Travis Christian Counseling
www.traviscounseling.com

114 East 6th Avenue
Belton, TX 76513
Phone: 254-421-3896

The following pages contain vital information for your counseling process. **Please read its contents carefully** and bring it completed to your first counseling session. Thank you.

COUNSELING INTAKE INFORMATION

Client's Name: _____ Therapist's Name: _____

HOW DID YOU HEAR ABOUT US?

___Church
Which church? _____
What pastor? _____
___ Personal friend
___ Insurance company list
___ Employee Assistance Program through your employer
___ www.traviscounseling.com
___psychologytoday.com
___ Online search
Which site? _____
___ Doctor
What is the doctor's name? _____
___Other
Please specify: _____

PERMISSION TO CONTACT YOU BY E-MAIL

From time to time, for your convenience we may contact you via e-mail about appointment times with your permission. This is one of the ways we may confirm appointments or contact clients. We will always be discreet; the name of this office will not be used in our correspondence. For example, we would say, "Reminding you of your appointment with (therapist's name) on Tuesday, March 17th at 2:00 pm. Please confirm, cancel, or reschedule. To assure absolute confidentiality, we will correspond via e-mail ONLY about appointment dates and times. We will NEVER disclose other information in e-mails even if you solicit a reply pertaining to another matter or issue.

I give permission to contact by email ___YES _____NO

I give permission to contact by text ___ YES ___NO

My home e-mail address is _____

My cell number to text is _____

Signature _____

Date _____

CONFIDENTIALITY INFORMATION---PROFESSIONAL SERVICES AGREEMENT

Travis Christian Counseling is concerned about confidentiality. As Christian counselors, we believe God expects us to be trustworthy and we believe it is God's will for His people to know safety and security. It is the goal of Travis Christian Counseling to provide an environment in which our clients may place their trust and confidence. Under both federal and state law, confidentiality means communication with your therapist and any records pertaining to your identity, evaluation, or treatment will be held in confidence. Where federal and state laws differ, we comply with the stricter standard to ensure that your right to confidentiality is respected at all times. Also, beyond the law, we know that a sense of safety and security are necessary to the process of healing in which our clients are engaged. Finally, we are happy to honor your written wishes to release information to parties you choose, but cannot be held liable for the distribution of that information once it has been sent. Holding to God's law as stated in His Word and by complying with federal and state laws, Travis Christian Counseling will maintain confidentiality to the fullest extent personally and professionally. You have a right to confidentiality.

Our Confidentiality Policy and Privacy Practices Brochure is available online at www.traviscounseling.com for you to read at any time. You will also be offered a copy of the brochure during your initial session.

Please read the document before signing this agreement

If you believe the Confidentiality Policy and Privacy Practices document does not answer all of your questions regarding confidentiality, talk with your therapist about any concerns you may still have.

Your signature at the end of the document indicates consent to use your personal health information for routine practices according to the law for treatment, payment, and health care operations. You may revoke this consent in writing at any time, except to the extent that Travis Christian Counseling has taken action relying on this consent.

RIGHTS AND RESPONSIBILITIES

Rights You have the right to be provided with professional and respectful care. You have the right to know your therapist's assessment of the problem, the recommended treatment, and resources available to help deal with your situation. You also have the right to refuse our suggestions.

Responsibilities

1. To be honest, open, and willing to share your concerns
2. To ask questions when you don't understand or need clarification
3. To discuss any reservations you have about your treatment plan
4. To follow agreed upon treatment plan
5. To report changes or unexpected events related to your problem
6. To keep appointments whenever possible or to call and cancel within 24 hours prior to your appointment. (see payment information – you will be charged a $75.00 fee for appointments not cancelled with 24-hour notification unless you and your therapist have a previously agreed upon alternative fee)
7. To not electronically record any aspect of yours or anyone else's experience while on Travis Christian Counseling premises.

Remember, you are responsible for your thoughts, feelings, actions, and growth. We are here to help facilitate that growth to the best of our ability.

PAYMENT INFORMATION

The following information is provided to avoid any misunderstanding or disagreement concerning your payment for professional services.

The fee for the 55-minute therapy sessions is $125.00. It is the same for individual, couple, or family therapy. Payment is expected at the time of service.

As a courtesy, Travis Christian Counselling (TCC) will file your insurance claims with your signed consent. TTC charges for missed appointments. TTC charges a $75.00 fee to your credit card for appointments that are not cancelled with 24-hour notification. Each of these payment requirements are discussed below.

Insurance

1. If you have managed care or employee assistance through your employer or through a private policy, TCC will file your insurance with your consent. Sign the insurance information sheet if you want us to file as a courtesy for you.
2. Co-payments must be made at the time of service.
3. If you have not met your required deductible, the regular fee of $125.00 per session is expected at time of service. We will then file the claim so that the amount is applied to your deductible.
4. If you are seeing a provider that is in your managed care network (In Network), your fee will be the negotiated rate as stated in the contract between the network and your therapist.
5. If you are seeing a provider that is not in your managed care network (Out of Network), you are responsible for the amounts your insurance does not pay up to $125.00 per session.
6. For clients using Employee Assistance Program (EAP), there is no charge for a set number of authorized sessions.
7. If you authorize this office to file insurance by your signed consent, we will do so, but you must understand that your insurance coverage is an agreement between you and your insurer. It is your responsibility to remit payment for charges not covered by the claim. If a problem occurs with your claim, you will be required to make payment or to establish a mutually agreed upon written financial payment plan with our office until your insurance problem is resolved. Periodically, insurance plans change, resulting in greater obligation for the client. You are expected to pay any balance in such cases.

Financial Payment Arrangements

1. There is a $35.00 service charge for returned insufficient fund checks. After the returned check, we will only accept cash or debit cards for payments for services rendered.

Appointment Cancellation Policy

Twenty-four hour (24) notification is an expected courtesy to the therapist who is reserving time for you and to other clients who are waiting to schedule appointments. You must give 24 hour advance notification for cancelled appointments. The advance notice is standard in our profession.

If you miss an appointment without 24 hour notification, you will be charged the $75.00 fee. If you do not notify us 24 hours in advance when cancelling an appointment, you will be charged the $75.00 fee. Insurance plans rarely pay for such charges.

Travis Christian Counseling has a 24 hour voicemail system to assist you in cancelling appointments in a timely manner. Please leave the time of your call as part of your voicemail message in order to make sure that you are not charged when you have given 24 hour notification. You may also text to the business phone, 254-421-3896.

1. You will receive written notification of the missed appointment and a bill for the agreed upon amount within a few days of the previously scheduled appointment time. If you think there is an error, contact our office immediately.
2. You must pay for the missed appointment charge in full at your next scheduled visit OR make a partial payment and arrange a payment plan.

3. Payments must be made in addition to other co-pay amounts or deductibles that may be due on subsequent visits.
4. Payment must be timely or we CANNOT continue to schedule appointments.

SIGNATURE FOR PROFESSIONAL SERVICES AGREEMENT

I do voluntarily agree to participate in the assessment and counseling as offered by Travis Christian Counseling. I am aware that treatment often involves family therapy or education which will be recommended if the therapist deems it important to the healing process. I acknowledge that no guarantees have been made to me regarding the outcome of my therapy. I understand my rights and responsibilities as stated in this document.

I consent to the use of my personal health information for routine practices for treatment, payment, and health care operations according to the laws of the State of Texas and the Federal government as outlined in the Confidentiality Section of this document and discussed in detail in the Confidentiality Policy and Privacy Practices Brochure.

I have been offered a copy of this Brochure.

I have read and agreed to the payment information as stated in this document.

I understand I may be charged for appointments that are not cancelled within 24 hours or for appointments I miss altogether.

By my signature below, I accept all terms and conditions as herein stated.

Client's Name _____

Client's Signature _____ Date _____

*Parent/Guardian's Signature _____ Date_____

*(required if client is 17 or under-in some cases the therapist may require legal documentation of guardianship of children 17 or under)

TRAVIS CHRISTIAN COUNSELING

Credit Card Authorization

(All clients must have credit card on file to receive services at this office.)

Please make no marks or add comments to this page of the document. It is your consent to make payment for services rendered and your treatment is conditional on your signing this consent form without modification. This form will be securely stored in your clinical file and may be updated upon request at any time.

In the case that you miss or fail to cancel an appointment within 24 hours of the scheduled time, or if a check is returned unpaid, you will be charged the full session fee. An additional $35 fee will be assessed for 1) returned checks, and 2) inaccurately disputed claims/charge backs.

I, _____, hereby authorize Travis Christian Counseling TCC to bill my credit card at the usual fee for professional services including all of the following:

- Appointments and/or copayments that I elect to pay for by credit card
- Missed appointments
- Telephone and email consultations
- Appointments that I have cancelled with less than 24 hours notice
- Returned checks
- Fees not covered by insurance or insurance payments made to patient rather than provider

Credit Card Type (check one):

____ Visa ____ MasterCard ____ Discover ____ American Express

Card # _____ Expiration Date: _____

Name as Printed on Card: _____

Verification/Security Code (3 digit code on back of card by signature line): _____

Billing Address: _____

City: _____ State: _____ Zip: _____

By signing below I am authorizing Travis Christian Counseling TCC to bill my credit card at the usual fee for professional services. I will not dispute charges ("charge back") for sessions I have received or appointments I have missed according to the above policy.

Signature: _____ Date: _____

Print Name: _____

CLIENT'S PERSONAL DATA

Today's Date: _____

Client's Name:_____ **Birth Date**:_____ **SS#**: _____
Is the client a minor (age 17 or younger)? YES_____ NO _____

Street Address: _____

City, State, Zip:_____

Home Phone:_____ **Work Phone**:_____

Cell Phone: _____ **Other Phone**: _____

Marital Status: Married (No. of years): ____ **1st Marriage**___ **2nd**___ **3rd**___ **Single**:____ **Separated** (since): _____
Divorced (since when): ____ **Living together, Not Married:** ____

Education (last year completed): _____ **Degree:** _____

Client's Occupation: _____ **Employer:** _____

If client is a minor, complete this section. Fill in all that apply.

Birth Mother's Name: _____ Step Father's Name: _____
Birth Father's Name: _____ Step Mother's Name: _____

Name of Responsible party: _____

Street address of responsible party: _____

City, State, Zip: _____

Who brought the minor in for counseling? _____

Who is the legal guardian for the minor client? _____

What is your relationship to the minor client if none of the above? _____

If divorce or a temporary order has precipitated arrangements, please provide a copy ASAP, particularly if one parent is sole conservator. If applicable, who is the sole conservator? (see child intake form) _____

Please list all members of your household:

Name - Relationship	Birth Date - Age	Sex

EMERGENCY CONTACT INFORMATION

Whom should we contact in case of an emergency? Name/Phone #____ _____
Name/Phone #_____

SPIRITUAL INFORMATION

Religion: _____
Do you consider yourself a Christian? YES _____ NO _____
If yes, when did you become a Christian? _____

My relationship with God is _____
I find my religion: Satisfying ____ Challenging ____ Dull____ Meaningless ____
Do you desire prayer and/or Bible reading as part of your counseling? YES _____ NO _____

Church Denomination: _____

What church do you attend? _____ Pastor: _____

How often do you attend worship services? _____

MEDICAL HISTORY

Name of Primary Physician: _____ **Phone #:** _____

List any medical conditions: _____
_____

Are you currently taking any medications? YES _____ NO _____
If so, please identify medication, dosages, and times taken: _____
_____

List any anti-depressants or similar medications you have taken in the past: _____
_____

Are you allergic to any medications? YES _____ NO _____
If yes, what are they? _____

SUBSTANCE USE HISTORY

	YES	NO	MAYBE
1. Do you drink alcoholic beverages?			
2. Have you or a family member ever been concerned about your alcohol usage?			
3. Have you ever been concerned about another family member's alcohol usage?			
4. Do you have a history of illegal drug use or prescription abuse?			
5. Have you or a family member ever been concerned about your illegal drug use or prescription drug abuse?			
6. Have you ever been concerned about another family member's illegal drug use or prescription drug abuse?			
7. Do you smoke cigarettes or other tobacco products?			
8. Have you been treated for an eating disorder?			
9. Do you use pornography or related material?			
10. Do you gamble at least once a month?			

LEGAL DATA

Are there any legal cases pending? YES _____ NO _____

Briefly describe the nature of those cases: _____
_____

Do you expect the counseling process to be part of any legal proceedings now or in the future? YES _____ NO_____

FAMILY

Where were you born? _____
Where did you grow up? _____
Mother's Name_____ **Age**:_____ **Occupation**:_____
Father's Name_____ **Age**:_____ **Occupation**:_____
How many siblings do you have?: **Brothers**:_____ **Ages**:_____
Sisters:_____ **Ages**:_____
You were child number ___ of ____ in the birth order.
Briefly describe your childhood: _____
Have you ever had a history of: ABUSE/TRAUMA ____ ABANDONMENT ____ LEGAL ISSUES ____
SCHOOL PROBLEMS ____
Briefly describe your family members:
Mother:_____
Father:_____
Brothers:_____
_____
Sisters:_____
_____
How does your family communicate?
_____
How is affection shown in your family?
_____
_____
How did your family celebrate birthdays or other holidays?
_____

Were both parents in the home? YES ____ NO ____
If not, please explain:_____

Briefly describe how close you are with your mother:
_____
_____
Briefly describe how close you are with your father:
_____
_____
Briefly describe how close you are with your siblings:
_____
_____
What are some things your family values?
_____
_____
How did your mother discipline you?
_____
_____
How did your father discipline you?
_____
_____
What would you change about your family?
_____
_____

PSYCHOSOCIAL INFORMATION

List some fun or enjoyable events in your childhood:

_____

_____

List any painful memories in you experienced as a child:

_____

_____

Life as a teen focused around:

_____

_____

Life now focuses around:

_____

_____

List some hobbies or activities you enjoyed doing as an adolescent:

_____

_____

List some activities you enjoy doing now?

_____

_____

Who do you do these activities with? (check all that apply)

ALONE ____ FRIENDS ____ FAMILY ____ SPOUSE ____ CHILDREN ____

ADULT CHECKLIST OF CONCERNS

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Other concerns and issues." You may add a note or details in the space next to the concerns checked.

	I have no problem or concern		Impulsiveness		Self-abuse – other
	Abuse – emotional		Indecision		Self-abuse – scratching
	Abuse - neglect		Inferiority Feelings		Self-centeredness
	Abuse – physical		Inhibitions		Self-control
	Abuse – sexual		Interpersonal Conflicts		Self-esteem
	Aggression		Irresponsibility		Self-neglect
	Anger		Irritability		Separation
	Anxiety		Judgment Problems		Sexual Conflicts
	Arguing		Laziness		Sexual Desire Differences
	Attention Problems		Legal Matters		Sexual Dysfunction
	Career Concerns		Loneliness		Sexual – other issues
	Childhood Issues		Loss of Control		Shyness
	Children – care of		Losses		Sleep – insomnia
	Children – custody		Low Energy		Sleep – nightmares
	Children – management		Low Frustration Tolerance		Sleep – too little
	Codependence		Low Income		Sleep – too much
	Compulsive Spending		Low Mood		Step-parenting
	Concentration Problems		Marital Coldness		Stress
	Confusion		Marital Conflict		Stress-management
	Crying		Marital Distance		Suicidal Thoughts
	Deaths		Marital Infidelity/Affairs		Suspiciousness
	Debt		Medical Concerns		Temper Problems
	Decision Making		Memory Problems		Tension/Stress
	Delusions – false ideas		Menopause		Thought Disorganization
	Dependence		Menstrual Problems		Threats of Violence
	Depression		Mixed Feelings		Tiredness
	Distractibility		Mood Swings		Tobacco Use
	Divorce		Motivation		Violence
	Drug abuse – over the counter		Mourning		Violence – victim of crime
	Drug abuse – prescription		Obsessions		Work Problems
	Drug abuse – street drugs		Outbursts		Weight and Diet Issues
	Drug abuse – alcohol		Oversensitive to Criticism		Withdrawal – isolating
	Eating – poor appetite		Oversensitive to Rejection		Employment Problems
	Eating – making myself vomit		Panic or Anxiety Attacks		Employment – lack of
	Eating – overeating		Parenting		Employment – overdoing
	Eating – under-eating		Perfectionism		Employment – termination
	Emptiness		Pessimism		**Other Concerns or Issues:**
	Failure		Phobias		
	Fatigue		Physical Problems		
	Fears		PMS		
	Financial Troubles		Poor Self-Care		
	Friendship Problems		Procrastination		
	Gambling		Relationship Problems		
	Goals Not Being Met		Relaxation		
	Grieving		Re-marriage		
	Guilt		Risk Taking		
	Headaches, Pains		Sadness		
	Health		School Problems		
	Hostility		Self-abuse – burning		
	Impulsive Spending		Self-abuse – cutting		

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:

COUNSELING DETAILS

Briefly describe your current difficulty: _____

What are your goals you hope to achieve through counseling? _____

Have you ever been to counseling before? YES ____ NO ____ **Support/Recovery Groups:** YES ____ NO ____

If yes, identify counselor and the dates: _____

Have you ever been hospitalized for mental health reasons? YES ____ NO ____

If yes, when, where, and why were you hospitalized?_____

Briefly explain the nature and outcome of that counseling: _____

FOR OFFICE USE ONLY: _____

INSURANCE INFORMATION SHEET

It is important that you thoroughly complete this form and provide a copy of both sides of your insurance card(s).
Thank you.

Therapist's Name: _____

CLIENT INFORMATION
Name: _____ **Birth Date:** _____

Address: _____ **SS#:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Mobile Phone:** _____

Employer: _____

Is client a dependent child? YES ____ NO _____ **Marital Status** (circle one) **M S Other**

PRIMARY INSURANCE INFORMATION
Who is the insured? _____ **SS#:** _____ **Birth Date:** _____
Relationship to Client: _____
Employer of the insured: _____ **Work Phone:** _____
Insurance Company Name:_____
Member ID#:_____ **Group ID#:**_____
Customer Service Phone: _____ **Mental Health Phone:** _____

DO YOU HAVE SECONDARY INSURANCE?
YES ____ NO ____
Who is the insured? _____ **SS#:** _____ **Birth Date:** _____
Relationship to Client: _____
Employer of the insured: _____ **Work Phone:** _____
Insurance Company Name: _____
Member ID#: _____ **Group ID#:**_____
Customer Service Phone: _____ **Mental Health Phone:** _____

DO YOU HAVE EAP?
YES ____ NO ____
Name of EAP: _____ **Phone of EAP:** _____
Authorization #: _____ **Sessions Authorized:** _____ __ From_____ To _____

I authorize the release of any medical or other information necessary to process an insurance claim. I understand that Travis Christian Counseling will diligently attempt to get accurate information regarding my mental health insurance benefits. I will not hold Travis Christian Counseling liable for insurance nonpayment due to misquoted benefits. I will not hold TCC responsible to know and understand my benefits plan. Travis Christian Counseling will file my insurance claims for me as a courtesy. I am ultimately responsible for all charges my insurance company does not pay, except for contracted network provider discounts that may apply. I also request benefits be paid to Travis Christian Counseling and/or the provider indicated above.

Signature of Client and/or Insured: _____

Date: _____

Travis Christian Counseling
114 East 6th Avenue
Belton, TX 76513
Phone: 254-421-3896
Fax: 254-613-4381

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care options.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement of activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice on our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Travis ChristianCounseling
114 East 6th Avenue
Belton, TX 76513
254-421-3896

For more information about HIPAA or to file a complaint:

US Dept. of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201
Toll Free: 1-877-696-6775

Travis Christian Counseling
www.traviscounseling.com
114 East 6th Avenue
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Phone: 254-421-3896
Fax: 254-613-4381

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I have received, read, and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy **Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:
Relationship to Patient:
Signature:
Date:

OFFICE USE ONLY

_____

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason: