheduled session.

I understand that my counselor is unable to make further appointments with me until any balance on my account is paid in full.

I am aware that I must return any resources (CDs, DVDs, books, etc.) loaned to me. If I do not return the material(s) by the deadline given by the counselor, I agree to the one-time charge or debit to my credit card in the amount of the replacement cost of the material(s).

Credit /Debit Card Information:

Name as it appears on the card_____
Credit/Debit Card #_____ Expiration Date_____
Security Code on back of card _____
Cardholder's Zip Code _____

All Clients' Printed Names that this form applies to (including parents & children):_____
_____
_____

_____ _____ _____
Parent/Guardian signature Printed Name Date

LIMITS OF THE COUNSELING RELATIONSHIP

Although sessions with your counselor may be very intimate psychologically and interpersonally, the relationship is a professional relationship rather than a social one. Contact must be limited to sessions you arrange with your counselor.

Due to ethical guidelines, you are asked not to invite your counselor to social gatherings, offer gifts, ask your counselor to write references for you or relate to you in any way other than the professional context of the counseling sessions (this includes any interaction involving social networking sites).

Your counselor is required to keep the identity of clients confidential. Therefore, your counselor cannot and will not acknowledge you outside of counseling sessions unless you first acknowledge them.

Again, in order to maintain proper ethical standards, when the counseling relationship ends, the limitations of contact with your counselor must remain the same.

I have read and understand the Limits of the Counseling Relationship.

_____ _____

Parent/Guardian Signature Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION
ABOUT YOU MAY BE USED AND DISCLOSED
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

We are required by The Health Insurance Portability & Accountability Act of 1996 (HIPAA) to provide confidentiality for all medical/mental health records and other individually identifiable health information in our possession. This Notice is to inform you of the uses and disclosures of confidential information that may be made by the practice, and of your individual rights and the practice's legal duties with respect to confidential information.

Ways in Which We May Use and Disclose your Protected Health Information:

We may use and disclose at our discretion your medical records for each of the following purposes only: treatment, payment and healthcare operations.

- **Treatment** means providing, coordinating, or managing mental health care and related services. *For example* – use or disclosure by the health care provider in training programs in which "students, trainees, or practitioners in mental health" learn under supervision to practice or improve their skills in group, joint, family, or individual counseling.

- **Payment** means activities such as obtaining payment for the mental health care services we provide for you either from your insurance or another third party payer. *For example* – we may include information with a bill to a third-party payer that identifies you, your diagnosis, and procedures performed.

- **Health care operations** include the business aspects of running our practice. *For example* – to evaluate our treatment and services, or to evaluate our staff's performance while caring for you.

We may contact you to provide appointment reminders or other services that may be of interest to you. We will disclose your protected health information to any person *you identify* that is involved in your care or payment for your care. For example - a family member, relative, close friend, a pastor or pastor's representative whom you have asked us to communicate with.

We will use and disclose your protected health information *when required to by federal, state, or local law*. There are certain situations in which, as a therapist, I am required by ethical standards to reveal information obtained during therapy to other persons or agencies - even if you do not give permission. These situations are as follows: (a) If you threaten grave bodily harm or death to yourself or another person, I am required by ethical standards to inform the intended victim and/or appropriate law enforcement agencies; (b) if you report to me your knowledge of physical or sexual abuse of a minor child or of an elder (over 65) or any sexual conduct/contact with a minor, I am required by law to inform the appropriate child welfare agency which may then investigate the matter; (c) if I am required by a court of law (court order) to turn over records to the court or are ordered to testify regarding those records.

Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked. You may revoke an authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Please sign to indicate you understand our operational use of your information for treatment, payment and healthcare operations as stated above.

_____ _____

Signature of Parent/Guardian Date

NOTICE OF PRIVACY PRACTICES CON'T

Your Health Information Rights:

Although your records are the physical property of **Elledge Counseling Associates**, the information belongs to you. You have the following rights with respect to your information, which you can exercise by presenting a written request to our office manager.

You have:

- The right to request restrictions on certain uses and disclosures of your information. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. For example – a request that we not identify the agency when we contact you. (i.e.- "This is **Elledge Counseling Associates** calling")
- The right to inspect and copy the information that we maintain about you. However, we ***may deny an individual access***, provided that the individual is given a right to have such denials reviewed, in the following circumstances:
    - a health care provider has determined, in the exercise of professional judgment, that the access requested is reasonably likely to ***endanger the life or physical safety of the individual or another person***;
    - the information makes ***reference to another person*** (unless the other person is a health care provider) and the health care provider has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or
    - The request for access is made by the individual's personal representative and the health care provider has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to ***cause substantial harm to the individual or another person***.
    - If you wish to inspect or copy your information, you must submit your request in writing to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.
- The right to billing records.
- The right to revoke your consent to release information except to the extent that the agency has taken actions in reliance on the previously signed consent form.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. For example – at your regularly scheduled appointment at a church satellite office, or by e-mail or fax.
- The right to amend your information if you feel that it is incomplete or inaccurate. You must make this request in writing to your therapist stating exactly what information is incomplete or inaccurate and your reasoning to support your request. We will respond to your request with in sixty (60) days. In rare cases your request may be denied. For a complete description of Rights of Amendment, please contact our office manager.
- The right to receive an accounting of disclosures of protected health information
- The right to obtain a paper copy of this notice from us upon request.
- The right to file a complaint if you believe we have violated your medical information privacy rights. You have the right to file a written complaint to our office manager, or Executive Director, or directly to the Secretary of Health and Human Services

To file a complaint with our practice, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to Brenda Elledge, Director, **Elledge Counseling Associates**, 103 West Red Oak Road, Red Oak, TX 75154. You should know there will be no retaliation for your filing a complaint.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. If and when one is available, you may request a written copy of a revised notice from this office.

Elledge Counseling Associates

Confidential Child Intake Information

Date _____

The purpose of this form is to obtain a comprehensive picture of your child's current circumstances. Answering these questions as fully and accurately as possible will facilitate the initial evaluation and make better use of our time. If there are questions on this form that you do not wish to answer, feel free to leave them blank.

Child's Name:_____ **Age**:_____ **Date of Birth**:_____ **Gender:** □MF

Your Name:_____ **Address**:_____ May we contact using:
City/State/Zip:_____ **Home Phone**:_____ □yes no
Work Phone:_____ **Cell Phone/Text**:_____ □yes no
Occupation:_____ **E-mail**:_____ □yes no
Date of Birth:_____ **Age**:____ **Your Relationship to Child**:_____

What is your relationship status? (please circle)
single divorced separated widowed married relationship remarried

Other Parent Name:_____ **Address**:_____ May we contact using:
City/State/Zip:_____ **Home Phone**:_____ □yes no
Work Phone:_____ **Cell Phone/Text**:_____ □yes no
Occupation:_____ **E-mail**:_____ □yes no
Date of Birth:_____ **Age**:_____ **Gender**: □MF

What is their relationship status? (please circle)
single divorced separated widowed married relationship remarried

Are both parents aware of this counseling appointment? □yes no
Are you willing for them to be involved in therapy as deemed necessary? □yes no
Are they willing to be involved in therapy as deemed necessary? □yes no

Please list any additional siblings:

1.	***Age:***	***Step:*** □yes no	***Adopted?*** □yes no	***Gender:*** □male female
2.	***Age:***	***Step:*** □yes no	***Adopted?*** □yes no	***Gender:*** □male female
3.	***Age:***	***Step:*** □yes no	***Adopted?*** □yes no	***Gender:*** □male female
4.	***Age:***	***Step:*** □yes no	***Adopted?*** □yes no	***Gender:*** □male female
5.	***Age:***	***Step:*** □yes no	***Adopted?*** □yes no	***Gender:*** □male female

Referred To Elledge Counseling Associates by: _____
Do you currently attend a church? □yes no If yes, Name of Church _____

Client Name _____

DOB /Age_____

LIFE FUNCTIONING INVENTORY

Please list the problem(s) with which you want help:_____
_____
_____

How long has this been a problem? _____
_____

How has this been a problem? _____
_____
_____
_____

Has your child had previous counseling or other psychological treatment(s)? □yes no
If yes, where and when was this received? For what problems? Was this a good or bad experience?

_____
_____
_____

What strategies have been used at home to address these problems?

verbal reprimands	avoiding the child	removal of privileges
time-out	yelling	giving in
physical punishment	rewards	communication

Over which of the following issues (if any) do you have regular conflict?

room cleaning	dating relationships	choice of friends
curfew	household chores	church attendance
music	clothes/appearance	other _____

Do you consider yourself (and your spouse) consistent in your disciplining?

most of the time	some of the time	none of the time

Do you and your spouse have any consistent differences in your approach to discipline or expectations of your child?
□yes no □n/a

Family Information:
Please list any previous mental health history of any family members: _____
_____
_____

Briefly describe your child's relationship with other members of your household: _____
_____
_____

Medical History:
Has your child had any of the following:

head injury	what age? _____	loss of consciousness? □yes no
surgery	for what? _____	
broke bones	describe: _____	
severe injury	describe: _____	
medications	list: _____	

Client Name _____

DOB /Age_____

Is your child having any difficulty with appetite or eating habits? □yes □ no
If yes, check were applicable:
□ eating less □ eating more □ binge eating □restricting calories □ significant weight change (in past two months)

Has your child ever been hospitalized for psychiatric reasons? □yes □no
If yes, please specify the following: Reason for hospitalization: _____
Hospital location: _____
Dates of hospitalization: _____
Duration of hospitalization: _____

Has your child had suicidal thoughts recently? □yes □no If yes, how often? □daily weekly □monthly □rarely
Have they had them in the past? □yes □no If yes, how often? □daily □ weekly □monthly □rarely

Has your child ever intentionally inflicted harm upon themselves? □yes □no
If yes, how often? □daily □weekly □monthly □rarely Nature of harm: _____

Academic History:
School currently attending: _____ Grade: _____
Grades (check all that apply):

Most recent report card:	___A's	___B's	___C's	___D's	___F's
Typical grade performance:	___A's	___B's	___C's	___D's	___F's

Has your child ever had an individual, educational assessment? □yes no
If yes, where, when, and what were the results? _____
_____
Has your child ever been held back a grade? □yes □no If yes, what grade? _____ Reason?
_____

Check any of the following learning problems that have been identified:

ADD/ADHD	Dyslexia	Reading Disorder
Math Disorder	Written Expression Disorder	Other: _____

How easily does he/she make friends?

better than average	average	worse than average

Does your child have a best friend? □yes no Friends how long? _____On average, how long does your child keep friendships?

less than six months	one year	more than a year

Miscellaneous:
Please list any major changes in your child's life over the past five years:
_____
_____
_____

Is there anything else you want me to know about your child? _____
_____
_____

Please list a few positive traits and strengths of your child: _____
_____
_____

Thank you for completing this paperwork. I look forward to meeting you and your child.

_____ _____
Form Completed By (Print Name) Signature of Parent/Legal Guardian