

Wise County Christian Counseling

1650 S FM 51 Ste 400

Decatur, TX 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.

Child's name _____ Date _____

Completed by: _____

Relationship to child: _____

Address _____

Phone numbers (List all that apply): _____

Email address: _____

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

Child's Age: _____ Sex: _____ Male _____ Female Date of Birth: _____

Caretaker's 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): _____

Brief description of living arrangement: _____

Child's Legal Guardian (Managing Conservator): _____

(If the child is not living with both biological parents, both adoptive parents, or only living parent, WCCC requires a photocopy of the legal document stating custody arrangements, consisting of the cover page, page specifying conservator(s), and signature page).

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

Name(s) Age/Grade Relationship Occupation

Briefly describe your reason(s) for seeking help:

What do you hope to accomplish through counseling/play therapy?

How did you find out about us?

Current School & Grade/Teacher:

Have you ever consulted a professional counselor? ____ YES ____ NO

If yes, name of agency: _____

How was counseling helpful then?

Please list any medications that the child is taking at present:

Has the child ever considered suicide? _____ YES _____ NO If so, when? _____ Has the child ever attempted suicide? _____ YES _____ NO If so, when? _____

Has the child experienced any trauma that has impacted his/her life (ex. Parents' divorce, abuse, death of a close relative/friend)? If so, please describe:

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

Problems Related to Abuse

Current or past physical abuse
Current or past sexual abuse
Current or past emotional abuse
Current or past neglect
History of abandonment
Suspected sexual abuse
History of family domestic violence

Mood-related Concerns

Disturbing memories
Difficulty going to sleep/staying asleep
Nightmares/night terrors
Suicidal ideation
Sadness
Feelings of guilt and shame
Excessive worrying
Anger/Irritable

Rule-Breaking/Behavior Problems

Aggression toward others
Drug/Alcohol use
Truancy
Running away
Stealing
Intentionally hurting animals
Fire-setting

Academic/School Problems

Learning difficulties
Problems with peers
Problems with teachers
Speech problem

Family-Relationship Concerns

Difficulty adjusting to family changes
Discipline concerns
Parent-child relationship problems
Sibling concerns

Other Behavioral Concerns

Sexual identity concerns
Inappropriate sexual behavior
Overeating/Refusal to eat
Hyperactive/Inattentive
Other Unusual Behaviors
(Please specify) _____

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

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

HISTORY OF TRAUMA/STRESSORS RELATED TO THE CHILD

(For each of the following items that apply, write in your child's approximate age at the time it occurred):

Chronic illness of family member____ Death of significant person____ Domestic violence____ Family member absent(explain)____
Family member's disability/major accident/illness_____

Family member emotional problems (explain)_____

Family member suicide (explain)_____

Parent's divorced_____

Child separated from parent (how long and when)_____

Death of a pet____ Difficult medical treatments____ Natural disaster____
Sexual assault____ Victim of trauma (unusual, terrifying experience)____
Other_____

History of your child having learning emotional, behavioral problems: Yes No
(If yes, please explain)

History of your child having alcohol/drug/substance abuse: Yes No
(If yes, please explain)

History of family violence: Yes No
(If yes, please explain)

History of criminal activity in the family: Yes No
(If yes, please explain)

Has your child been abused (check all that apply): Physically____ Emotionally____
Sexually____ Has your child been neglected (check all that apply): Physically____
Emotionally____

School problems (check all that apply):

Academic problems____ Discipline problems____ Social problems____ Other____

Early language/Speech problems (explain):

History of health/physical problems includes (check all

that apply):

Nervous Stomach____

Neurological problems/exam____

Severe PMS____

Serious overeating/under eating____ Shortness of breath without exercise____ Sleep
problems____

Surgeries____ Other_____

Asthma____ Bedwetting____ Bone/joint/muscle____ Chest pain____

Chronic illness____ Developmental delay____ Chronic Diarrhea____

Disability____ Dizziness____

Severe headaches____ Heart Palpitations____ Hospitalization____ Major accident____

Major illness____

Heather A. Bedinger, M.Ed., LPC

Wise County Christian Counseling
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Decatur, Texas 76234
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Informed Consent to Counseling

Welcome to Wise County Christian Counseling! Thank you for choosing me for your counseling needs. This document is designed to inform you about my background and to ensure that you understand agency policies, procedures, and services.

Qualifications: I am a Texas State Licensed Professional Counselor (TX 69461), specializing in play therapy. I hold a Bachelor of Science degree in Communication from Abilene Christian University and a Master of Education degree in Counseling from University of North Texas.

Counseling Relationship: During our counseling relationship, we will direct our mutual efforts toward agreed upon goals determined on an individual basis. Sessions will last approximately 45-50 minutes. Although sessions may be very personal, the relationship between you and I, and your child, is a professional one, rather than a social one. If I see you in public, I will protect your confidentiality by acknowledging you only if you approach me first. Services are by appointment only and you are responsible for keeping your appointments and arriving on time. In the event that you cannot keep an appointment, it is your responsibility to call the office at least 24 hours in advance to cancel or reschedule. Cancellations made within the 24 hours prior to the session or no-showed, will be billed the full hourly fee.

You have the responsibility to notify me of any other ongoing mental health relationship. If you are seeing another mental health professional, then permission must first be granted by the first therapist to proceed with a secondary counseling relationship. During the course of this relationship, if you choose to seek counseling elsewhere, you have the responsibility to terminate this counseling relationship before being seen by another mental health professional. 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 Hot Line at 1-800-942-5540.

We may utilize email or text as a means of communication, but it is important to understand the parameters of this medium. I will not engage in therapy over the Internet or through text. There may also be times where I receive, but do not respond to your email or text. I will respond if I believe it is appropriate and/or necessary. My lack of response does not indicate a lack of interest.

Any type of audio/visual recording is prohibited in counseling sessions.

Referrals: Should you or I believe that a referral is needed, I will provide some alternatives including programs and/or people who may be available to assist you. A verbal exploration of alternatives to counseling will also be made available upon request. You will be responsible for

contacting and evaluating those referrals. In the event that you have a mental health emergency, you may wish to call 911 or University Behavioral Health at (940) 320-8100.

Records and Confidentiality: All of our communication becomes part of the clinical record. Adult records are disposed of six years after the file is closed. Minor client records are disposed of six years after the client's 18th birthday. In the case of my incapacitation or death, you would be contacted by one of my colleagues at Wise CCC, who would handle your records and care, as needed.

I will keep confidential anything you say to me with the following exceptions:

- (a) If you direct me to release your records
- (b) I have reason to believe you are a danger to yourself or others
- (c) In the case of billing or collection of fees
- (d) In the cases of abuse, neglect, or exploitation of a child or elderly adult
- (e) I am ordered/subpoenaed by a court to disclose information
- (f) I am otherwise required by law to disclose information
- (g) If you disclose sexual contact with another health professional

Supervision is a process within the counseling profession whereby cases are reviewed with professional, objective colleagues to ensure quality counseling. It is understood that this process may be utilized within the professional at Wise CCC, in order to provide the highest quality services.

Fees: 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 per year, please consider paying \$10 per session, up to \$120. (Example: if your family brings home \$50,000 per year, please pay \$50 per session.) Checks or cash will be accepted. Checks will be made payable to Wise County Christian Counseling.

Mrs. Bedinger charges \$125 per hour for court appearances, depositions, and arbitrations, including related travel and preparation. If I am subpoenaed to court because of your case, then I will block out a 4 hour portion (unless I am notified that I will be required to stay longer) of my work day. If your hearing is rescheduled, it is your responsibility to notify me at least 48 business hours in advance, so that I may re-book those appointments. If you fail to notify me within the appropriate time frame, you will be billed for that block of time and your minimum court fee will not be refunded. I require the minimum court fee (\$500.00) 48 business hours in advance of the hearing, and any additional fees will be billed, and are expected to be paid, within 48 hours of the court appearance. You are responsible for any legal fees I incur as related to your case (litigation issues, lack of payment, etc.).

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.

Please provide an emergency contact with whom you give permission for me to contact in case of intended harm or threat to self or others:

Phone Number	Relationship	Name
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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 Heather Bedinger 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 of parent(s)/couple/individual:

Client: _____

Date: _____

Counselor: _____

Date: _____

Wise County Christian Counseling Parental Consent for Counseling

By signing this consent form, I am giving permission to Heather Bedinger to provide counseling services for my child. I recognize that the therapist listed above is a Licensed Professional Counselor with WiseCCC. I understand that there is no guarantee that my child's problems will get better by seeing a therapist. I understand that my child's condition may even worsen if I remove my child from counseling too soon or against the advice of my child's therapist. I know that I also have the right to talk to my child's counselor about any aspect of counseling or how my child is responding to counseling. I also understand that my participation with my child in therapy could benefit him/her.

I hereby state that I have managing conservatorship for

_____ (child's name) and have the legal right to grant consent for mental health treatment. I give my permission for him/her to receive counseling services and will provide court documentation regarding conservatorship.

_____ (Parent/Guardian initial)

Parent/Guardian

Parent/Guardian

Date

Child or Children's Name(s)

HIPAA 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. This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and this is related to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your therapist and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the therapist's practice as necessary, and any other use required by law.

Treatment: We will use and disclose your protected health information as necessary to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; or your protected health information may be provided to a physician to whom you have referred to insure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay or a higher level of treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of therapists associated with this practice, licensing, marketing and fund raising activities, and conducting or arranging for other business activities. For example, we may call you by name in the waiting room when the therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization: communicable diseases, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, and if you present a threat to yourself and others.

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

Yes No – A text message sent to the cell phone number provided.

Yes No – Telephoning my home or cell and leaving a message on my answering machine or with the individual answering the phone.

Yes No – An email sent to the email address provided.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization and opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your therapist or therapist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I acknowledge that I have received and understand the HIPAA Notice of Privacy Practices for this office:

Client Signature (parent or guardian if minor client) Date

You have the right to request restrictions of uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance to this consent. Your treatment by this office is conditional on your signing this consent.

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