Grant Services Program

Mobile Counseling is pleased to offer grant funded professional counseling services to youth and families in the north Texas area to qualified families. These funds are limited to 10 Family Counseling sessions by the grant provider; however, the parent support classes may be accessed without limit as long as the case is open for services under the grant.

Please complete the attached documents BEFORE your schedule intake session.

Parent/Guardian signature needed on pages: 5, 8, 13, 14, 15, and 16
Youth signature needed on pages: 8 and 13

Your counselor will work to schedule your family counseling sessions to meet your family's schedule. **The parent support classes are held on Monday evenings from 6:00pm – 7:30pm** via Zoom (a link will be provided at your intake meeting).

Parents are offered counseling skills classes to support the work they are doing in their family counseling sessions. Families are encouraged to attend as many parent support classes to supplement the work being done in family counseling as these classes are designed to generate a healthy discussion with other participants. The following topics are discussed in the classes: communication, conflict resolution, decision making, problem solving, peer refusal skills, and anger management. Parents may attend as many classes as they choose for free while they are in the grant funded program. Once your grant services have ended, the cost for group classes is $30/family/class.

All families are eligible to continue their professional counseling services beyond the grant funded 10 family sessions at the current counseling rates:

	Office Visits	Home Visits	Online Sessions
LPC or LPC-S			
Regular Session (up to 60 minutes)	$125.00	$125.00	$125.00
Group Session	$30.00	n/a	$30.00
LPC-Associate			
Regular Session (up to 60 minutes)	$60.00	$60.00	$60.00
Group Session	$30.00	n/a	$30.00
Specialized Services (all levels)			
Bio-feedback (all varieties)	$10.00	$10.00	n/a
EMDR	$10.00	$10.00	$10.00
Play Therapy	$10.00	$10.00	n/a

INDEX CHILD/YOUTH INFORMATION

PEIRS ENROLLMENT ID NO.

*First Name:	Middle Name:
*Last Name:	Suffix: ☐ II ☐ III ☐ IV ☐ JR ☐ SR

*Date of Birth:	*Gender: ☐ Male ☐ Female	*SSN:

Primary Phone:	*Primary Email:

*Hispanic Origin (select only one): ☐ Hispanic ☐ Non-Hispanic ☐ Unable To Determine

*Race (select all that apply): ☐ American Indian/Alaska Native ☐ Asian ☐ Black ☐ Native Hawaiian/Pacific Islander ☐ Unable To Determine ☐ Declined to Indicate ☐ White

INDEX CHILD/YOUTH - PRIMARY ADDRESS INCLUDING APARTMENT/LOT # (Only list *one* address)

*Address:

*City:	*State: TX	*Zip Code:	*County:

INDEX CHILD/YOUTH - OTHER INFORMATION

*Disability Status: ☐ Yes ☐ No ☐ Not Assessed

Highest Education Attained

☐ Less than K	☐ 5th Grade	☐ 11th Grade	☐ Completed Associate Degree
☐ Kindergarten	☐ 6th Grade	☐ 12th Grade	☐ Some College
☐ 1st Grade	☐ 7th Grade	☐ Did Not Graduate	☐ College Graduate
☐ 2nd Grade	☐ 8th Grade	☐ Graduated H.S.	☐ Post Graduate
☐ 3rd Grade	☐ 9th Grade	☐ Received GED	☐ Not Assessed
☐ 4th Grade	☐ 10th Grade	☐ Post H.S. Technical Degree	☐ Other

Current Living Situation:

- ☐ I am staying in a public or private facility providing temporary shelter (i.e. shelter, mission, single room facility or motel)
- ☐ I live in my home which I own
- ☐ I live in my home which I rent
- ☐ I am staying with friends or family members on a temporary basis
- ☐ I live with parents or family members
- ☐ I live in public housing
- ☐ I live in some other stable arrangement
- ☐ I am incarcerated
- ☐ I am staying on the streets, in a car, park, sidewalk, abandoned building, or any unstable or nonpermanent situation
- ☐ I live in a foster care environment
- ☐ Not assessed

Expectant Parent: ☐ Yes ☐ No | Delivery Due Date:

Education Status: ☐ Licensed day care ☐ Certified Pre-K ☐ Elementary school ☐ Middle school ☐ High school ☐ College ☐ Tech training ☐ GED ☐ Not Enrolled ☐ Not Assessed

Is your current living situation a temporary arrangement due to housing loss or economic hardship?
☐ Yes ☐ No ☐ Not Assessed

PRIMARY PARTICIPATING CAREGIVER INFORMATION

Person ID NO.

***First Name**:	Middle Name:
***Last Name:**	Suffix: ☐ **II** ☐ **III** ☐ **IV** ☐ **JR** ☐ **SR**
***Date of Birth:**	***Gender:** ☐ **Male** ☐ **Female**
***Primary Phone:**	***Primary Email:**

***Hispanic Origin (select only one):** ☐ **Hispanic** ☐ **Non-Hispanic** ☐ **Unable To Determine**

***Relationship to Target Client:** ☐ Parent/Adoptive ☐ Foster Parent ☐ Stepparent ☐ Grandparent ☐ Aunt/Uncle ☐ Cousin ☐ Sibling ☐ Caregiver's Partner ☐ Fictive Kin ☐ Unrelated

***Race** (select all that apply): ☐ American Indian/Alaska Native ☐ Asian ☐ Black ☐ Native Hawaiian/Pacific Islander ☐ Unable To Determine ☐ Declined to Indicate ☐ White

***Disability Status:** ☐ Yes ☐ No ☐ Unknown

Primary Language Spoken in the Home: ☐ English ☐ Spanish ☐ Vietnamese ☐ Chinese ☐ Other ☐ Not Assessed

Marital Status: ☐ Single, Never Married ☐ Not married, but living together with partner ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Unknown

Highest Education Attained

☐ Less than K	☐ 5th Grade	☐ 11th Grade	☐ Completed Associate Degree
☐ Kindergarten	☐ 6th Grade	☐ 12th Grade	☐ Some College
☐ 1st Grade	☐ 7th Grade	☐ Did Not Graduate	☐ College Graduate
☐ 2nd Grade	☐ 8th Grade	☐ Graduated H.S.	☐ Post Graduate
☐ 3rd Grade	☐ 9th Grade	☐ Received GED	☐ Not Assessed
☐ 4th Grade	☐ 10th Grade	☐ Post H.S. Technical Degree	☐ Other

Military Status:
☐ No Military Service ☐ Not Indicated ☐ Active Duty ☐ Active Reserve ☐ Inactive Reserve ☐ National Guard ☐ Retired ☐ Veteran (discharge other than dishonorable) ☐ Discharged – Dishonorable

Current Living Situation:
- ☐ I am staying in a public or private facility providing temporary shelter (i.e. shelter, mission, single room facility or motel)
- ☐ I live in my home which I own
- ☐ I live in my home which I rent
- ☐ I am staying with friends or family members on a temporary basis
- ☐ I live with parents or family members
- ☐ I live in public housing
- ☐ I live in some other stable arrangement
- ☐ I am incarcerated
- ☐ I am staying on the streets, in a car, park, sidewalk, abandoned building, or any unstable or nonpermanent situation
- ☐ I live in a foster care environment
- ☐ Not assessed

Expectant Parent: ☐ Yes ☐ No | Delivery Due Date:

Is your current living situation a temporary arrangement due to housing loss or economic hardship?
☐ Yes ☐ No ☐ Not Assessed

SECONDARY PARTICIPATING CAREGIVER INFORMATION (Optional)

Person ID NO.

*First Name:	Middle Name:
*Last Name:	Suffix: ☐ II ☐ III ☐ IV ☐ JR ☐ SR
*Date of Birth:	*Gender: ☐ Male ☐ Female
*Primary Phone:	*Primary Email:

*Hispanic Origin (select only one): ☐ Hispanic ☐ Non-Hispanic ☐ Unable To Determine

*Relationship to Target Client: ☐ Parent/Adoptive ☐ Foster Parent ☐ Stepparent ☐ Grandparent ☐ Aunt/Uncle ☐ Cousin ☐ Sibling ☐ Caregiver's Partner ☐ Fictive Kin ☐ Unrelated

*Race (select all that apply): ☐ American Indian/Alaska Native ☐ Asian ☐ Black ☐ Native Hawaiian/Pacific Islander ☐ Unable To Determine ☐ Declined to Indicate ☐ White

Disability Status: ☐ Yes ☐ No ☐ Unknown

Primary Language Spoken in the Home: ☐ English ☐ Spanish ☐ Vietnamese ☐ Chinese ☐ Other ☐ Not Assessed

Marital Status: ☐ Single, Never Married ☐ Not married, but living together with partner ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Unknown

Highest Education Attained

☐ Less than K	☐ 5th Grade	☐ 11th Grade	☐ Completed Associate Degree
☐ Kindergarten	☐ 6th Grade	☐ 12th Grade	☐ Some College
☐ 1st Grade	☐ 7th Grade	☐ Did Not Graduate	☐ College Graduate
☐ 2nd Grade	☐ 8th Grade	☐ Graduated H.S.	☐ Post Graduate
☐ 3rd Grade	☐ 9th Grade	☐ Received GED	☐ Not Assessed
☐ 4th Grade	☐ 10th Grade	☐ Post H.S. Technical Degree	☐ Other

ADDITIONAL PARTICIPANT INFORMATION (Others attending sessions)

	*First Name	Middle Name	*Last Name	Suffix	*Gender	*Date of Birth	*Relationship to Client
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							

PREVENTION AND EARLY INTERVENTION (PEI) DIVISION
CLIENT REGISTRATION FORM
(*INDICATES REQUIRED FIELD)

Program

[X] Services to At-Risk Youth (STAR)

Contract ID No.	Subcontractor	Workflow	Planned Service Frequency
24555273	CCD Counseling PA	STAR	More than 2x Month

***Enrollment/Service Start Date**	***Initials of Intake Staff**	*** Initials of Staff Assigned to Family**
PEIRS Enrollment ID No.	CCD ID No.	CCD Staff Data Entry Name and Data

AUTHORIZATION FOR SERVICE

I have been provided information on the referenced Prevention and Early Intervention Program and wish to receive services. I understand that data on my child/youth/family will be collected, maintained, and entered into a secure database. The information will be utilized to track services for evaluation purposes and to ensure quality services are being provided. I hereby authorize my child/youth/family to participate in the program.

_____ _____
Signature of Parent or Guardian Date

_____ _____
Printed Name of Parent or Guardian Index Child/Youth Name

Authorization for Service must be completed per Index Child/Youth at enrollment and annually.

*CONTRIBUTING FACTORS *(Check all that apply)*

- ☐ Behavioral Concern
- ☐ Current or Former Military Connection
- ☐ Current or Past Alcohol Abuse - Caregiver
- ☐ Current or Past Alcohol Abuse - Youth
- ☐ Current or Past Child Maltreatment or Child Welfare Involvement
- ☐ Current or Past Conflict at School
- ☐ Current or Past Criminal Justice Involvement - Youth
- ☐ Current or Past Domestic or Interpersonal Violence
- ☐ Current or Past Use or Abuse of Other Substance - Youth
- ☐ Developmental Delay or Disability - Caregiver
- ☐ Developmental Delay or Disability - Index Child/Youth
- ☐ Family Dynamics/Structure Concern
- ☐ Family or Household Conflict
- ☐ High Stress Level
- ☐ Homeless/Runaway
- ☐ Household has a child with developmental delays or disabilities
- ☐ Household has a history of alcohol abuse or a need for alcohol abuse treatment
- ☐ Household has a history of substance abuse or needs substance abuse treatment
- ☐ Low School Attainment - Caregiver
- ☐ Low-Income Household
- ☐ Mental Health Concern - Caregiver
- ☐ Mental Health Concern - Index Child/Youth
- ☐ Parenting Skills Concern
- ☐ School Engagement Concern
- ☐ Social Support Concern
- ☐ Household contains an enrollee who is Pregnant and under 21

***PRIMARY LANGUAGE SPOKEN IN THE HOME**:

☐ English ☐ Spanish ☐ Vietnamese ☐ Chinese ☐ Other ☐ Not Assessed

***Referred By:**

- ☐ Self-Referral (Parent)
- ☐ Self-Referral (Youth)
- ☐ Friend/Relative
- ☐ School, daycare or other education provider
- ☐ Healthcare provider
- ☐ Clergy/Church
- ☐ Child Protective Services
- ☐ Law Enforcement
- ☐ Juvenile Justice System
- ☐ Texas Youth/Runaway Hotline
- ☐ 211 or other hotline
- ☐ Prior Participant
- ☐ Family Connects
- ☐ Other Community Agency: _____
- ☐ Other: _____

***Estimated Monthly Gross Income:** $_____ | *** # Household Members:** _____

I _____ choose not to share my child
(Caregiver's name)

_____'s Social Security Number
(Child's name)

because _____

_____

_____

_____
(Caregiver's signature)

Family Tree Counseling Program

You are receiving services from CCD Counseling PA (CCD) or an individual or organization that is a subcontractor for CCD. CCD administers the Family Tree Program for Denton and Dallas Counties. Those services are funded by the state of Texas through their Services To At-Risk Youth (STAR) Program. A CCD employee, the Family Tree Case Manager enters information about you and the services you receive into an electronic database maintained by the State of Texas.

Authorization for Release of Confidential Information

I hereby authorize CCD (including any subcontractor) to disclose any and all records and information concerning myself and/or my family's participation in the Family Tree program to the state funded STAR program.

The disclosure of information authorized herein is made for the following purposes:

1. For the billing and reporting of service delivery by CCD and/or their sub-contractors
2. For the management and administration of STAR services by the state, and,
3. To evaluate and maintain the quality services delivered to me and or my family.

In addition, I consent for a staff member at CCD to communicate with me by mail, email and by phone at the contact numbers and addresses I provide. I understand that information may be conveyed electronically and the privacy of those various communication methods cannot be guaranteed.

I understand that my records are protected under state and federal regulations and cannot be disclosed without my written consent, at any time, except to the extent that action has been taken in reliance to it. I further understand that because of these laws, neither CCD or a CCD subcontractor can provide STAR services to me or my family without this authorization. I also understand that this authorization is voluntary, and that other options are available to me. Other options include refusal of services, seeking alternative services, electing to fund my own services, and/or seeking services that have a different source of funding.

_____ _____
Signature of Youth Date

_____ _____
Signature of Parent, Guardian, or Managing Conservator Date

_____ _____
Signature of Parent, Guardian, or Managing Conservator Date

Protective Factors Survey for Caregivers			
PROGRAM STAFF USE ONLY			
PRE TEST ☐	IN SERVICE TEST ☐	POST TEST ☐	PEIRS Registration ID#
Caregiver First Name			Caregiver Last Name:
Caregiver DOB:			Today's Date:
Is this family member an expectant parent with no other children in the home?			Yes ☐ No ☐
Has this family member completed the program?			Yes ☐ No ☐

Thank you for taking the time to fill out this survey! The information will be used to evaluate the program. For each of the questions, please answer in your own opinion or experience instead of trying to answer for other members of your family. Please answer honestly. There are no right or wrong answers.

If you have any questions about one of the statements or the answer scale, ask one of the program staff. Please do not skip a question.

Part I. *Please circle the number that describes how often the statements are <u>true</u> for you or your family. The numbers represent a scale from 1 to 7 where each of the numbers represents a different amount of time. For example, the number 4 means that the statement is true about half the time.*

	Not Answered	Never	Very Rarely	Rarely	About Half the Time	Frequently	Very Frequently	Always	N/A
1. In my family, we talk about problems.	0	1	2	3	4	5	6	7	0
2. When we argue, my family listens to "both sides of the story."	0	1	2	3	4	5	6	7	0
3. In my family, we take time to listen to each other.	0	1	2	3	4	5	6	7	0
4. My family pulls together when things are stressful.	0	1	2	3	4	5	6	7	0
5. My family is able to solve our problems.	0	1	2	3	4	5	6	7	0

Part II. *Please **circle** the number that best describes how much you <u>agree or disagree</u> with the statement.*

	Not Answered	Strongly Disagree	Mostly Disagree	Slightly Disagree	Neutral	Slightly Agree	Mostly Agree	Strongly Agree	N/A
6. I have others who will listen when I need to talk about my problems.	0	1	2	3	4	5	6	7	0
7. When I am lonely, there are several people I can talk to.	0	1	2	3	4	5	6	7	0
8. I would have no idea where to turn if my family needed food or housing.	0	1	2	3	4	5	6	7	0
9. I wouldn't know where to go for help if I had trouble making ends meet.	0	1	2	3	4	5	6	7	0
10. If there is a crisis, I have others I can talk to.	0	1	2	3	4	5	6	7	0
11. If I needed help finding a job, I wouldn't know where to go for help.	0	1	2	3	4	5	6	7	0

Part III. *This part of the survey asks about parenting and your relationship with your child. For this section, please focus on the child that you hope will benefit most from your participation in our services. Please write the child's age or date of birth and then answer questions with this child in mind.*

Child's Age _____ or DOB _____/_____/_____

If you are expecting your first baby and there are no more children in your home, STOP here.

	Not Answered	Strongly Disagree	Mostly Disagree	Slightly Disagree	Neutral	Slightly Agree	Mostly Agree	Strongly Agree	N/A
12. There are many times when I don't know what to do as a parent.	0	1	2	3	4	5	6	7	0
13. I know how to help my child learn.	0	1	2	3	4	5	6	7	0
14. My child misbehaves just to upset me.	0	1	2	3	4	5	6	7	0

Part IV. *Please tell us how <u>often</u> each of the following happens in your family.*

	Not Answered	Never	Very Rarely	Rarely	About Half the Time	Frequently	Very Frequently	Always	N/A
15. I praise my child when he/she behaves well.	0	1	2	3	4	5	6	7	0
16. When I discipline my child, I lose control.	0	1	2	3	4	5	6	7	0
17. I am happy being with my child.	0	1	2	3	4	5	6	7	0
18. My child and I are very close to each other.	0	1	2	3	4	5	6	7	0
19. I am able to soothe my child when he/she is upset.	0	1	2	3	4	5	6	7	0
20. I spend time with my child doing what he/she likes to do.	0	1	2	3	4	5	6	7	0

Program Schedule/Parameters

Sessions

_____ 1st Session
_____ 2nd Session
_____ 3rd Session
_____ 4th Session
_____ 5th Session

If two classes were attended before the 5th session:

_____ 6th Session
_____ 7th Session
_____ 8th Session
_____ 9th Session
_____ Final Session

Classes

*_____ Youth/Parent Class
*_____ Youth/Parent Class
***Must be completed BEFORE your 5th session**
_____ Youth/Parent Class
_____ Youth/Parent Class
_____ Youth/Parent Class
_____ Youth/Parent Class
_____ Youth/Parent Class

Please initial the following statements to ensure understanding of program parameters:

_____ I understand that if I choose not to attend the classes before session #5, then I am choosing for the fifth session to be my final session.
_____ I understand that if I do not attend a session or class in 30 days my family's case will be closed.
_____ I understand that I may not be able to access these services again for a year after being closed.
_____ I understand that if I am more than 10 minutes late to my session, my counselor may not be able to see me for my scheduled appointment.

Client Rights & Responsibilities

Name of Parent/Guardian _____

Youth Name _____

Name of Counselor: _____

□ License Type: **Licensed Professional Counselor-Supervisor** Texas License # _____
□ License Type: **Licensed Professional Counselor** Texas License # _____
□ License Type: **Licensed Professional Counselor-Associate** Texas License # _____
□ under the supervision of **Carolyn "Janie" Stubblefield, MA. LPC-S, TX License #62980**
□ under the supervision of: _____

TO REPORT A RULES VIOLATION BY THIS LICENSEE, CONTACT:
THE TEXAS STATE BOARD OF EXAMINERS OF PROFESSIONAL COUNSELORS
333 Guadalupe St., Tower 3, Room 900
Austin, TX 78701
(512) 305-7700 or toll-free complaint system at (800) 821-3205

_____ **METHOD OF TREATMENT**

Counseling methods combine Motivational Interviewing 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. 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:
THE TEXAS STATE BOARD OF EXAMINERS OF PROFESSIONAL COUNSELORS
333 Guadalupe St., Tower 3, Room 900
Austin, TX 78701
(512) 305-7700 or toll-free complaint system at (800) 821-3205

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 seven years after the file is closed; minor client records are disposed of five years after their eighteenth birthday once 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

During office hours, the client can contact their counselor or Janie Stubblefield at (214) 542-5642. If the client is unable to reach their counselor in a timely manner, they should contact their 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 her commitment to conform to its specifications.

Guardian Signature:_____ Printed Name: _____ Date: ___

Guardian Signature:_____ Printed Name: _____ Date: ___

Youth Signature:_____ Printed Name: _____ Date: ___

Counselor Signature:_____ Printed Name: _____ Date: _____

MOBILE COUNSELING, PLLC
HIPAA Notice of Privacy Practices

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

_____ e-mail correspondence regarding <u>appointments</u> to the following account

_____

_____ telephone and voice message correspondence regarding <u>appointments</u> to the following number(s)

_____

_____ text correspondence regarding <u>appointments</u> to the following number(s)

_____

_____ other: _____

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

_____ _____

Printed Name Date

_____

Signature

MOBILE COUNSELING, PLLC

CONSENT FOR COUNSELING OF MINORS

Name of Parent/Guardian _____

Name of Minor _____Minor's Date of Birth _____

Name of Counselor: _____

□ License Type: **Licensed Professional Counselor-Supervisor** Texas License # _____
□ License Type: **Licensed Professional Counselor** Texas License # _____
□ License Type: **Licensed Professional Counselor-Associate** Texas License # _____
□ under the supervision of **Carolyn "Janie" Stubblefield, MA. LPC-S, TX License #62980**
□ under the supervision of: _____

This is to certify that I am the parent/legal guardian for the named child with full rights and authority to consent for the counseling/treatment services for this child. I give permission to **MOBILE COUNSELING, PLLC** for the treatment of my child. This counseling may include individual or family psychotherapy, counseling, and testing. This counseling may also include referrals to other appropriate state and county or professional agencies for further consultation, if necessary.

If the child no longer resides with both biological parents due to divorce or change in guardianship, please provide the legal paperwork regarding custody and guardianship information related to who is able to seek medical/psychological attention.
Date custody/guardianship paperwork was provided _____

If there is no formal custody paperwork:

I certify that I am the biological parent/legal guardian of the above named child. I certify that no formal custodial paperwork has been filed regarding this child and therefore cannot be provided.
Initials and Date discussed with therapist of record _____

I hereby waive my right as a parent to obtain information from and copies of any records from **MOBILE COUNSELING, PLLC** pertaining to the evaluation and treatment of the following child: _____ _____, age ____. I understand that **MOBILE COUNSELING, PLLC** *may* refuse to provide me, or any third party acting upon my request or authorization, with information and records pertaining to this child's mental health evaluation and treatment, if disclosure in the opinion of the child's therapist would negatively impact the child or the child's evaluation and treatment. I hereby release **MOBILE COUNSELING, PLLC** from any and all liability for good-faith refusal to disclose the child's private information or records.

Signature of Parent/Guardian_____ Date_____

Street Address _____

City/State/Zip _____

Home Phone _____Work Phone _____

Emergency Contact (Other than yourself):
Name _____ Phone _____

Counselor Signature:_____ Printed Name: _____ Date: ___

MOBILE COUNSELING, PLLC

LATE CANCELLATION AND NO SHOW POLICY (update January 2021)

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.

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-Associate			
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)	$40.00	n/a	n/a
Regular Session (up to 60 minutes)	$30.00	n/a	n/a
Group Session	$30.00	n/a	n/a

PATIENT PAYMENT RESPONSIBILITIES:

I authorize MOBILE COUNSELING, PLLC to charge my account within 24 hours of LATE CANCELLATION OR NO SHOW of a counseling appointment.

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