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.)

____
____
____
____

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

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 Devon McCain and I am a Texas State Licensed Professional Counselor (TX 79607). I hold a Bachelor of Science degree from Texas Woman's University and a Master of Arts degree in both School Counseling and Professional Counseling 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 Devon McCain 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: ______________

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.