Abiding Hope
Christian Counseling

19115 FM 2252, Ste. 12, San Antonio, TX 78266
210-951-0049
www.abidinghopecc.com

Kelly Anderson, LPC-Intern
Supervised by Shelly Cook, LPC-S, RPT-S

INFORMED CONSENT FOR INDIVIDUAL THERAPY, TREATMENT AGREEMENT FOR PSYCHOTHERAPY AND OFFICE POLICIES

Welcome to Abiding Hope Christian Counseling. This document contains important information about my professional services and business policies. Please read it carefully and let me know if you have any questions. When you sign this document, it will represent an agreement between us. If you decide that you do not wish to consent to these services and policies and, therefore, would not like to proceed with services here, there will be a $75 charge for our meeting today regardless of the length of the meeting. If you would like to know more about me on a personal level please read my bio on the website: www.abidinghopecc.com.

PSYCHOTHERAPY SERVICES

I conceptualize psychotherapy from a systems perspective, in which the experiences of an individual is interrelated, both influencing and being influenced by the behaviors of the other member(s) of the individual's relationship or family. Within this general framework, I generally approach therapy from an integrative theoretical orientation, which means that I endeavor to choose theoretical approaches suited to the particular presenting issues and concerns of the client. For example, I typically draw from cognitive-behavioral theory to address communication skill deficits, whereas insight-oriented approaches may be better suited to address emotional relationship trauma. I view psychotherapy as a collaborative task, in which you take an active role in working toward your goals, both within and between sessions. As a Christian counselor, I am available to help clients with spiritual issues, and am happy to incorporate spiritual interventions into the counseling process.

A therapist helps clients with mental, emotional, cognitive, and behavioral difficulties. Psychotherapy is intended to help you reach a better understanding of specific problems or increased self-awareness. It is also intended to work toward improvement of the identified problems, offer support in problem solving, provide some symptom relief, and improvement in coping with daily life activities. Your progress in psychotherapy and its outcome depends upon many factors including but not limited to your level of motivation and desire to change, the effort that you put forth in following through with agreed upon therapeutic tasks outside of session, keeping your appointments, and your willingness to be open with me as we work together.

Therapy may have both risks and benefits. It often involves discussing difficult or unpleasant aspects of your life, and you may experience uncomfortable feelings about these discussions, such as sadness, guilt, anger, and frustration. Some of the changes you make as a result of psychotherapy may not be welcomed by other people in your life. This may result in some strain in your relationships with family and others. Therapy may disrupt a romantic relationship. Sometimes, too, it is possible for a client's problems to worsen immediately after beginning therapy. Most of these risks are to be expected when people are making important changes in their lives.

On the other hand, research has shown that therapy may also be beneficial, leading to improvements in individual psychological health, communication and problem-solving skills, and relationship satisfaction. It is important to understand that there are no guarantees about what you may experience during therapy or how therapy may affect you.

INITIAL ASSESSMENT

Our first session, and possibly the first few sessions, will involve an assessment of your therapy needs and goals. There are several possible outcomes of this initial assessment, as it is an opportunity for us to decide if working together may beneficial for you.

If my therapeutic approach appears to fit with your individual goals, I will offer you some first impressions of what our work will include if you decide to continue with therapy. I encourage you to evaluate this information, along with your own opinions of whether you feel comfortable working with me, in deciding whether to continue with therapy. If you have any questions about my procedures during the initial assessment, or at any point in subsequent treatment, please bring them to my attention.

Therapy involves a large commitment of time, money, and energy, so you should be careful about the therapist you select. If you decide to continue with treatment, then we will move toward scheduling therapy sessions. If, after our initial assessment, you believe that you would be more comfortable working with another mental health provider or I believe that another mental health provider may be better suited to assist you with your specific concerns, I will be happy to provide referrals.

THERAPY SESSIONS AND ATTENDANCE

If psychotherapy is begun, I will typically schedule therapy sessions 52 minutes duration for one session. When an appointment hour is scheduled, you will be expected to pay for the session unless you provide 24 hours advance notice of cancellation, except in the case of an emergency: unexpected illness or hospitalization of yourself or immediate family member, car accident or other car emergencies such as flat tires, dead batteries, or the death of a family member. If you determine more than 24 hours in advance that you may be unable to attend, please contact me via my voice mail number **210-951-0049,** so that you can schedule an alternative time. If you cancel without 24 hours notice, there is a $75 late cancellation fee. If I am running late, you will get your full therapy hour. If you are more than 25 minutes late, you will be considered a late cancellation, charged the late cancellation fee and be rescheduled.

Together we will typically agree on specific goals for therapy, such as symptom reduction, behavioral change, improved communication and/or interpersonal skills, the ability to return to work or school, and I will prepare a written treatment plan. Goals will in all likelihood change as the therapy progresses and should be renegotiated accordingly. The therapeutic approach used will vary and should be discussed with me whenever you have questions or when you believe therapy is not helpful.

How long you remain in therapy and the frequency of sessions is a matter best discussed while we work together to achieve your goals. While it is your right to end therapy at any time, when you decide to end treatment it is in your best interest to discuss this with me beforehand and before what you believe will be the last session.

Parents. If you are a parent your participation in your child's counseling is important for long-term gains. You may need to learn a different way of dealing with your child to facilitate and maintain gains. I will ask for your feedback and views on your (your child's) therapy, progress and other aspects of the therapy and will expect you to respond openly and honestly.

Minors. When working with minor clients I will initially meet with all involved parents or caregivers before meeting with the client. From that point forward all discussions about clinical matters and concerns about the client will be done in the presence of the minor. Meetings without the client present tend to undermine the trust and therapeutic relationship. How frequently caregivers attend is something that can be negotiated at the outset of treatment and can be adjusted as needed.

For minor clients who are between 16-17 years of age, it is my policy to request an agreement from the patient and his/her parents that the parents' consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's consent, unless I feel that the child is in danger or is a danger to someone

else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

Additionally, if you are a parent or guardian who is consenting to treatment for a minor, by signing this Agreement, you affirm that you are the parent or legal guardian of the child; that you have the legal right to consent to psychological treatment for the child; that there has not been a Divorce Decree or any other Court Order that limits your ability to consent to the child's treatment. If the child's parents are divorced or never married, it is my practice to require BOTH parents to consent to treatment, in compliance with any Divorce Decree or Court Order that may be in place. I will also require a copy of the Divorce Decree or Court Order prior to providing any services to the child, and by your signature below, you agree to provide it immediately upon request.

In my practice, if the parents of the child client have remarried or have significant others who may be involved in the child's therapy, I like to meet with all the adults before seeing the child to obtain signed Authorizations for the limited sharing of information regarding the child, and to establish the boundaries for my treatment of the child. My first rule is that none of the adults should ask to speak with me before the child's appointment in front of the child. If you have information to share, please do it privately. Also, I do not generally allow step-parents to make therapy appointments for child clients unless the child's parents have signed an Authorization allowing the step-parent to schedule the child's appointments.

TERMINATION OF TREATMENT

I hope we will mutually agree about when you have met your treatment goals, so we can schedule final sessions to review your progress and develop a plan to help protect your relationship from future distress. However, there are a few instances in which I may terminate our work together before reaching that point. If I believe that my approach and training is no longer appropriate for your specific concerns, or that either of you are not benefitting from treatment, I will inform you that I can no longer provide services and give you referrals to other mental health professionals who may be better suited to meet your needs.

I understand that any termination may be difficult, but my decision on this matter will be final. If you request and authorize it in writing, I will confer with your new therapist to help with the transition. Upon termination of therapy for any reason, the termination will be confirmed in writing.

If you choose to involve the legal system in our work together by issuing a subpoena for my treatment records or my testimony in court, this will represent a conflict of interest for me, and I will terminate our therapeutic relationship and provide referrals to other providers.

In addition, if you schedule a session and do not attend the session or call me within 7 days of that appointment, I will understand that as a termination in our services. If you cancel three appointments in a row, you will also be terminating our services. If you wish to resume services after this occurs, please contact me via my voice mail, 210-951-0049. You must agree to pay for the full fee, $75, in advance to be able to resume services and understand this is non-refundable in the event you cancel or no-show for that appointment.

PROFESSIONAL FEES

My hourly fee for a single therapy session is $75. In addition to therapy appointments, I may charge my standard $75 hourly fee for other professional services you may need, although I will prorate the hourly cost if I work for periods of less than one hour. Other services may include report writing, telephone conversations lasting longer than 15 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.

LITIGATION POLICY AND FEES FOR COURT-RELATED SERVICES

I do not want to be involved in your litigation. I do not want to deal with subpoenas or lawyers or having to disclose your confidential information in court. I do not enjoy going to court and I do not want to deal with the negative feelings that can result from court or deposition testimony. The nature of the therapeutic process often involves making a full disclosure with regard to many matters which may be extremely private, upsetting or

embarrassing. If you become involved in any legal proceeding during your therapy with me, including but not limited to divorce and custody disputes, or personal injury lawsuits, you agree that neither you, nor your attorneys, nor anyone acting on your behalf will subpoena records from my office, or subpoena me to testify in court, in a deposition or in any legal proceeding. By your signature below, you acknowledge my position and agree to abide by my litigation policy.

If you involve me in your litigation, or if you or your attorneys subpoena me to provide my records, testify in court or give a deposition in violation of this agreement and against my stated wishes, I will comply with lawfully issued subpoenas. **My hourly charge for all time related to court cases or litigation is $350 per hour. You also agree by your signature below to execute and sign a Credit Card Authorization and provide a valid credit card to ensure payment for the time I must spend dealing with your litigation.**

If I am subpoenaed to provide records or testimony in violation of this agreement and against my stated wishes, you also acknowledge and agree that you will pay for all of my professional time, including but not limited to preparation, record review, transportation charges (door-to-door), waiting time, and time spent testifying in court or deposition **regardless of which party issues the subpoena or requires me to testify**.

If I am required to testify in court or give a deposition in Bexar County, I will charge an hourly fee of $350 per hour for a minimum of 4 hours, for a minimum of $1400 and this includes preparation time, travel time, and attendance at any legal proceeding. If I am required to testify in court or give a deposition outside of Bexar County, the hourly fee will be $350 for a minimum of 6 hours for a minimum of $2100. If the testimony or deposition exceeds 4 hours (in Bexar County) or 6 hours (outside Bexar County), there will be an additional charge of $350 per hour for every hour spent in court or deposition.

When I go to court or give a deposition, I have to clear my schedule and not see other clients, so there is a 48-hour cancellation policy for court and depositions. For example, if the court appearance or deposition is scheduled for Monday, this office must be notified of any cancellation no later than Noon on the Thursday before. Any cancellations that occur within the 48-hour time frame of the court appearance or deposition are **NON-REFUNDABLE**.

I will accept cash, money order, cashier's check, or credit cards for payment of time related to court appearances or deposition. **NO PERSONAL CHECKS WILL BE ACCEPTED FOR THESE SERVICES**. All payments are due one week prior to the scheduled court appearance or deposition. By your signature below, you expressly authorize me to run these charges to the credit card on file in our office unless you notify me that you intend to make payment by cash, money order or cashier's check.

Finally, if I am subpoenaed by one party to provide records or testimony in violation of this agreement and against my stated wishes, I reserve the right to terminate our professional, therapeutic relationship immediately and refer you to other mental health providers.

I will NOT perform social studies or custody evaluations. I will NOT provide recommendations regarding possession, custody, access to or visitation with minor children. I will NOT provide medication or medical advice. I will NOT provide legal advice. These services are NOT within the scope of my practice.

BILLING AND PAYMENTS

You will be expected to pay for each session either before or at the time it is held. Payment schedules for other professional services will be agreed to when they are requested. Payment may be made in the form of cash, personal checks, or credit card (Visa, MasterCard, American Express or Discover. It is your responsibility to keep your credit card information up-to-date. If your credit card declines for any reason and you have to be contacted to update that information, there will be a $25 fee. If any amount remains unpaid, no additional sessions will be scheduled until the balance is paid in full.

I am an LPC-Intern and therefore I do not accept insurance of an kind. All services are on a cash, check, or credit card basis.

If your account has not been paid for more than 45 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 client's treatment is his/her name, the nature of services provided, and the amount due.

CONTACTING ME

Other than session attendance, the only way I may be contacted is by the office phone, 210-951-0049. My office hours vary and I am often not immediately available by telephone.

I routinely return calls within 24-48 hours during regular business hours, Monday through Thursday, 9:00 a.m. to 9:00 p.m. If you do not hear from within that time frame, you can assume I did not get your message. Please call back and leave a second message clearly stating your name and number more than once. If you are difficult to reach, please inform me of some times when you will be available when leaving a message. Please set your phone to accept private calls, otherwise I may be unable to reach you. Any calls lasting longer than five minutes will be charged $35 per 15 minute increment.

I am not available for emergencies. If you experience a life-threatening emergency, you should go immediately to the nearest hospital emergency room and request to see a mental health professional. Another option is to call 911. If you are suicidal you can call the local crisis hotline 1-800-316-9241**.** If you have insurance you can call the number listed on the back of your card and get a referral to an in-network psychiatric hospital for consultation with an intake specialist.

USE OF ELECTRONIC COMMUNICATIONS

E-mail is for scheduling matters only. I do not use e-mail with clients regarding clinical matters. If you need to discuss a clinical matter between sessions please call me. If you choose not to respect my policy regarding e-mail communications, I will take steps to block further e-mail communications. I also reserve the right to terminate therapy and refer you to other providers. Any e-mails you send to me will be printed and will become part of your clinical record. Use of e-mail is allowed for administrative purposes only.

I do not have conversations with clients via text. Texting is for minor issues such as canceling or changing appointments. All clients should contact me by telephone for any substantive matter relating to their therapy.

I do not engage in communication or relationships via social media with clients. This is for the protection of your privacy as well as the therapy relationship. If you happen to encounter me by accident through social media or the internet please feel free to discuss this with me in session. I do not accept "friend" requests from current or former clients on my psychotherapy related profiles on social networking sites due to the fact that these sites can compromise clients' confidentiality and privacy. For the same reason, I request that clients do not communicate with me via any interactive or social networking websites.

I would never post information about a client on a public website. I ask that you respect my privacy and refrain from posting any "reviews" or other information regarding my practice or me on any website such as HealthGrades, Angie's List, or other forum for posting public reviews of health care providers. By your signature below, you agree that you will not post any "review" or any other information on any website without my prior written permission. If I believe that you have violated this agreement, I reserve the right to terminate our professional relationship immediately and refer you to other mental health professionals.

OTHER OFFICE POLICIES

Non-client children are not allowed to be left unaccompanied in our office. **DO NOT** allow children to play with the fountain. **DO NOT** bring food or drink into our office. **DO NOT** use your cell phone in the waiting area. **DO NOT** adjust the music, rearrange the furniture or turn lights off. It is our goal to make you feel comfortable in our waiting area, however, **YOU ARE A GUEST IN OUR LOBBY, IT IS NOT YOUR HOME.**

GIFTS, DUAL RELATIONSHIPS AND PHYSICAL TOUCH

The American Counseling Association Code of Ethics does not allow Licensed Professional Counselor Interns to receive gifts valued at more than $25.00 and gifts given are usually limited to a natural time of gift-giving such as termination of services or Christmas. Beautiful cards with a heartfelt message are more appropriate than gifts. The American Counseling Association Code of Ethics also prohibits a Licensed Professional Counselor Intern from having more than one relationship with a client. Therefore, once you are a client, you cannot become a friend, involved in any business together, including buying or selling of products or any other relationship other than client-therapist. The policy of this office is that physical touch is not a part of the therapeutic intervention and is not used as such during counseling sessions.

INTERACTIONS OUTSIDE THE OFFICE

If we happen to encounter each other outside of the professional setting I will not address you unless you address me first. This is also for the protection of your privacy from those either of us may be with. I'm happy to return a friendly greeting but will allow you to take the initiative if you would prefer to do so.

PROFESSIONAL RECORDS

Documentation of sessions consists of a summary of each meeting and may include general issues addressed, possible symptom presentation or change, level of functioning, mental status, diagnosis and treatment plans. Texas law requires that I maintain appropriate treatment records for at least 6 years from the last date of service.

As a client, you have the right to obtain a copy of your records upon submission of a written authorization. The records of your treatment will contain confidential information about you. Texas law requires that all requests to review or obtain copies of your records must be made in writing. In my practice, I require that clients sign an appropriate authorization before I release any records to them. I also request a copy of valid identification.

Records of therapy can be misinterpreted and/or can be upsetting to lay readers. If you request a copy of your records, I will provide them to you within 15 days of receiving the request unless I believe that to do so would endanger your life or the life of another person. If I believe that I must withhold the records due to a situation involving life endangerment, I will write you a letter to explain my reasons for withholding the records and your options.

I have determined that a reasonable, cost-based charge for providing you with a copy of your records will be $50. Generally, I am not required to provide copies of requested records until the fee is paid. If something must be mailed, then you will be responsible for the postage fees which usually include certified postage.

LIMITS ON CONFIDENTIALITY

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

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the therapist-client privilege law. I cannot provide any information without your written authorization. However, if your records are subpoenaed or if a judge issues a court order for your records, I am legally obligated to comply. In the case of a subpoena, I will contact you so you (and/or your attorneys) can take steps to contest the subpoena. If you do nothing to contest the subpoena after being notified by me, I will obey the subpoena.
2. If I believe that you are a danger to yourself or to other persons, I will contact medical or law enforcement personnel.
3. If you disclose information that leads me to suspect that a minor, elderly, or disabled person is being abused or neglected, I am required by law to notify authorities within 48 hours and I will comply with this requirement.
4. If you file a lawsuit or a complaint against me for any reason related to your therapy, I am allowed to use confidential information to defend myself.

5. If a court order or other legal proceeding or statute requires disclosure of your information, I will obey the court order or the law.
6. If you waive the rights to privilege or give written authorization to disclose information, I will comply with your authorization.
7. Information contained in communications via computers with limited security/control, such as e-mail and telephone conversations via cell phone is not secure and can compromise your privacy.
8. If I learn of previous sexual exploitation by a mental health provider I am required to report it to the district attorney in the county of the alleged exploitation and the appropriate licensing board of the provider. The client has the right to remain anonymous when the report is filed.

Most insurance companies require a clinical diagnosis to reimburse for treatment. Some may require additional clinical information to support payment. Information collected by an insurance company will become part of the company's files. 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 possession. Medical data has been also reported to be legally accessed by enforcement and other agencies, which may place you in a vulnerable position. The safest way to protect confidentiality is to pay cash for treatment.

By your signature below, you acknowledge that you have been advised of these limits to confidentiality and potential risks. If you elect to use your insurance coverage to pay for treatment, I will assume that you have evaluated the stated risks and elected to proceed.

PLAN FOR PRACTICE IN CASE OF DEATH OR DISABILITY

In the event of my death, incapacity or disability, I have made arrangements for another psychotherapist to take over my practice, meet with clients, make appropriate referrals to other providers, if necessary, and take all reasonable steps to manage the practice for the benefit of my clients. By your signature below, you authorize my designee to contact you directly, and use and disclose your confidential mental health information and records for the stated purposes.

COMPLAINTS

You have a right to have your complaints heard and resolved in a timely manner. If we cannot work things out to your satisfaction you may inform your insurance carrier and file a complaint with them or with my licensing board: Texas State Board of Examiners of Professional Counselors, 512-834-6658. If you have a complaint concerning the HIPAA Privacy Regulations, you may contact the U. S. Department of Health and Human Services, Office for Civil Rights, at OCRMail@hhs.gov.

Please Initial

_____ _____ I understand the nature of the proposed therapeutic treatment and that Kelly Anderson, LPC-Intern is an LPC-Intern. I understand this means my case may be discussed in detail with both Shelly Cook, LPC-S, RPT-S and Ginger Gray, LCSW. I therefore give my informed consent for psychotherapeutic treatment by Kelly Anderson, LPC-Intern.

_____ _____ I understand that the fee for service is $75 for each individual session. I have also been informed regarding fees related to legal proceedings and Kelly Anderson LPC-Intern's litigation policy and I agree to abide by it.

_____ _____ I understand that the counseling session is **52 minutes** in length.

_____ _____ I agree it is my responsibility to keep my credit card information up-to-date and agree to pay the $25 fee if my credit card declines.

_____ _____ I agree to pay $75 for any missed appointments. To avoid a fee, please give 24 hours advanced notice if you must cancel or reschedule an appointment.

_____ _____ I agree that during the treatment of my minor child I will be provided with only general information about the progress of my child's treatment, and his/her attendance at scheduled sessions. I relinquish my right to my child's complete records.

_____ _____ I understand that if I am experiencing a medical or mental health emergency, I have been advised to dial 911 or go to nearest emergency room, and I agree to abide by these instructions**.**

I have read the above Agreement carefully, I understand the terms of this Agreement and I agree to comply with them. I understand that this Agreement is a contract between me and Kelly Anderson, LPC-Intern, supervised by Shelly Cook, LPC-S, RPT-S and may be enforced as a written contract. I agree that this Agreement will stay in effect until I revoke it in writing. I understand that any written revocation must be dated AFTER the date of this Agreement and must be provided to Kelly Anderson, LPC-Intern supervised by Shelly Cook, LPC-S, RPT-S. I agree that a copy of this Agreement has the same force and effect as a copy.

By my signature below, I also acknowledge that I have received and read the HIPAA Notice of Privacy Practices.

_____ _____

Signature of Client or Parent Date Signed

_____

Printed Name of Client

_____ _____

Relationship to Client or Legal Authority (attach supporting documentation)

Abiding Hope Christian Counseling, Ltd.
Kelly Anderson, LPC-Intern
Supervised by Shelly Cook, LPC-S, RPT-S
19115 FM 2252 Ste. 12
San Antonio, Tx 78266

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION

I hereby authorize Kelly Anderson, LPC-Intern supervised by Shelly Cook, LPC-S, RPT-S and Abiding Hope Christian Counseling, Ltd. to disclose the individually identifiable health information as described below, which may include psychotherapy notes. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment for my health care will not be affected if I do not sign this form. I also understand that if I do not sign this form, federal and state law will prohibit Ms Anderson and her practice from releasing records regarding her treatment of me/my child to the designated Recipient.

By accepting the records pursuant to this Authorization, the Recipient acknowledges that the protected health information covered by this release is confidential, privileged and protected by federal and state privacy statutes and regulations, and agrees that Ms Anderson's release of the individually identifiable health information will continue to be protected by federal and state privacy statutes and regulations.

_____

Print Patient Name Date of Birth Social Security Number

Date(s) of service (if known): _____

Description of information to be released: (check all that apply)

____ Entire Record _____ Evaluation Reports
_____ Billing Records _____ Consultation Notes
_____ Psychotherapy Notes
____ Other: _____

Description of the purpose of the use and/or disclosure: _____
_____

The individually identifiable health information described herein shall be released to:

[INSERT NAME AND ADDRESS OF DESIGNATED RECIPIENT]

I intend for this Authorization to remain in full force and effect until I revoke it in writing. Further, it is my intent that a copy of this Authorization shall have the same effect as the original.

I further understand that I may revoke this authorization at any time by notifying Kelly Anderson, LPC-Intern in writing at Abiding Hope Christian Counseling, 19115 FM 2252, Suite 12, San Antonio, TX 78266. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____
Signature of Client or Client's Representative Date

_____
Printed Name of Client or Client's Representative

_____ or _____
Relationship to Client Legal Authority (attach supporting documentation)

CREDIT CARD AUTHORIZATION FORM

I hereby authorize Kelly Anderson, LPC-Intern supervised by Shelly Cook, LPC-S, RPT-S and Abiding Hope Christian Counseling, Ltd. to maintain a record of my credit card and my signature on file for payment of the following services: psychotherapy services, including deductibles, co-pays, non-cancelled or late-cancelled appointment fees, any charges owed that are not covered by my insurance company, and the litigation policies that are set forth in the Informed Consent Agreement. These charges include, but are not limited to, payment of retainer for court/deposition/legal proceeding preparation and appearance, consultation and telephone appointments, report and letter writing, and completion of disability paperwork.

My signature below authorizes Kelly Anderson, LPC-Intern supervised by Shelly Cook, LPC-S, RPT-S and Abiding Hope Christian Counseling. Ltd. to charge my credit card for all applicable charges on an on-going basis. I understand that if I decide to terminate services with Ms Anderson, and my account is paid in full upon termination, I may withdraw the authorization to charge my credit card in the future.

NOTE: Often, insurance companies pay us several weeks or months after the date you attend a session. In that event, we may not be aware that there is a charge due for some period of time. We will bill any non-paid charges as your insurance company submits an Explanation of Benefits regarding their payment to us.

In the event your credit card expires, or is lost or stolen, of if you desire to use another credit card, please notify us and we will have you complete a new Credit Card Authorization Form, and will delete your old information. We are equipped to utilize Health Savings Account cards, and accept MasterCard, Visa, Discover and American Express.

PLEASE PRINT LEGIBLY:

Client Name: _____

Cardholder's Name (as it appears on the credit card):_____

Credit Card Billing Address (the address where the credit card statement is received)

Street_____ Apt/Suite_____

City and State_____Zip Code_____

Credit Card Type Visa_____ MasterCard_____ Discover_____ AMEX_____

Credit Card Number:

_____

Expiration Date_____CCV Code:_____

SIGNATURE:_____

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Voice mail: 210-951-0049
www.abidinghopecc.com
akd700@gmail.com

NEW MINOR CLIENT INTAKE FORM

(Please Print and fill out before first session)

TODAY'S DATE: _____ HOME PHONE: _____

NAME: _____CELL: _____

ADDRESS:
_____D.O.B._____

CITY, STATE, ZIP: _____STATUS: S M D W

E-Mail address: _____

REFERRED BY: _____

School if Student _____ Grade: _____

Parent/Guardian Name: _____

Relationship to Client: _____

Is your child presently under the care of a psychiatrist? Yes / No

Psychiatrist Name: _____

Phone: _____

Does your child have any medical or mental health diagnoses?

_____

_____

Has your child been in counseling before? Yes / No

What medication is your child presently taking and for what conditions?

_____

_____

Is your child on a particular diet at this time? Please describe.

_____

_____

Please indicate any of the following symptoms your child has experienced:

___ Anxiety How long? _____

___Depressed Mood How long? _____

___Low energy level How long? _____

___Racing thoughts How long? _____

___Poor concentration How long? _____

___Indecisiveness How long? _____

___ Change in sleeping How long? _____

___Change in appetite How long? _____

___Angry outbursts How long? _____

___Crying spells How long? _____

___Lack of motivation How long? _____

___Weight change How long? _____

___Feeling others are against him/her How long? _____

___Excessive guilt How long? _____

___Isolation How long? _____

___Mood swings How long? _____

___Feelings of hopelessness How long? _____

___Low self-esteem How long? _____

___Difficulty with memory How long? _____

___Thoughts/plans of suicide How long? _____

___Self-harm How long? _____

___Thoughts/plans to hurt others How long? _____

___Alcohol use How long? _____

___Drug use How long? _____

___Bedwetting How long? _____

___Soiled pants How long? _____

___Trouble in school How long? _____

___Truancy How long? _____

___Trouble with peers How long? _____

___Disobedient How long? _____

___Conflict with family How long? _____

___Running away How long? _____

___Problems with the law How long? _____

___Rocking	How	long?
___Head-banging	How	long?
___Destructive	How	long?
___Fire-setting	How	long?
___Harm to animals	How	long?
___Infantile	How	long?
___Sexual behavior	How	long?
___Lying	How	long?
___Over-active	How	long?
___Fearful	How	long?
___Impulsive	How	long?
___Phobic	How	long?
___Other	How	long?
___Other	How	long?

Bio-Psycho-Social-Spiritual History of Minor

Please describe the problem/ circumstances that led to you seeking counseling for your child:

_____

_____

_____

_____

What changes would you like to see in your child as a result of counseling:

_____

_____

_____

_____

Please list the name, age and relationship of everyone presently living with your child:

_____

_____

_____

_____

Where was your child born?

_____

Where has your child lived?

_____ Age when living there _____ to _____

_____ Age when living there _____ to _____

_____ Age when living there _____ to _____

_____Age when living there _____ to _____

How would you describe your economic status?

___ Lower class ____ Middle Class ____ Upper Middle Class ____

Upper Class In what ways has this affected your child?

_____

_____

_____

_____

Please describe your child's relationship with each of his/her parents:

Mother:

_____

_____

_____

Father:

_____

_____

_____

Please identify any history of divorce and/ or remarriage as related to the child's parents:

_____

_____

_____

_____

Please identify any significant relationships the child has had with step-parents:

_____

_____

_____

Please describe any criminal history associated with either parents or step-parents:

_____

_____

_____

Was your child adopted? Yes/No

Please describe the circumstances of the adoption:

_____

_____

_____

Siblings (age, sex, and relationship):

_____

_____

_____

Please describe any history of physical illness or injury in your family:

Please describe any history of psychiatric, emotional, drug/alcohol abuse, or other problems in your family:

_____

_____

_____

_____

Please describe any history of sexual, physical, or emotional abuse of your child:

_____

_____

_____

_____

Has your child has any history of drug/ alcohol abuse or eating disorders?

_____

_____

_____

Has your child had any history of serious illness, injury or hospitalizations? Please describe.

_____

_____

_____

_____

Has your child experienced any developmental delays? Yes / No If yes, please describe.

_____

_____

_____

_____

Were there any problems with the pregnancy or delivery of your child?

_____

_____

_____

What do you perceive to be your child's greatest strengths?

_____

_____

_____

What areas of your child's life do you feel need improvement most?

_____

_____

_____

Please describe discipline in your home and who enforces it.

_____

_____

_____

Please describe the role of religion and spirituality in the environment where your child lives.

_____

_____

_____

What churches or denominations has the family primarily attended?

_____

_____

_____

Are you comfortable incorporating your faith into the counseling process?

_____

_____

Are you comfortable with prayer in counseling sessions?

_____