FAMILY COUNSELING INTAKE

(form to be completed by parent or guardian – some questions require input from youth)

INSURANCE INFORMATION (IF APPLICABLE)

Primary Insured's Information:

Name: _____ Date of Birth: _____

Address: _____

Employer (unless self-insured): _____

Insurance Carrier: _____ Mental Health Phone (on the back of card): _____

Group Number: _____ ID Number: _____

*Patients who are uninsured or whose insurance does not cover the cost of mental health counseling because of high deductibles or other limitations are personally responsible for payment. Payment is dues at the time of service. Please speak with your counselor if you have questions about billing.

GENERAL INFORMATION:

Date: _____ Referred by: _____

Youth's Name: _____ Date of Birth: _____ Age: _____

Father's Full Name: □ Mr. □ Dr. □ Rev. _____

Name you prefer: _____ Date of Birth: _____ Age: _____

Race: □ White □ Black □ Latino □ Asian □ Other: _____ Gender: □ Male □ Female

Do you want your counselor to incorporate faith/spiritual issues into your counseling? □ Yes □ No

Do you believe in God? □ Yes □ No Do you have a religious preference? _____

How much influence does religion have on your daily activity? □ A lot □ Average □ A little □ None

Mother's Full Name: □ Mrs. □ Ms. □ Miss □ Dr. □ Rev. _____

Name you prefer: _____ Date of Birth: _____ Age: _____

Race: □ White □ Black □ Latino □ Asian □ Other: _____ Gender: □ Male □ Female

Do you want your counselor to incorporate faith/spiritual issues into your counseling? □ Yes □ No

Do you believe in God? □ Yes □ No Do you have a religious preference? _____

How much influence does religion have on your daily activity? □ A lot □ Average □ A little □ None

CURRENT RELATIONSHIP INFORMATION:

Marital Status: □ Single □ Engaged □ Married □ Separated □ Divorced □ Widowed □ Co-habituating

If Married, How long? _____ # of Previous Marriages for You? _____ Your Spouse? _____

If Separated or Divorced, How long? _____ If Widowed, How long? _____

With Whom Do You Currently Live (Check all that apply): □ Alone □ Spouse □ Children (# _____)

□ Parents □ Sibling(s) □ Boyfriend/Girlfriend □ Other: _____

CONTACT INFORMATION:

Street Address: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Mobile Phone: (_____) _____ Other Phone: (_____) _____

E-mail Address: _____

How do you prefer to be contacted? □ Home □ Work □ Mobile □ E-mail

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Mobile Phone: (_____) _____ Other Phone: (_____) _____

E-mail Address: _____

CHILDREN:

*Please List **All** Your Children (Living or Deceased) as well as Children You Have Placed for Adoption*

Name	Sex	Current Age or Year of Death	Relationship to You (i.e., Natural, Step, Adopted)	Living with You?	Describe Him/Her

Do any of your children have special needs (i.e., learning disabilities, physical disabilities, etc.)? If so, what are they? _____

Do you have a support system to help you with these special needs? If so, who? _____

_____

THIS SECTION MAY REQUIRE PARENTS & YOUTH INPUT

MEDICAL HISTORY OF YOUTH (all questions relate to the youth's health)**:**

Primary Care Physician: _____ Phone #: _____

Rate your current level of health: □ Very Good □ Good □ Fair □ Poor □ Very Poor

List any medical problems: _____

What prescription medications are you taking? _____

_____

What over-the-counter medications do you regularly take? _____

_____

Have you been in any type of accident (automobile or fall) in the past year? □ None

If so, please explain. _____

On average, how many hour do you sleep each night? _____

Have you gained/lost more than 10 pounds in the past month? □ Yes □ No How much? _____

Do you suffer from chronic pain? □ Yes □ No How long has this been a problem? _____

LEGAL HISTORY OF YOUTH (all questions relate to the youth's history)**:**

Do you have any pending legal charges? _____

SUBSTANCE ABUSE HISTORY OF YOUTH (all questions relate to the youth's history)**:**

Do you drink coffee/caffeinated drinks? □ Yes □ No How much? _____ How often? _____

Do you smoke cigarettes? □ Yes □ No How much? _____ How often? _____

Do you drink alcohol? □ Yes □ No How much? _____ How often? _____
Which kind(s)? _____

Do you use other drugs? □ Yes □ No How much? _____ How often? _____
Which one(s)? _____

COUNSELING HISTORY OF YOUTH (all questions relate to the youth's history)**:**

Are you currently seeing a psychiatrist? □ Yes □ No

Psychiatrist Name: _____ Phone #: _____

Have you ever had **individual** counseling? □ Yes □ No For how long? _____

Name and Location of Counselor: _____ Was counseling helpful? □ Yes □ No

Have you ever had **family** counseling? □ Yes □ No For how long? _____

Name and Location of Counselor: _____ Was counseling helpful? □ Yes □ No

Has anyone in your family ever been diagnosed or treated for any type of mental illness? □ Yes □ No

If yes, who and which type? _____

Has anyone in your family ever been hospitalized for any type of mental illness? □ Yes □ No

If yes, who, which hospital, and dates of stay? _____

_____

Have you ever tried to harm yourself? □ Yes □ No When? _____

What was your plan? _____

Have you ever tried to harm someone else? □ Yes □ No When? _____

What was your plan? _____

Do you have any fears about the counseling process that need to be addressed for you to get the most out of your experience? _____

PERSONAL HISTORY OF YOUTH (all questions relate to the youth's history)**:**

Highest level of education: _____

Did you have any difficulty in school? If so, please explain.

Learning disability? _____

Behavior problems? _____

Current Hobbies/Activities: _____

What are your strengths? _____

What weaknesses do you struggle with the most? _____

Do you want your counselor to incorporate faith/spiritual issues into your counseling? □ Yes □ No

Do you believe in God? □ Yes □ No Do you have a religious preference? _____

How much influence does religion have on your daily activity? □ A lot □ Average □ A little □ None

Is there any other information you want me to know about you and your situation?_____

_____

_____

_____

REASONS FOR SEEKING HELP:

Please describe why you are seeking counseling **now**: _____

_____

_____

_____

_____

THIS SECTION IS RELATED TO THE PARENTS CONCERNS

Where are your concerns causing the most problems for you? (please check all that apply)

□ Home □ Work □ Marriage □ Other Relationships □ God

Indicate how stressed you are by placing an "X" on the scale (1 = Very Little Stress; 10 = Extreme Stress)

1 2 3 4 5 6 7 8 9 10

Please check any of the following problems that apply to you and/or your family:

Abortion	□ You	□ Family	□ Child	Loneliness	□ You	□ Family	□ Child
Aggressiveness	□ You	□ Family	□ Child	Marriage	□ You	□ Family	□ Child
Alcohol Use	□ You	□ Family	□ Child	Memory	□ You	□ Family	□ Child
Anger	□ You	□ Family	□ Child	Mood Swings	□ You	□ Family	□ Child
Anxiety	□ You	□ Family	□ Child	Nervousness	□ You	□ Family	□ Child
Bad Dreams	□ You	□ Family	□ Child	Obsessions	□ You	□ Family	□ Child
Career Concerns	□ You	□ Family	□ Child	Panic	□ You	□ Family	□ Child
Childhood Abuse	□ You	□ Family	□ Child	Physical Abuse	□ You	□ Family	□ Child
Children	□ You	□ Family	□ Child	Pregnancy	□ You	□ Family	□ Child
Communication	□ You	□ Family	□ Child	Recent Death	□ You	□ Family	□ Child
Concentration	□ You	□ Family	□ Child	Recent Loss	□ You	□ Family	□ Child
Depression	□ You	□ Family	□ Child	Risky Behavior	□ You	□ Family	□ Child
Disaster	□ You	□ Family	□ Child	Self-Control	□ You	□ Family	□ Child
Divorce	□ You	□ Family	□ Child	Self-esteem	□ You	□ Family	□ Child
Drug Use	□ You	□ Family	□ Child	Sexual Abuse	□ You	□ Family	□ Child
Eating Problem	□ You	□ Family	□ Child	Sexual Problems	□ You	□ Family	□ Child
Emotional Abuse	□ You	□ Family	□ Child	Shyness	□ You	□ Family	□ Child
Fatigue	□ You	□ Family	□ Child	Sleep Problems	□ You	□ Family	□ Child
Fears	□ You	□ Family	□ Child	Stress	□ You	□ Family	□ Child
Finances	□ You	□ Family	□ Child	Suicidal Thoughts	□ You	□ Family	□ Child
Friends	□ You	□ Family	□ Child	Temper	□ You	□ Family	□ Child
Gambling	□ You	□ Family	□ Child	Trauma	□ You	□ Family	□ Child
Grief	□ You	□ Family	□ Child	Trouble w/job	□ You	□ Family	□ Child
Guilt	□ You	□ Family	□ Child	Unhappiness	□ You	□ Family	□ Child
Hopelessness	□ You	□ Family	□ Child	Verbal Abuse	□ You	□ Family	□ Child
Headaches	□ You	□ Family	□ Child	Violence	□ You	□ Family	□ Child
Health Issues	□ You	□ Family	□ Child	Other: _____	□ You	□ Family	□ Child
Legal Problems	□ You	□ Family	□ Child				

What do you hope to gain from counseling? _____

_____

_____

_____

_____

_____

CLIENT RIGHTS & RESPONSIBILITIES

Youth Name/Age _____

Parent Name _____

Name of Counselor: **Carolyn "Janie" Stubblefield, M.A.**
License Type: **Licensed Professional Counselor - Supervisor** Texas License # **62980**

To report a rules violation by this licensee, contact:

The Texas State Board of Examiners of Licensed Professional Counselors
P.O. Box 141369
Austin, TX 78714-1369
800-942-5540

METHOD OF TREATMENT

Counseling methods combine Brief and Solution-Focused therapy with Family Systems principles and an emphasis on relationship dynamics. A positive approach to problems is taken, believing that people are resilient and have tremendous resources to address life's situations. It is the role of the counselor to help the client understand the dynamics of his/her situation and to assist him/her in using their particular strengths to address these issues. In family counseling, each member of the family must acknowledge and address their part in the process of change for the most effective outcomes. It is the client's responsibility to provide detailed and accurate information for the best evaluative response.

GOALS, RISKS & BENEFITS

There is always a risk of emotional side effects from counseling. *Sometimes symptoms worsen before they get better*. Often counseling brings up painful emotions. Your counselor's goal is to confront issues and emotions together and to work through them over time. Other types of counseling such as support groups or therapy groups may also be appropriate in a particular situation. Together, the client and counselor will determine if one or more types of counseling are appropriate for the individual/family situation.

LENGTH OF TREATMENT

Length of treatment will vary and will be determined together by the client and counselor. Each individual and relationship has unique strengths and weaknesses, and each problem is different from the next. The goal is that each client will finish counseling in a timely manner, without unnecessary use of time.

GREIVANCES

I also acknowledge that I may submit a Grievance to the Provider at any time to register a complaint about any aspect of my care or with the administrator of Mobile Counseling by calling (214) 542-5642. If I am not satisfied with the responses I receive, I may submit the Grievance to the address below:

To report a rules violation by this licensee, contact the Licensing Board:

Texas State Board of Examiners of Licensed Professional Counselors
P.O. Box 141369
Austin, TX 78714-1369 (1-800-942-5540)

APPOINTMENTS

Together, the client and counselor will make decisions concerning how often and for how long they should meet. In the event the client is unable to keep an appointment, notification is required at least 24 hours in advance. If you fail to provide the required notification in a timely manner, you will be charged the full appointment fee. An exception may be made if your counselor deems the situation an emergency.

RIGHT TO PRIVACY/CONFIDENTIALITY

All communication between the client and counselor becomes part of the clinical record. Records are the property of the counselor in accordance with legal requirements, adult client records are disposed of five years after the file is closed; minor client records are disposed of five years after the file is closed; and all records will be destroyed by the managing conservator of the counselor's estate upon death of the clinician (reasonable efforts will be made to contact the client before destruction of the file).

While most communication between a client and counselor is confidential, the following limitations and exceptions do exist:

- The counselor determines the client is a danger to himself or someone else.
- The client discloses abuse, neglect or exploitation of a child, elderly or disabled person.
- The client authorizes the counselor to release records to another professional.
- The counselor is ordered by a court to disclose information.
- The counselor is otherwise required by law to disclose information.
- Insurance claims audit.

In marriage or family counseling, confidentiality belongs primarily to the relationship and not solely to the individual.

EMERGENCIES

The client can call the counselor at (214) 542-5642. If the client is unable to reach his counselor in a timely manner, he should contact his physician, a local emergency room, the local police department, or 9-1-1 when necessary and appropriate. It is the client's responsibility to seek the appropriate resources in emergency situations.

By your signature below, you indicate that you have read and understood this statement, and any questions about this statement were answered to your satisfaction. You also indicate that you have received a copy of this statement for your records. Your counselor's signature verifies the accuracy of this statement and acknowledges his/her commitment to conform to its specifications.

Client Signature:_____ Printed Name: _____ Date: _____

Parent Signature:_____ Printed Name: _____ Date: _____

Counselor Signature:_____ Printed Name: *Janie Stubblefield, M.A., LPC* Date: _____

MOBILE COUNSELING, PLLC

FEE POLICY (update 1/1/2018)

COUNSELING SERVICES OFFERED[1]:

MOBILE COUNSELING, PLLC offers services by fully licensed professional counselors as well as counseling services conducted by counseling interns and counseling students. The following is the fee schedule for the various counseling services.

Licensed Professional Counselor (LPC) and Licensed Professional Counselor-Supervisor (LPC-S) Fully licensed to practice independently by the state of Texas.

Licensed Professional Counselor – Intern (LPC-Intern)
Completed Master's Degree in Counseling and passed state board exam, and currently completing 3000 hours of supervised experience for licensure.

Counseling Student
Currently enrolled in an accredited Master's level counseling program (sessions may be video taped for review).

FEE SCHEDULE:

	Office Visits	Home Visits	Online Sessions
LPC			
Intake Session (up to 90 minutes)	$150.00	$150.00	$150.00
Regular Session (up to 60 minutes)	$125.00	$125.00	$125.00
Group Session	$30.00	n/a	n/a
LPC-Intern			
Intake Session (up to 90 minutes)	$75.00	$75.00	n/a
Regular Session (up to 60 minutes)	$60.00	$60.00	n/a
Group Session	$30.00	n/a	n/a
Counseling Student			
Intake Session (up to 90 minutes)	$30.00	n/a	n/a
Regular Session (up to 60 minutes)	$20.00	n/a	n/a
Group Session	$30.00	n/a	n/a
Specialized Services (all levels)			
Bio-feedback (all varieties)	$10.00	$10.00	n/a
EMDR	$10.00	$10.00	n/a
Play Therapy	$10.00	$10.00	n/a

[1] Note: These prices are for standard professional counseling services only. Please ask your counselor for a list of other fees for extended services if needed (i.e., clinical report services, professional consultation services, etc.).

CANCELLATION POLICY

The **full session fee** (paid by the client not insurance) is charged for any appointments that are not cancelled **at least 24 hours in advance**. For your convenience, you may provide notice of cancellation by e-mail (info@mobilecounselingdallas.com) or voice-mail (214-542-5642) or directly to your counselor.

ASSIGNMENT OF BENEFITS FOR INSURED PATIENTS:

I _____ authorize all insurance payments for myself and my dependents to be made to **CAROLYN "JANIE" STUBBLEFIELD, MA, LPC-S** (Texas professional license number 62980) or **MOBILE COUNSELING, PLLC**. This agreement will remain in effect until revoked by me in writing. I understand that this order does not relieve me of my obligation to pay such bills if not paid by my insurance company, or any balance due after payments by my insurance company.

It is the patient's responsibility to provide correct insurance information in order to file claims properly with the insurance company. Claims not paid due to incorrect information will then become the patient's responsibility.

_____ _____

SIGNATURE DATE

PATIENT PAYMENT RESPONSIBILITIES:

As a courtesy to you, we are pleased to file **PRIMARY INSURANCE BENEFITS** with contracted carriers. Please remember, however, that you are ultimately responsible for payment should your insurance carrier deny payment for any service provided. Payment for deductibles and co-pays are due at the time of service. **MOBILE COUNSELING, PLLC** accepts cash, checks, and credit cards.

MOBILE COUNSELING, PLLC will charge your account within 24 hours of counseling appointment.
For credit card processing, please complete the following:

TYPE OF CARD ❑ AMEX ❑VISA ❑ MC ❑ DISCOVER

ACCOUNT # _____ EXP. DATE _____

THREE DIGIT CID NUMBER (4 DIGIT FOR AMEX) _____

CARDHOLDER'S NAME _____

BILLING ADDRESS _____

_____

I agree to the above terms and authorize MOBILE COUNSELING, PLLC *to charge any payment for counseling services, missed appointments, or outstanding balances including return check fees and charges denied by insurance to the above credit card.*

_____ _____

SIGNATURE DATE

MOBILE COUNSELING
HIPAA Notice of Privacy Practices

Understanding that **MOBILE COUNSELING** cannot guarantee confidentiality or security through any telephonic or electronic communication, I request the following:

_____ e-mail correspondence regarding appointments to the following account

_____

_____ telephone and voice message correspondence regarding appointments to the following number(s)

_____

_____ text correspondence regarding appointments to the following number(s)

_____

_____ other: _____

My signature below indicates that I have received a copy of, read, and understand the Health Information Portability and Protection Act (HIPPA) updated September, 2013. I also release **MOBILE COUNSELING** *and any affiliate from liability related to the above requests.*

_____ _____

Printed Name Date

_____

Signature