

Life Educational Counseling (LEC)

Client Intake Information

Client's Name (First, Initial, Last) _____

Address: _____ City _____ State _____ ZIP _____

Sex: M F Age ____ Date of Birth ___/___/___ Drivers License or ID # _____ State _____

Marital Status: Single Married Separated Divorce Common-Law Marriage Widow No. times Married _____

Date of current Marriage ___/___/___ Separation ___/___/___ Divorce ___/___/___ Death of spouse ___/___/___

Occupation: _____ Yearly Gross Income: _____

Phone Numbers/e-mail (**only include those that we have permission to call or leave a voice/email message**):

Home _____ Work _____ Cell _____

Personal E-mail _____ Work E-mail _____

Spouse **Fiancé** **Parent** or **Guardian** (**required if client is a minor or if also plan to receive counseling**)

Name (if applicable) _____

Address: _____ City _____ State _____ ZIP _____

Sex: M F Age ____ Date of Birth ___/___/___ Drivers License or ID # _____ State _____

Marital Status: Single Married Separated Divorce Common-Law Marriage Widow No. times Married _____

Date of current Marriage ___/___/___ Separation ___/___/___ Divorce ___/___/___ Death of spouse ___/___/___

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Date of current Marriage ___/___/___ Separation ___/___/___ Divorce ___/___/___ Death of spouse ___/___/___

Occupation: _____ Yearly Gross Income: _____

Phone Numbers/e-mail (**only include those that we have permission to call or leave a voice/email message**):

Home _____ Work _____ Cell _____

Personal E-mail _____ Work E-mail _____

Religious Orientation _____ Church Affiliation _____

How did you find out about Life Educational Counseling? _____

Briefly state your reason for seeking counseling. _____

Family Members living at home

Name(s) (list all last names if different from client (additional on back)) Age Relationship to client

Legal Authorization to Provide Child with Emotional Counseling (If applicable for ages 17 and under)

As parent/guardian do you have **Legal Authorization** to provide this child with emotional treatment? Yes No

Explain: _____

If not, do you have written authorization from such parent/guardian to provide this child with emotional treatment while in your care? Yes or No

Explain: _____

Parent/Child Confidentiality Statement

As therapists, we respect your right as a parent to gain access to all information included in the emotional care of your child. However, we believe that in the best interest of the therapeutic relationship, confidentiality should be maintained between your child and the therapist, except in the following cases:

- When child abuse is suspected
- When the child poses a "clear and imminent danger" either to self or another person
- When the therapist believes it is in the best interest of the child to disclose information to the parent

Given the above, we request your permission to maintain a confidential relationship with your child. If you understand and agree, please provide your signature below.

Print Client (Child) Name _____
Date

Print Parent/Guardian Name _____
Signature _____
Date

Print Parent/Guardian Name _____
Signature _____
Date

Print Counselor's Name _____
Signature _____
Date

Parent/Guardian Comments:

Concerns:

Medical/Health Information:

Personal Physician: _____ Phone # _____

Date of last visit: _____ Results: _____

Date of last physical: _____ Results: _____

Major illnesses/conditions _____

Medications or treatments you are currently taking (list additional on backside of form): _____

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Previous Counseling? YES or NO If YES, Date: _____

With whom: _____

Reason: _____

Outcome: _____

In Case of emergency call _____

AM Phone # _____ PM Phone # _____ Relationship _____

The undersigned authorizes the release of all client information by the therapist for the purpose of review with client's physician if necessary, and/or for third party payers (when applicable). Such disclosures are limited to information that is reasonably necessary for treatment planning and/or payment.

Signature of Client Date

Signature of Parent/Guardian (if applicable) Date

Signature of Parent/Guardian (if applicable) Date

Communications

I hereby authorize **LCC** and/or my therapist to communicate with me through: **(please where applicable)**

Personal e-mail address _____

Work e-mail address _____

I prefer a voice mail message left on my: home phone work phone cell phone

Please list any Family or Friend(s) that **LCC** may release medical/billing information to in case of emergency/debt collection

_____ phone # _____

_____ phone # _____

Signature of Client Date

Signature of Parent/Guardian Date

Signature of Parent/Guardian Date

Policies and Procedures

The following information is provided to acquaint you with the policies and procedures of **LEEC**. If you have any questions about this information, please feel free to discuss them with your therapist. Please initial after reading each policy.

1. _____ **Sliding Fee Scale for Sessions:** *

Counseling Session Fee is to be paid following each session and no later than same day. A flat fee of \$100.00 will be charged for the Initial Evaluation/Counseling Session for an Individual, Couple and/or Family. Subsequent Counseling Sessions will be charged on a Sliding Fee Scale based on the client or responsible party's current Combined Family Gross Annual Income. Couples and family rates will increase by \$15. To determine your counseling rate, use the Sliding Fee Scale below and check box that best fits your current Combined Family's Gross Annual Income.

Please check your current Combined Family Gross Annual Income:

- Less than \$34,999: fee is \$70.00 per 45 min. session (couple & family rate: \$85)
- \$35,000 to \$44,999: fee is \$80.00 per 45 min. session (couple & family rate: \$95)
- \$45,000 to \$54,999: fee is \$90.00 per 45 min. session (couple & family rate: \$105)
- \$55,000 to \$64,999: fee is \$100.00 per 45 min. session (couple & family rate: \$115)
- \$65,000 to \$74,999: fee is \$120.00 per 45 min. session (couple & family rate: \$135)
- \$75,000 to \$84,999: fee is \$130.00 per 45 min. session (couple & family rate: \$145)
- \$85,000 and above fee is \$150.00 per 45 min. session (couple & family rate: \$165)

2. _____ **Lengths of Sessions:**

Counseling sessions are usually 45 minutes. We make it a goal to start and end on time. If you or your therapist deems it necessary to extend the session over 45 minutes, you will be charged accordingly (i.e., \$ 70 rate = \$1.55 per additional min.; \$ 80 rate = \$1.77 per additional min.; \$ 90 rate = \$2 per additional min.; \$100 rate = 2.22 per additional min.; \$120 rate = \$2.66 per additional min.; \$130 rate = \$2.88 per additional min.; \$150 rate = \$3.33 per additional min.).

3. _____ **Return Check Policy:**

If a check is issued for payment and it is returned due to Non-Sufficient Funds (NSF) or other reasons, a \$25 fee will need to be paid along with the session fee either in cash or money order. Once a client issues a check that is returned, cash payments will be required for a period of 60 days after which time client can resume check payments.

4. _____ **Scheduling Appointments:**

If you wish to schedule an appointment, please call **LEEC** today. If no one is available, please leave a message and your call will be returned as soon as possible, but no later than 24 hours.

5. _____ **Cancellation of Appointments:**

If you need to cancel or reschedule an appointment, please do so **at least 24 hours in advance**. Failure to do so will result in a \$60 charge. Proper notice enables **LEEC** to give your time slot to someone on the waiting list or respond to an emergency case. Your consideration to this matter is greatly appreciated. Exceptions will be made in rare unavoidable situations such as emergencies (i.e., illness, accidents, or death in the family).

6. _____ **Emergencies:**

Call 911 in case of a serious emergency. To contact **LEEC** in case of a crisis or minor emergency, call (281) 441-9703. If no one is available to answer your call, please leave a message stating your name, phone number and emergency and **LEEC** will call you as soon as possible. Please make sure that the nature of your call is a real emergency if you leave this type of message (i.e. in a genuine crisis or feeling suicidal). **If your life is in immediate jeopardy, call 911 or go to the hospital emergency room for help.**

7. _____ **Other Telephone Calls:**

If you have a routine question please feel free to call **LEEC**. Your call will be returned as soon as possible, but remember your therapist may be in session and will have to call you when she is available. If your question requires a lengthy conversation (over 10 minutes) or appears to be of a nature that needs to be handled in a therapy session, we will need to schedule an extra appointment for you. Please do not use phone calls as a substitute for your appointment. Such calls are subject to a minimum professional fee of \$50.00- \$100 depending on length of call. In the event that this happens, you will be billed within 24 hours of conversation.

8. _____ Caller ID Issues:

There are times that your therapist may need to return your call from home as office hours vary from one day to the next. If your home number is blocked to anonymous callers, you will need to disconnect that service by dialing *87 on your phone. Some of our therapists keep their home number blocked for all outgoing calls and they will be unable to reach you otherwise. You can reconnect your anonymous call blocking after your call by dialing *77. If you are uncertain that your Caller ID has anonymous blocking, you may want to dial *87 to be sure. *In any event – please do not return calls to numbers that show up on your caller ID—please call the number that your therapist leaves as a call-back number.*

9. _____ Therapist-Client Relationship:

It is very important that you have a good level of comfort and trust in your relationship with your therapist. Your sense of well-being and your therapist level of efficacy in treating you depend on this. We recognize in some cases that this may not always happen. Some clients and some therapists just “don’t fit”. If you should significantly disagree with or feel uncomfortable with your therapist’s clinical decisions please let your therapist know and feel free to discontinue your therapist-client relationship. We say this wholeheartedly because it is our hope for clients that they feel assured in their relationship with their therapist, be it with someone at **LSC** or somewhere else. In turn, we will also reserve the ability to end a therapist-client relationship with a client in situations where there has been client non-compliance with treatment or payment of services to the point that it is dangerous or non-therapeutic. In the extremely rare event that this should be the case, your therapist will inform you of this so that you can make arrangements to continue your counseling elsewhere.

10. _____ Confidentiality:

Concerning confidentiality, “*what is said in the room, stays in the room*” with a few exceptions. If you tell your therapist something that indicates that you or someone else is in danger, as the therapist he/she will, because of legal precedent and law, break confidentiality to help ensure safety. In the case of child clients, the therapist may share some general comments about the child’s therapy sessions that they think will be helpful for the parent to know, but for therapeutic reasons, the contents of therapy sessions will be kept confidential. Certain legal situations may also force the therapist to breach confidentiality. Finally, the therapist may talk about your care with other health care practitioners and colleagues who are or may be providing treatment for you, such as your psychiatrist, your primary care physician, or the therapists on call when your therapist is out of town or called away on an emergency. Your therapist will strive, within the confines of the law, to maintain confidentiality in your therapist-client relationship.

11. _____ Therapist Emergencies:

Your healing is first priority. To better accommodate your needs and to prevent any unnecessary cancellation or rescheduling of your treatment plan, the therapist on call will step in for your scheduled session in the event of an emergency whereby your regularly scheduled therapist may need to be absent.

12. _____ Couples and Families:

Couples and families seeking marriage counseling and/or family therapy may encounter times when the therapist may require individual sessions with some or all members in addition to the couple and/or family sessions. **LSC** looks forward to working with you.

* Policies, rates, counselors, location, etc., within **LSC** are subject to change without notice. Existing clients may be given a verbal or written notice prior to changes that may directly affect them; except when emergencies, catastrophes or unforeseen problems arise.

Consumer Rights and Responsibilities

1. Consumer Rights

- ♥ Be informed of the qualifications of your counselor: education, experience, and professional counseling certifications.
- ♥ Receive an explanation of services offered, your time commitments, fees, and billing policies prior to receipt of services.
- ♥ Be informed of limitations of the counselor's practice to special areas of expertise (e.g., career development, ethnic groups, etc.) or age group (e.g. adolescents, older adults, etc.).
- ♥ Have all that you say treated confidentially and be informed of any state laws placing limitations on confidentiality in the counseling relationship.
- ♥ Ask questions about the counseling techniques and strategies and be informed of your progress.
- ♥ Participate in setting goals and evaluating progress toward meeting them.
- ♥ Be informed of how to contact the counselor in an emergency situation
- ♥ Contact the appropriate professional organization if you have doubts or complaints relative to the counselor's conduct.
- ♥ Terminate the counseling relationship at any time.

2. Consumer Responsibilities

- ♥ Set and keep appointments with your counselor. Let him/her know at least 24 hours prior to appointment if you cannot keep an appointment.
- ♥ Pay your fees in accordance with the schedule you pre-established with the counselor.
- ♥ Help plan your goals.
- ♥ Follow through with agreed upon goals.
- ♥ Keep your counselor informed of your progress toward meeting your goals.
- ♥ Terminate your counseling relationship before entering into arrangements with another counselor.

If you have questions about any of these consumer rights and responsibilities please discuss them with your counselor. Thank you for allowing **LEC** the privilege to serve you.

Elizabeth (Liz) Childress, BCCC, B.Th, BCBT
President LEC

Life Educational Counseling

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Humble, TX 77346

Office: (281) 812-0783

Cell: (281) 441-9703

Email: Contact@LECounseling.com

Website: www.LECounseling.com

Member:



Consent to Treatment

I acknowledge that I have received and read (or have had read to me) the following documents:

- ♥ **Client Intake Information**
- ♥ **Policy and Procedures**
- ♥ **Client Rights and Responsibilities.**

I have had all my questions answered fully. I do hereby seek and consent to take part in the treatment by *Life Educational Counseling*. I understand that developing a treatment plan and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. I understand my therapy will involve a combination of therapeutic approaches that may include insight oriented, cognitive-behavioral, and/or various types of brief or Biblical solution focused counseling. Interactive play therapy is often the model of choice with children. Couple therapy is based on a combination of marital therapies including communication skills training and Biblical principles therapy, etc. My therapist will discuss the specifics of my particular treatment plan with me and inform me of the cost of my treatment.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist. I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment **at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I know that in most cases LEC will bill me for that appointment.** The exceptions to this are clearly identifiable, for example; an accident, sudden illness, a death in the family, etc. I am aware that a third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive without completely breaking confidentiality. I understand that if payment for the services I receive is not made, the therapist may discontinue my treatment. I understand that if my third-party does not reimburse my therapist that I am responsible for the charges for my treatment. I further understand that changes within *LEC* are subject to take place without notice. Existing clients will be given a verbal or written notice prior to such changes, except when emergencies, catastrophes or unforeseen problems arise. My signature below shows that I understand and agree with all of these statements.

Signature of client

Date

Signature of Parent/Guardian

Date

Signature of Parent/Guardian

Date

I, the therapist, have discussed and/or clarified the issues of concern herein with the client (and/or his or her parent or guardian). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of therapist

Date