Wise County Christian Counseling
1650 S. FM 51 Suite 400
Decatur, Texas 76234
(940) 627-1618

Client Information Questionnaire

Your cooperation in completing this questionnaire will be helpful in planning our services for you. Please answer each item carefully. Ask your therapist for clarification if you do not understand an item.

Full name _____ Date _____

Address_____

_____

Phone numbers (List all that apply.): _____

Please indicate if a message can be left at any of these numbers:_____

Age: _____ Sex: _____ Male _____Female Marital status: _____

Occupation(s):_____

Household family income (including child support, unemployment, disability, etc.): _____

Religious preference: _____ Where do you attend? _____

Check all of the following which reflect the parent figures currently in your home:
_____Single parent _____Both birth parents _____Birth parent & Step-parent _____Adoptive parents
_____Foster parents _____Grandparents _____ Other relatives
Other (Please explain):_____

Briefly describe your reason(s) for seeking help:
_____
_____
_____
_____

What do you hope to accomplish through counseling?
_____
_____
_____
_____

How did you find out about us? _____

Have you ever consulted a professional counselor? _____YES _____NO
If yes, name of agency:_____

How was counseling helpful then?
_____
_____
_____

If applicable, briefly describe your marital history (divorce, # of marriages, etc):
_____
_____

Please list any medications that you are taking at present:

Have you ever considered suicide? _____YES _____NO If so, when?_____
Have you ever attempted suicide? _____YES _____NO If so, when?_____

Have you ever had struggles with an addiction of any type? If so, please describe:

Have you experienced any trauma that has impacted your life (ex. Parents' divorce, abuse, death of a close relative/ friend)? If so, please describe:

Mark any of the following which are presently causing you difficulty (Put a * by the two most important items):

Abuse	Depression	Insomnia	Religion
Alcohol use	Divorce	Legal Matters	Sadness
Allergies	Drug use	Loneliness	Self-Concept
Anxiety	Education	Marriage	Self-control
Appetite	Energy	Memory	Separation
Assertiveness	Fears	Mood swings	Sexual problems
Asthma	Finances	Motivation	Shyness
Bed-wetting	Food	My past	Sleep
Bowels	Friends	My thoughts	Stress
Career Choices	Guilt	Nervousness	Suicidal thoughts
Children	Headaches	Nightmares	Temper
Concentration	Health problems	Parenting	Tiredness
Confusion	Inferiority	Parents	Ulcers
Dating	Infidelity	Premarital	Unhappiness
Decision-making	In-laws	Relaxation	Work

Please provide any additional information which you feel may be useful to your therapy.

List the members of your family and all others that are currently living in your home.

Name(s)	Age/Grade	Relationship	Occupation

Who has custody of minor children living in your home? _____

Is there any history of mental illness in the family, including yourself? (anxiety, depression, OCD, schizophrenia, bipolar, addictions, etc.)

_____
_____
_____
_____

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Informed Consent

Welcome to Wise County Christian Counseling. Thank you for choosing me for your counseling needs. Starting counseling is a major decision and you may have many questions. This document is designed to inform you about agency policies and procedures as well as your rights, so that you can consent to treatment. If you have other questions or concerns, do not hesitate to ask me about them.

My name is Beverly Ross and I am a Texas State Licensed Professional Counselor, and a member of The American Association of Christian Counselors and The American Counseling Association, I hold a Bachelor of Science degree from Stephen F. Austin University and a Master of Arts degree from Amberton University.

All information pertaining to your counseling experience, including the knowledge that you are being seen for counseling is strictly confidential. By law, information cannot be released without your consent, with the following exceptions:

- I have reason to believe that you are a danger to yourself or others
- I have reason to believe you intend to physically harm someone else
- I have reason to believe you are abusing or have abused a child or elderly person
- I am ordered by a court to disclose information

I assure you that my services will be rendered in a professional manner consistent with accepted ethical standards. Please note that it is impossible to guarantee any specific results regarding your counseling goals. Together we will work to achieve the best possible results for you. Other options for counseling include talking with other professionals, your clergy person, or choosing to let the situation remain the same. If you have any complaints, please discuss them with me. If you are not satisfied with the resolution of the problem, you have the right to call the Consumer Complaint Hotline at 1-800-942-5540.

I am dedicated to providing counseling services to my clients knowing certain financial limitations exist. Being a non-profit organization, I can set my fees at a lower rate. No family will be turned away because of lack of funds. This agency asks our clients to determine their fees by using a sliding scale. For every $10,000 your household brings home a year, please consider paying $10 a session, up to $120. (Example: if your family brings home $50,000 a year, please pay $50 a session.) Checks or cash will be accepted. Checks will be made payable to Wise County Christian Counseling. Because there is a waiting list for our services, we ask that you notify us at least 24 hours in advance if you are unable to come at your scheduled time. **If you do not notify us before the appropriate time, you will be charged your full session fee for the missed appointment.**

Your signature below indicates your understanding of and agreement to the terms and conditions stated on this form. If you have any questions, please feel free to ask for an explanation.

By signing this consent form, we give our permission for any or all of our family members including minors to enter into a counseling relationship with Beverly Ross at Wise County Christian Counseling. We do this of our own free will. We recognize there is no guarantee expressed or implied that our problems will be alleviated in coming to counseling, and that in some cases our situation/problems may initially worsen before they improve. We recognize that we can terminate counseling at any time that we choose.

Signature(s) of parents(s)/couple/individual:

Client: _____ **Date:** _____

Client: _____ **Date:** _____

Counselor: _____ **Date:** _____

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Patient Consent for Use and/or Disclosure of HIPAA Defined Protected Health Information to Carry Out Treatment, Payment, and Healthcare Operations

I, _____, hereby state that by signing this consent, I acknowledge and agree as follows:

The Provider's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Provider to provide treatment to me, and also necessary for the Provider to obtain payment for that treatment and to carry out its health care operations. The Provider explained to me that the Privacy Notice will be available to me in the future at my request. The Provider has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

The Provider reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

I understand that, and consent to, the following appointment reminders that may be used by the Provider:

___ Yes ___ No — A postcard mailed to me at the address provided by me.
___ Yes ___ No — Telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
___ Yes ___ No — Telephoning my office and leaving a message on my phone mail or with the individual answering the phone.

The Provider may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Provider to treat me and obtain payment for that treatment, and as necessary for the Provider to conduct its specific health care operations.

I understand that I have a right to request that the Provider restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Provider is not required to agree to any restrictions that I have requested. If the Provider agrees to a requested restriction, then the restriction is binding on the Provider.

I understand that this Consent is valid for seven years and that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Provider has already taken action in reliance on this consent.

I understand that if I revoke this consent at any time, the Provider has the right to refuse to treat me.

I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Provider will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____
Signature of Legal Representative Relationship to Patient
(e.g., Attorney-In-Fact, Guardian, Parent if a minor)

Date Signed _____ Witness: _____

Wise County

CHRISTIAN COUNSELING

Due to the length of our waiting list and our deep desire to help people, beginning January 1, 2017, there will be a $50 charge for all appointments not kept or broken without 24 hour notice.

Signature(s) of couple/individual

X_____ _____

Client signature Date

X_____ _____

Client signature Date

X_____ _____

Counselor signature Date